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Abstract

Purpose: This case study identifies rural health care stakeholder perspectives on the Affordable Care Act (ACA) and describes the health policy context in Idaho, the only state in the United States to reject Medicaid expansion yet develop a state-run health insurance exchange.

Sample: The sample included 20 rural health care stakeholders, including clinicians, elected officials, state agency administrators, health care facility administrators, and interest group leaders.

Method: A single-case study of stakeholder perspectives on the ACA and rural health care access in Idaho was conducted from 2014 to 2016. Data sources include qualitative interviews with 20

rural health care stakeholders and public documents relating to the ACA and rural health care from Idaho governmental and nongovernmental entities' websites.

Findings: Since the 2010 passage of the ACA, opposition to “Obamacare” became associated with a conservative stance on health care reform. However, in this case study, diverse health care stakeholders who criticized aspects of the ACA identified several components of the policy, including Medicaid expansion, as essential in ensuring access to rural health care. Some stakeholders called for federal legislation authorizing nurse practitioners to practice as independent primary care providers. However, the politics of medical sovereignty present challenges to this relevant strategy and to full implementation of Idaho’s Nurse Practice Act for increasing access to primary care in a rural state.

Conclusions: The case study approach can be effective in illuminating stakeholder perspectives and policy strategies that may fall outside of polarized health care policy debates. Examination of the state-level political context of rural health care must consider concurrent battles about state sovereignty over health care policy and professional-clinical battles about sovereignty over primary care.

Keywords: Affordable Care Act, case study, Idaho, rural health care policy, advanced practice nurses

Diverse Stakeholder Perspectives on Rural Health Care Reform in a U.S. State that Rejected the Affordable Care Act: A Case Study

Since the passage of the Affordable Care Act (ACA) in 2010, opposition to “Obamacare” has become associated with a uniform conservative stance on health care reform. However, in a

case study conducted in Idaho from 2014 to 2016, diverse health care stakeholders who criticized or expressed ambivalence about the ACA identified several of its policy components as essential for an effective rural health care system. In Idaho, the only state in the United States to reject Medicaid expansion yet develop a state-run health insurance exchange (Norris, 2017), rural health care stakeholders described Medicaid expansion as key to ensuring access to rural health care. Some stakeholders called for federal legislation that authorizes nurse practitioners (NPs) to practice as independent primary care providers, particularly relevant for rural states that struggle to recruit and retain physicians.

Here, we present a case study of Idaho, a rural, conservative state. Two major definitions of rural are used by the Federal government (U.S. Department of Health and Human Services [USDHHS], 2013). The first, developed by the United States Census Bureau (2015), identifies urbanized areas (UAs) as those with populations of 50,000 or more and urban clusters (UCs) as those with populations of between 2,500 and 50,000. Any area not designated as UA or UC is considered rural (USDHHS, 2013). The federal Office of Management and Budget (OMB, 2013) designates counties containing at least one city with a population of 50,000 or more as metropolitan and counties with city populations between 10,000 and 50,000 as micropolitan; any counties with city populations outside of those ranges are considered rural (OMB, 2013). Seventeen of the 20 interviewees in this study reside in areas of Idaho that meet the criteria for both of two federal rural definitions. Three nonrural residents were included because of their role in rural health policy development in the state of Idaho. We identify rural stakeholder perspectives and their policy recommendations on key aspects of the U.S. health care system that are currently under debate. We also discuss the effectiveness of the case study approach in illuminating policy perspectives and policy strategies that may fall outside of polarized political debates.

Rural Disparities in Access to Health Care in the United States and Idaho

Access to health care resources declines as population density decreases and geographic isolation increases (Aylward et al., 2012; Jones, Parker, Ahearn, Mishra, & Variyam, 2009). Rural residents have fewer health care providers, greater health risks, poorer health outcomes, and greater mortality than their urban counterparts (Bailey, n.d.; Jones et al., 2009; United Health Group, 2011). Rural residents typically must travel further than urban residents to access care, particularly for specialty care (Chan, Hart, & Goodman, 2006). Rural ethnic and racial minority residents experience even greater disparities in health care access and health outcomes (Rural Health Information Hub, 2014).

