



REQUEST FOR BOARD ACTION

ITEM NO. 16.

DATE OF MEETING: December 9, 2013

REQUESTED BY: Carolyn Moser, Health and Human Services Director

SHORT TITLE: Resolution Authorizing Approval to Contract for a Primary Care Physician

BACKGROUND: The Pender County Health Department is requesting approval to contract for a Primary Care Physician. Data indicates that Pender County has 2.8 primary care physicians for a population of 10,000 compared to the states at 7.8 primary care physicians per 10,000. As the Affordable Care Act begins implementation many individuals will be faced with difficult choices and they must decide if they will pay the penalty or purchase insurance. These individuals do not qualify for Medicaid or tax credits and will be stuck in the gap.

The Pender County Health Department proposed to the Advisory Board of Health on November 14, 2013 to consider a contract for a Primary Care Physician. The Advisory Board of Health has agreed, and is recommending that the BOCC consider approving.

SPECIFIC ACTION REQUESTED: To consider a resolution approving to contract for a Primary Care Physician.

COUNTY MANAGER'S RECOMMENDATION

Respectfully recommend approval.



Initial

RESOLUTION

NOW, THEREFORE BE IT RESOLVED by the Pender County Board of Commissioners that

The Chair/County Manager is authorized to execute any/all agreements necessary to implement the resolution.

AMENDMENTS:

MOVED _____ SECONDED _____

APPROVED _____ DENIED _____ UNANIMOUS

YEA VOTES: Brown ___ McCoy ___ Tate ___ Ward ___ Williams ___

Chairman Date

ATTEST Date

Pender County Health Department

...Building a healthier tomorrow...

Carolyn Moser, MPA
Health Director

Proposal for Physician Based Primary Care Services November 14, 2014

Problem: Recent data indicates Pender County has 2.8 primary care physicians/10,000 population compared to the state rate of 7.8/10,000 population. As the Affordable Care Act begins implementation in January 2014, many individuals, especially the "working poor" will be faced with difficult choices. Unable to keep their current "bad apple" plans, citizens will have to decide on whether to purchase insurance or pay the penalties. Policies are often much higher than the insurance plan they currently have and the deductibles are exorbitant. These individuals do not qualify for Medicaid or tax credits and will be stuck in the gap. As stated in the attached Star News article, existing community services will be tapped to meet the health care needs.

Proposal: To hire a part-time family practice physician (24 hours/week) to provide primary care services to Pender County residents beginning in January 2014. **No county dollars will be needed.**

Expense:

Physician 3 days/week at \$85/hour	\$106,080
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Revenues:

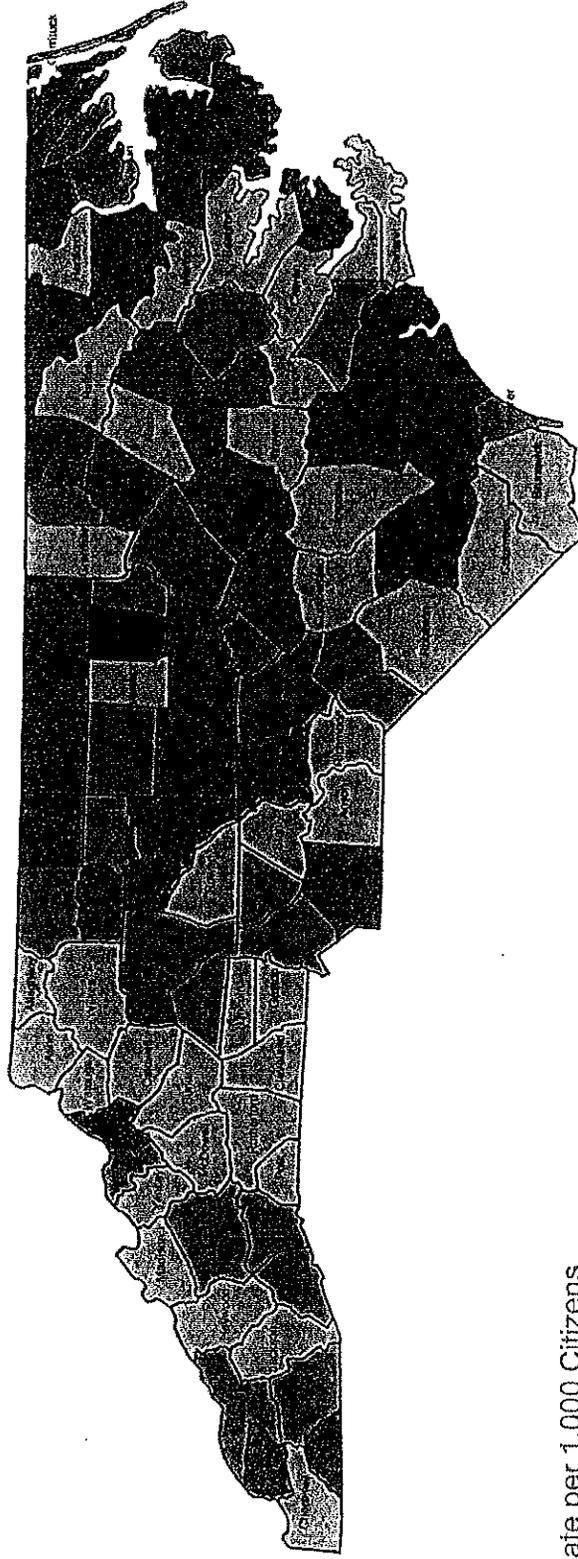
Utilize as Medical Director, ending current director contract	\$ 43,000
Place Nurse Practitioner at West Pender, salary paid by PATH	\$ 22,000
*Portion of physician revenues assigned to salary	\$ 41,080
Total	<u>\$ 106,080</u>