Rural residents are more likely to lack health insurance than urban residents, further contributing to poorer health outcomes and higher mortality than those with coverage (Institute of Medicine, 2009; Kaiser Commission, n.d.). Rural uninsured individuals are more apt to be hospitalized for preventable conditions than the urban uninsured (Zhang, Mueller, & Chan, 2008). Access to health care among the rural uninsured is further constrained by shortages of primary care practitioners (which includes physicians and advanced practice nurses [APRNs]), as well as a lack of specialists, pharmacists, dentists, registered nurses, mental health professionals, hospitals and clinics (Aylward et al., 2012; Bailey, n.d.; Chan et al., 2006; United Health Group, 2011). By 2020, a 36% shortage of nurses is anticipated (USDHHS, 2013).

The rural ratio of primary care physicians per 100,000 is less than half that of urban areas (Sanders, 2013; United Health Group, 2011). This ratio is not anticipated to improve because only 3% of medical students plan to practice in rural areas, and only 2% plan to go into primary care (Bailey, n.d.).

More than one third of Idaho's population is dispersed across rural- and frontier-designated counties, with nearly 20% of residents located in frontier counties (Skillman, Patterson, Lishner, Doescher, & Fordyce, 2013). According to the United States Census Bureau (2015), 93% of Idaho's population reports being white. In Idaho, 12% of residents live below the federal poverty level (FPL), and an additional 20% report incomes between 100% and 199% of the FPL (Kaiser Family Foundation, 2015). Approximately 11% of Idaho's population is uninsured; this number jumps to 27% among nonelderly with incomes below the FPL (Kaiser Family Foundation, 2015).

Idaho has a dramatic shortage of health care providers, with 96% of the state being designated a Health Professional Shortage Area (Idaho Department of Health and Welfare, 2015). Furthermore, 100% of Idaho is designated a Mental Health Professional Shortage Area (Idaho Department of Health and Welfare, 2015). Idaho's Nurse Practice Act authorizes independent practice and prescriptive authority for APRNs, and approximately 20% of APRNs in Idaho practice in rural settings (WWAMI Rural Health Research Center, 2015).

The ACA and the Politics of Federal, State, and Medical Sovereignty

Signed into law on March 23, 2010, the ACA requires all Americans to purchase health insurance or pay a fine; establishes a federal health insurance exchange, which states would default to if they chose not to establish their own exchange; and offers enhanced federal funding for Medicaid expansion (Affordable Health California, n.d.). Twenty-six states (including Idaho) and the National Federation of Independent Business sued the federal government, arguing that sections of the ACA were unconstitutional. The Supreme Court ultimately upheld federal health insurance subsidies and the individual mandate, while allowing Medicaid expansion to be voluntary (Kaiser Family Foundation, 2012).

The ACA became a flash point for conservative assertions of state sovereignty against a federal policy advanced by a Democratic and African American president. In the Federalist Papers, James Madison (1787) wrote of the necessity for a balance of power that would enable the federal and state governments “to resist and frustrate the measures of each other” (Thompson & Fossett, 2008). During ACA implementation, this “resistance and frustration” intensified, as some states made claims about their own sovereignty over health care. Decisions about state-level ACA implementation have been at stake in this political battle, with consequences for the number of residents who can acquire insurance and access care.

The politics of ACA implementation involved a less publicly visible and ongoing struggle over sovereignty within health care. Physicians were the first clinicians in the United States to obtain legislative recognition of their practice and for over a century have expanded the reach of their influence well beyond medicine into state and national politics (Starr, 1982). Since the early 1900s, the medical profession in the United States has controlled the number of available health care providers via restrictive licensing laws and limited medical school seats. Organized medicine has exhibited significant influence over both the health care market and the various organizations that govern health care (Starr, 1982). Starr (1982) notes that the medical profession not only developed extensive cultural and scientific authority, but members of the medical profession extended their power to the “control of markets, organizations, and governmental policy” (p. 580).

The medical profession’s control waned somewhat since the 1980s with health care corporations and insurance companies’ widespread efforts to limit physician autonomy, often in the guise of taming health care costs. Indeed, as community hospitals began to buy individual physician practices, these acquisitions served to ease individual physicians’ financial strain, yet came with the price of decreased economic autonomy (Starr, 1982). This same trend established

a set of new, less generously paid roles for nurses as members of “clinical teams,” further challenging physicians’ clinical autonomy and instituting well-funded political pushback by national- and state-level physician organizations (Starr, 1982).

The ACA’s inclusion of incentivized payment plans to improve health care quality and control health care spending (Coburn, Lundblad, MacKinney, McBride, & Mueller, 2010; Kaiser Family Foundation, 2013; MacKinney, Mueller, & McBride, 2011) further intensified professional competition between nurse practitioners and physicians who vie for primary care dollars. States have flexibility in their payment models for rural health clinics and community health centers; policies impacting funding of those facilities and their providers vary greatly (Health Resources and Services Administration [HRSA], 2006). Funding of health care provided by nonphysicians also varies widely among states, within a state depending on the payer, and even among various federal agencies (HRSA, 2006; Safriet, 2011; Summers, 2011; Weiland, 2008). Thirty-three percent of health maintenance organizations and 40% of managed Medicaid companies recognize NPs as primary care providers. Of those, only 52% reimburse APRNs at the same rate as physicians (Hansen-Turton, Ritter, Rothman, & Valdez, 2006). Medicaid, Medicare, or other payers may reimburse APRNs at 65%, 75%, or 85% of physician rates for the same care, depending on state-level reimbursement policies (Safriet, 2011). These federal, state, and corporate policy variances are “exacerbating the current maldistribution and shortage of providers” (Safriet, 2011, p. 6).

Advanced practice nursing developed in the 1970s to strategically address the primary care provider shortage. APRNs are registered nurses with a master’s- or doctoral-level nursing education in the assessment, diagnosis, and management of patient problems; they obtain state licensure and national certification in a specific aspect of care, and can order tests and prescribe

medications (APRN Consensus Work Group & National Council of State Boards of Nursing., 2008).

Several factors have constrained APRN independent practice. Organized medicine has defended primary care as the exclusive domain of physicians and advocated to limit the primary care provision activities of APRNs (Safriet, 2011; Starr, 1982), despite extensive evidence that APRNs provide primary care of comparable quality to that of physicians and at a lower cost (Kitchenman, 2012; Weiland, 2008). Some states require APRNs to be supervised by a physician or prohibit APRNs from prescribing medications (Cassidy, 2012; Safriet, 2011). In states that do authorize APRNs' independent practice, physician attitudes have hampered independent APRN practice (Aquilino, Damiano, Willard, Momany, & Levy, 1999; Street & Cossman, 2010). These politics of medical sovereignty (Starr, 1982) and the lack of uniform federal APRN policies have hindered the full roll-out of advanced practice nursing as a solution to mitigate the devastating primary care practitioner shortage in rural areas.

Methods

Case studies involve “naturally occurring situations without control of variables” (Gomm, Hammersley, & Foster, 2000, p. 3), collection of multiple types of data, and qualitative analysis with the aim of understanding “a complex entity located in a milieu or situation embedded in a number of contexts or backgrounds” (Stake, 2006, p. 449). Case studies have examined state policies for informal care providers (Ceccarelli, 2010), the politics of national child care policymaking (Cohen, 2001), the relationship between education and health policies in elementary schools (Seibold, 2006), and nursing workforce issues in Mexico (Squires, 2007).

Idaho is the specific unit of analysis for this single-case study of stakeholder perspectives on the ACA and rural health care access (Gerring, 2004). The time boundary is from the enactment

of the ACA in March 2010 to the conclusion of data collection in December 2015, with historical context provided. Institutional review board approval (Institution and protocol number blinded for review purposes) was secured and written consent obtained from 20 rural health care stakeholders, including clinicians, elected officials, state agency administrators, health care facility administrators, and interest group leaders. Thematic and narrative analyses were conducted on transcripts of semistructured interviews and public documents on governmental and nongovernmental entities' websites (Stake, 2006). Patients were not included in the stakeholder sample. A consideration of the Indian Health Service in Idaho was beyond the scope of the study.