NOTE: *Physician revenues based on fees, Medicaid, and insurance. Revenue projections will exceed the amount allocated for salary.

803 S. Walker St., Burgaw, NC 28425 (910) 259-1230 Fax (910) 259-1258

Dental Center (910) 259-1503 Environmental Health (910) 259-1233 WIC (910) 259-1290

Active Primary Care Physicians (2011)



Rate per 1,000 Citizens

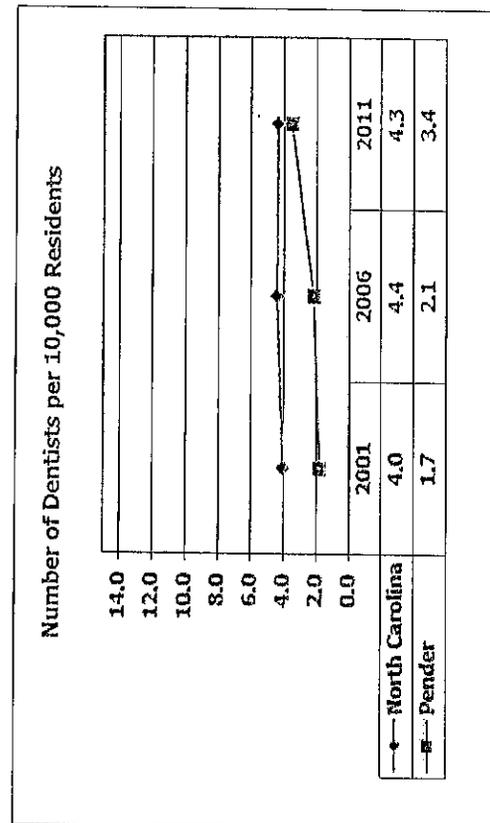
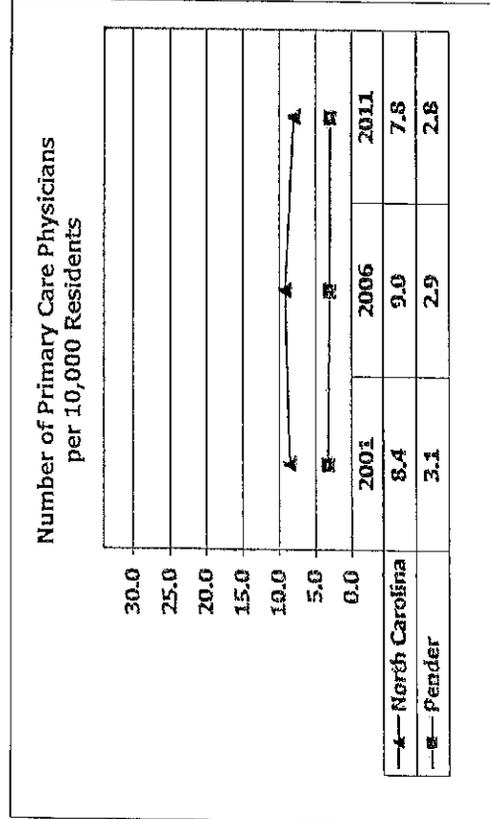
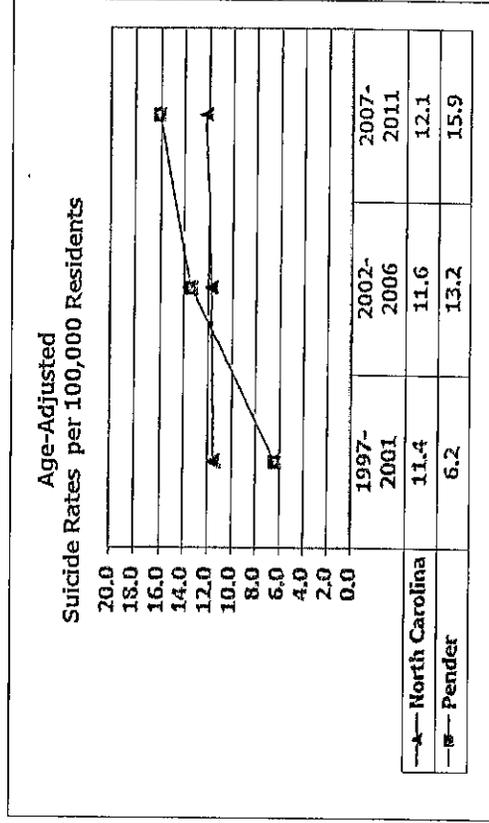
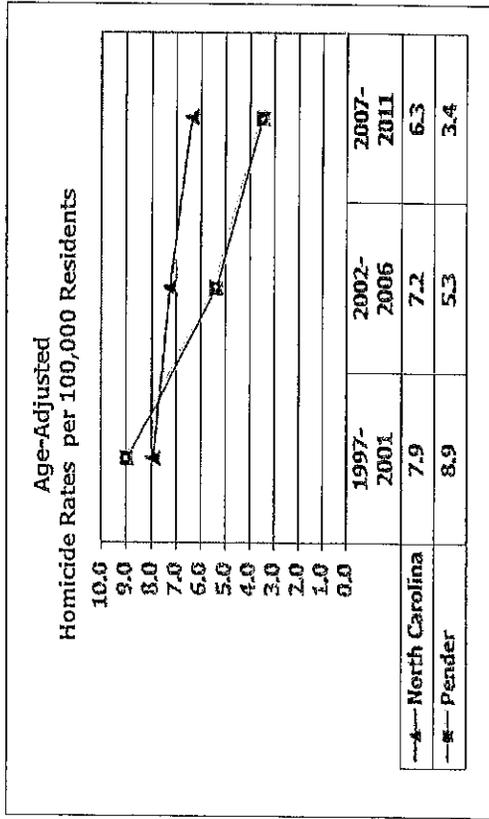
- None
- 0.01 to 0.50
- 0.51 to 0.75
- 0.76 to 2.00
- 2.01 to 3.35