Case Study: Idaho's Health Policy Context

The State of Idaho promoted its consistent opposition to the ACA using a narrative that pitted federal against state sovereignty. In a March 5, 2010, press release disseminated shortly after the ACA was passed by the Senate but before it was passed by the House, Idaho Governor Butch Otter expressed his frustration over federal health care reform, emphasizing the primacy of state sovereignty:

For 35 years now the federal government has been essentially running healthcare in America, masking market signals and supplanting the judgment of patients and physicians with the determinations of politicians, bureaucrats and lawyers....Now the federal government is poised to rescue us from the disaster it created, promising "reform" that amounts to little more than increasing government's already dominant role in the healthcare system and further reducing the role of states like Idaho, not to mention individual patients and providers....The public, policy makers and even patients contributed to the problem with their complacency. Having been lulled into a false sense of security by the promise of Medicaid and Medicare, we failed to insist on meaningful change and self-determination. (Otter, 2010, p. 1)

The Idaho legislature blocked federal health care reform even before Congress passed the ACA. On March 17, 2010, the Governor signed the Idaho Health Freedom Act, ensuring “that the citizens of our state won’t be subject to another federal mandate or turn over another part of their life to government control” (Idaho.gov, 2010, p. 1). One week later, Idaho became one of 26 states to legally challenge the constitutionality of the ACA (Kaiser Family Foundation, 2012). In the 2011 session, the predominantly Republican state legislature passed a bill to nullify Obamacare; however, the Governor vetoed it, instead issuing an executive order prohibiting state agencies from implementing Obamacare (State of Idaho, 2011). The Governor, while stating that “no one has opposed Obamacare more vehemently than me,” nevertheless chose to retain the ability to develop a state-run health insurance exchange and avoid “further control over Idahoans” in a federally run insurance exchange should the Supreme Court uphold the ACA (State of Idaho, 2011, p. 1).

After the Supreme Court upheld the individual mandate and health insurance subsidies of the ACA, a Governor-appointed task force recommended the establishment of a state-run health insurance exchange. Significant outcry ensued among conservative legislators, one even likening a state-run health insurance exchange to the Holocaust (Russell, 2013). By the time legislation to establish a state-run exchange was passed, the first ACA open enrollment period had already begun. Therefore, Idaho used the federal exchange for the initial open enrollment and then transitioned to its state-run exchange in time for the second open enrollment period in 2015.

Idaho became the only state in the union to build its own health insurance exchange yet opt out of Medicaid expansion (Norris, 2016). In 2015, 54,000 Idahoans were denied coverage through the state-run exchange. Their incomes were too low to qualify for the health insurance premium subsidy via the ACA and yet, because Idaho had not expanded Medicaid, they were ineligible for Medicaid (Russell, 2016). Even though a series of Governor-convened health care

task forces had all recommended expanding Medicaid, no bill on Medicaid expansion ever made it to the Idaho legislature floor for vote (“A True Idaho Solution,” 2016).

Stakeholder Perspectives on Medicaid Expansion

In qualitative interviews, health care system stakeholders described stymied efforts at state-level health care reform. Several expressed frustration over Idaho’s failures to legislate Medicaid expansion as part of the ACA implementation. One interest group administrator explained:

We’ve had three shots at the legislative assembly and failed every time to get them to seriously consider Medicaid expansion. Idaho you know has its single party system. The numbers of Democrats is so small that the Republicans can substantially ignore them. You know this anti-federal, the “Obama is evil” vibe, to where we’re just being senseless and we’re actually causing harm. It’s interesting on Medicaid expansion we have 78,000 people that you could help, but you’re choosing not to.

That same administrator suggested that health care professionals contribute to the problem by becoming complacent, not with Medicaid and Medicare, but with state government:

At the end of the last session,...the governor...gave the legislature...an “A” in education funding, a “B–” in transportation....In Idaho he doesn’t even have to give a letter grade [for] health and social services....In health care we’re having the conversation about to what degree are we contributing to that by not exercising the voice we should be exercising.

An elected official noted Idaho’s political environment itself as negatively impacting access to health care services in rural Idaho:

We can’t get Medicaid expansion passed yet. And so the politics are profoundly effective simply because it’s pitting a political ideology against...your citizens. And, so far the political ideology is winning.

Unlike the unified state government position, stakeholders' perspectives on the ACA and Medicaid expansion reflected a spectrum of political opinions not necessarily conforming to political party narratives, illustrated by the comments of two hospital administrators:

I don't believe in taking care of people through government programs, but if we had Medicaid expansion in this state it would have resulted in more people having the potential ability to access health care in rural areas.

The biggest policy change that's needed is a redesign of Medicaid. The service is so abused;...the use of the [emergency room] for nonurgent care needs to be limited...I hear a lot of people coming in, "Well, I've got the card, I don't have to pay for it" when they're coming in for a cough. That's abusing the system. And when I see at the grocery store somebody using their card to buy steaks most of us can't afford I think there needs to be limits put on that.

Even while arguing against "government programs," conservative stakeholders proposed retaining, reforming, or expanding Medicaid in Idaho. The responses described through liberal ideology consistently focused on the lack of Medicaid expansion in Idaho. One state administrator stated:

[Repeatedly] the legislature has chosen not to expand Medicaid, so we are losing federal dollars into the state, we're losing the ability to increase medical services for people....We're losing money...health care jobs...health care services, and people are losing their lives....This is not a civil right or a civil liberty, it's a human right, to be able to be taken care of.

Across political ideologies, stakeholders associated the loss of federal funding or health care jobs with state restrictions on Medicaid.

Stakeholder Perspectives on the ACA

Interviewees provided multiple viewpoints on the impact that the ACA, regardless of Medicaid expansion, has had on health care access. Hospital administrators in particular argued that the ACA had not enhanced access to health care services in rural Idaho, due to “extreme compliance requirements” and the “complexity” and “confusion” of assuming that “everybody was getting insurance.”

Stakeholders also recognized the conflict demonstrated by community members who appreciate the individual benefits from the ACA but oppose or demonize the policy. An interest group administrator commented:

We’ve been in a lot of community groups where there’s a lot of vitriol against Obamacare and how horrible it is, but then when you ask the obvious questions, like does anybody in the room have somebody in the family who is uninsured because they fall into the coverage gap, [then] everybody knows somebody. Or, has anybody in the room benefitted because now their kids can be covered under their group coverage to age 26? A lot of hands go up. Has anybody benefitted from the no preexisting condition elimination? Hands go up. That’s Obamacare.

In an environment where perspectives on the ACA are informed by ideology and highly charged emotions, some stakeholders focused on the observed positive changes the ACA has generated in their practices:

With the ACA I’ve seen a lot more new patients come in for a wellness exam so I was able to provide a lot of good health information and screenings. [The ACA] is getting more people access to good information about preventative health care so they can avoid issues 5 to 15 years down the road.

The majority of rural clinicians interviewed indicated that more people were accessing preventive care and seeking care for health issues sooner since ACA implementation.

Stakeholder Perspectives on APRNs

Although Idaho has a robust Nurse Practice Act authorizing APRNs' full scope of practice independent of physician supervision, few interviewees independently mentioned APRNs in their comments regarding the rural provider shortage, and even fewer referenced the state's Nurse Practice Act. Most stakeholders spoke disparagingly of APRNs and physician assistants (PAs) as a single "mid-level" class of health care provider:

If a mid-level doesn't know when they're in over their head then that's dangerous. If they don't know their limits and don't ask for help then by the time they get to a physician the patient has been completely mismanaged. They should have a limited role.

Several rural physicians echoed this perspective. One stated, "APRNs and PAs are imperative as extenders to the physicians, but without the physicians there to ground and lead the team, then it's somewhat dangerous." Another physician noted, "In one respect they can improve access to care, but if they're not part of a physician-led team it can lead to higher costs with unnecessary referrals to specialists."