Primary care physicians are defined as active physicians in the specialties of general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology. The data are assigned to the counties by the physicians' physical address.

Calculation: The count of primary care physicians divided by the county population multiplied by 1,000 to determine the rate of primary care physicians per 1,000 county residents.

Source: University of North Carolina at Chapel Hill

NORTH CAROLINA STATEWIDE AND COUNTY TRENDS IN KEY HEALTH INDICATORS: PENDER COUNTY



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N.C. refusal of Medicaid leaves large group in 'gap'

By [Molly Parker](#) & [Mike Vanebois](#)

Molly.Parker@StarNewsOnline.com

Published: Thursday, October 24, 2013 at 2:33 p.m.

Roughly 7 percent of the nation's 5 million poor uninsured adults who fall into the so-called health insurance "coverage gap" live in North Carolina, according to the nonprofit Kaiser Family Foundation.

That means they make too much to qualify for Medicaid but not enough for marketplace premium tax credits offered under the Affordable Care Act.

North Carolina ranks fourth nationally in this category, with 318,710 people fitting that bill, Kaiser reported recently.



Photo By Mike Spencer

Kevie Wilkins, Outreach Enrollment Specialist for the Affordable Care Act with Med North Health Center, talks with Currie, N.C. resident Mary Carr, 47, about the Affordable Care Act at the New Hanover County Health Department Wednesday, October 23, 2013.

A face among those numbers is Steve Vernon, artistic director of Big Dawg Productions in Wilmington.

Already thousands of dollars in debt from a 19-day hospital stay and subsequent surgeries and treatments in 2013, Vernon had hoped that the Affordable Care Act would offer him a chance to purchase insurance in 2014 that was, well, affordable.

Being a single adult without children, he was denied Medicaid. Still, Vernon didn't make enough money to qualify for federal health insurance subsidies.

"I was hoping that it would help a large amount of people, including myself," Vernon said. "The problem is that it's become impossible to separate this from a political issue."