Some stakeholders described APRNs as lesser-skilled, mid-level providers with different training than physicians, yet they compared APRNs with "their physician counterparts" when discussing their interest in specialization, willingness to practice in a rural locale, and value in generating reimbursement revenue.

One rural APRN noted the role of conflicting state and federal policies on conflicted attitudes toward APRN independent practice:

APRNs can practice independently in Idaho [but] are required to have all their charts and orders signed off on by a MD in a critical access facility or rural health clinics. Medicare and Medicaid rules are the reason APRNs have to have physicians co-sign everything; they overrule state law.

Some stakeholders distinguished APRNs from physician assistants and emphatically valued APRNs' independent role as primary care providers. A rural hospital administrator noted:

We should separate out nurse practitioners from physician assistants. Nurse practitioners are fully trained and capable of providing a full spectrum of primary care services, whereas physician assistants have to operate under the license of a physician so they are not as valuable in rural care settings where they are required to have a physician quote unquote “supervise” them. Nurse practitioners should be more widely utilized and they could answer a lot of the access issues here in Idaho.

One rural APRN described economic competition between APRNs and MDs, noting that rural physicians value APRNs as a way to increase revenue, but not to provide independent primary care:

More APRNs would practice in rural settings if [physicians] were more accepting of independent APRNs. The doctors like us to work for them, not as competitors, so we APRNs sometimes have a bit of a fight on our hands....[One] doctor told my patient that about the only person I'm good to see is one with a runny nose, a bloody nose, or a hang nail, and that he should see a “real doctor.”

Despite a Nurse Practice Act authorizing full scope, independent practice for APRNs in a state that values state-level “self-determination” of health care, APRNs described a context of

economic competition, federal and hospital policy constraints, and everyday workplace opposition to their independent role in rural primary care provision.

Stakeholder Policy Recommendations

When asked to identify policy changes they saw as crucial to optimizing access to rural health care in Idaho, stakeholders prioritized Medicaid expansion, enhanced physician reimbursement, and health care payment system revision, and described these policy reforms as economic development strategies. Some saw Medicaid expansion as a way to address the primary care workforce shortage, “help[ing] with rural physician recruitment and reimbursement,” “bring[ing] jobs and money into Idaho,” and enabling states to pay for health care: “Medicaid rates...would be better than no reimbursement.”

Other stakeholders argued for broad reimbursement reform, recommending changing health care payment from a volume-based system to a value-based model that emphasizes holistic, preventive care. Enhanced Medicaid and Medicare reimbursements for physician services were cited as a key incentive to attract physicians to rural Idaho. Medicaid expansion, advocated using varied rationales even alongside criticisms, was the single most common policy change recommended by interviewees, valued for its role in increasing patients’ access to rural health care, building the primary care workforce, sustaining the state’s health care system, and stimulating state economic development.

Conclusion

This study demonstrates the utility of the case study approach in capturing diverse stakeholder perspectives on rural health care and health care policy in ideologically charged environments. State-level case studies can identify the perspectives of those actually engaged in the rural health care arena and document policy viewpoints ignored or marginalized in public

debate. In the political context of a rural, conservative state, participants who held “opposing” political views surprisingly valued similar aspects of the ACA and recommended similar policy changes to enhance access to rural health care services. In addition, the use of governmental and nongovernmental Web site sources enables case study researchers to describe state-level policy context, particularly when access to public officials for research interviews may be prohibitive.

In a national context where federal sovereignty and state sovereignty are increasingly pitted against each other, a third battle—one over medical sovereignty—significantly shaped the politics of rural health care in Idaho. As APRNs advocate for federal legislation granting independent practice and equitable reimbursement throughout the United States, public and professional messaging will be essential in countering the medical sovereignty narrative and advancing APRNs as an effective strategy to improve access to rural primary care services. State-level case studies can give voice to those who are actually involved in the everyday work of health care, illuminating stakeholder support for rural health care policy reforms that may or may not align with dominant political narratives. Attention to the state-level political context of rural health care can illuminate concurrent battles about state sovereignty over health care policy and a less publicly visible professional-clinical battle about sovereignty over primary care.

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