STUCK IN THE GAP

It's a familiar tale to Laura Vinson-Garvey, executive director of St. Mary's Health Center in Wilmington. She expects that many of her working-poor clients will fall into the coverage gap, or otherwise be unable to afford health insurance even with the help of federal subsidies. She said that means they are still likely to go without health insurance despite a mandate that everyone have it nationally by the beginning of 2014 or face penalties starting March 31. She cited the case of a 64-year-old patient who receives \$1,100 per month from Social Security. She no longer qualifies for Medicaid and is a few years shy of qualifying for Medicare.

She needs a \$300 inhaler for chronic obstructive pulmonary disease, or COPD, in addition to medication for hypertension and high cholesterol.

"We took her on in June or July, and she hadn't had any medications in a while," Vinson-Garvey said, adding that she doesn't know if the woman would qualify for a subsidy but doubts she could afford the premium anyway.

"I know people who are working poor who can't afford to get insurance....," she said. "There's a lot of people who fall into the gap."

Last year, the U.S. Supreme Court struck down a provision of Obamacare requiring states to expand Medicaid, while upholding the mandate that residents have insurance coverage – giving birth to the coverage gap.

North Carolina is one of 26 largely Republican-led states that turned down the expansion of Medicaid, with leading GOP officials noting cost concerns and annual program overruns already plaguing the system.

ESTIMATES VARY

But just exactly how many people fall into that gap in North Carolina is unclear. A half million has been widely reported for months as the estimate, though Kaiser's recent study pegged it at closer to 300,000. Don Dalton, spokesman for the N.C. Hospital Association, said he's seen figures as high as 625,000. The state Department of Health and Human Services says it's more like 155,000, according to the conservative John Locke Foundation.

Regardless of the number it's a "sticky situation" to address, said Katherine Restrepo, health and human services policy analyst at the John Locke Foundation. Her organization opposes Medicaid expansion and is advocating for sweeping changes that would increase competition within the program via a system of managed care. That's a policy change that Gov. Pat McCrory has advocated recently.

"Medical assistance should be more of a temporary program to help people in financial straits and the most vulnerable instead of expanding it to able-bodied citizens that could potentially provide for themselves," Restrepo said.

For his part, McCrory hasn't completely ruled out an expansion of Medicaid while he advocates system reform.

McCrory: Fix system first

"The governor's position on any past, current or possible future Medicaid expansion is clear," said DHHS spokesman Ricky Diaz. "Before the state can consider expanding Medicaid, we must first reform the system to improve the quality of care while controlling costs."

 For those individuals stuck in the gap, DHHS recommends tapping into existing services, which vary by community. As examples, Diaz cites federally qualified health clinics, community health centers, rural health centers, school-based clinics, free clinics, donated physician services and medication assistance programs.

"DHHS is encouraging county departments of social services to connect these individuals to those resources," Diaz said.

McCrory, though, raised eyebrows when he said this week during a speech at the Heritage Foundation that a new federal regulation may force North Carolina to expand Medicaid after all.

Shortly thereafter, the left-leaning nonprofit ProgressNC Action sent an email blast proclaiming "our efforts are paying off."

"After we launched our petition calling for the expansion of Medicaid, Gov. McCrory went on the record saying he is considering doing just that," the email said.

Executive Director Gerrick Brenner said that either McCrory is positioning the state to expand Medicaid and use the federal government as an excuse, or he is confused.

Diaz said it's neither, noting that the governor was referring to the Section 2202 of the Affordable Care Act that gives hospitals new authority starting Jan. 1 to make "presumptive eligibility" calls for patients before they are officially enrolled in Medicaid.

North Carolina law currently only allows presumptive eligibility for pregnant women and newborn children. The change expands those categories to include parents and other caretakers, individuals under 65, former foster care children, breast and cervical patients and individuals wanting family planning services.

The state must guarantee payment for the services rendered during a period that could range from 60-105 days, and if the hospital is incorrect in its determination, the state can't recoup money spent during that period, Diaz said.

An official with the federal Centers for Medicare and Medicaid Services said hospitals must still follow the state's eligibility guidelines and can be revoked of their newly granted authority if it is abused. Because hospitals must abide by the laws of the state they are living in, it in no way amounts to an expansion of Medicaid, said CMS spokeswoman Emma Sandoe.

As for Vernon, he said he could project his 2014 income at a higher rate and qualify for the subsidies. But if his income did not increase and he fell short of his projection, he would have to repay thousands of dollars of subsidies.

For now, Vernon is working with three agencies to make payments on his existing medical expenses. The hospital did absolve him of having to pay some charges, but other medical bills are sent directly to the collection agencies.

Unless something changes dramatically, he will enter 2014 without the means to afford health insurance.

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The Examiner WASHINGTON

For some, losing so-called bad apple health insurance plans will mean paying more for less

BY SUSAN FERRECHIO | NOVEMBER 4, 2013 AT 12:15 PM

Hadley Heath's health insurance plan seemed to have it all. A low deductible, low monthly premium, and comprehensive coverage that even included free preventative care.

But Heath's insurer, CareFirst Blue Cross Blue Shield just sent her a letter, announcing they will terminate her plan because it lacks "Essential Health Benefits," mandated under the Affordable Care Act.

Heath is one of millions of people holding individual health insurance plans who are about to lose them. Florida Blue will drop 300,000 policies that don't meet the ACA requirements, while 150,000 Oregon residents who are signed up under individual plans will also lose their current coverage. California's Blue Shield sent termination notices to 119,000 policy holders, an official told the *Washington Examiner*.

Many of those policy holders are now facing higher deductibles and higher monthly premiums if they purchase a new policy under Obamacare.

In Heath's case, if she chooses the cheapest policy known as the bronze plan from the newly-created health care exchanges, she will pay a \$200 monthly premium, up from the \$113 she pays under her soon-to-be-cancelled plan. And her deductible would increase from \$2,700 per month to \$3,500, according to estimates from her current insurance provider.

In the words of President Obama, Heath holds a policy issued by a "bad apple" insurer. Health and Human Services Secretary Kathleen Sebelius called plans like Heath's "medically underwritten," while Rep. Henry Waxman, D-Calif., said last week such plans are being eliminated because they have "flimsy" and "deficient" coverage "that disappears when people actually need it."

Waxman added, "Nobody should want that."

But Heath was happy with her policy and wanted very much to keep it.

"My plan is not a junk plan," said Heath, who is a health care policy analyst at the Independent Women's Forum in Washington D.C.

"It's got emergency room care, primary care, immunizations and it has hospitalization coverage."

Heath's deductible is higher than some policies but there is no lifetime cap on coverage and she utilizes a tax-exempt medical savings account to ensure she can meet the deductible if needed.

"That way, I feel some responsibility," Heath explained.

Heath's insurer offered no details about why her plan was dropped, other than to report that it does not include one or some of the 10 "essential health benefits," now required on every insurance policy under Obamacare.

According to the healthcare.gov website, all health care plans must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

Heath, who is 25 and doesn't have children, said she wasn't looking for a plan that included things like pediatric dentistry, chronic disease management or substance abuse help.

"I feel a little insulted," Heath said. "I'm a grown up. Let me decide what's best for me. I think I should be in charge of that."

By some estimates, up to 80 percent of the individual market, which includes as many as 16 million people, will lose their plan because it does not meet the new coverage standards under Obamacare. And new reports suggest when the employer mandate kicks in next year, tens of millions more people will be dumped from their employer-sponsored plans and into the health care exchanges.

The Obama administration, meanwhile, has continued to defend the cancellations of individually purchased policies as necessary in order to rid the market of so-called junk plans.

In California, Blue Shield decided not to allow any customers to keep their individual plans. They sent cancellation notices to all 119,000 of their policy holders.

"It would have been difficult to find plans that had all ten essential health benefits," Stephan Shivinsky, Blue Shield's vice president of corporate communications, told the *Examiner*.

Policies purchased before the health care law took effect in March 2010 are supposed to be exempted by the new health care law requirements, so long as they do not alter their coverage or prices too dramatically.

On Fox News Sunday, host Chris Wallace challenged an Obamacare architect, Ezekiel Emanuel, on the administration's exclusion of policies that have as little as a \$5 increase for co-payments.

"That's usually a 25 percent change," Emanuel said. "That's a big change."

Mike Tanner, a health care policy scholar at the libertarian Cato Institute, said people are discovering that the plans offered on the health care exchanges are not always cheaper, in part because more comprehensive coverage is required and because the costs are shifted around to cover the sickest. Young people like Heath, Tanner said, "are getting charged significantly higher premiums."

Independent Women's Voice has launched the website, mycancellation.gov to showcase the cancellations letters people are receiving from health insurance companies.

A Blue Cross Blue Shield letter posted Sunday from a North Carolina policy holder showed a 2013 premium of \$456 per month increasing to \$1,200 per month.

Another letter, also posted Sunday, showed a policy holder losing a plan that costs \$367 per month and being offered a plan for a monthly rate of \$641. The deductible on the new plan would increase from \$2,200 out-of-pocket maximum for an individual plan to \$6,350.

Web URL: <http://washingtonexaminer.com/article/2538405>