National Conference of State Legislatures

STATE HEALTH NOTES

FORUM FOR STATE HEALTH POLICY LEADERSHIP

NOVEMBER 29, 2004

VOLUME 25, NUMBER 433

Telepsychiatry: Going Where Few Providers Can Go

It's been around for decades, but as the Internet age has advanced – and the costs of technology have dropped – more and more states have begun using telepsychiatry to diagnose and treat rural residents with mental illnesses.

By enabling patients to consult with mental health professionals over secure teleconferencing networks, telepsychiatry overcomes not only the lack of providers in rural areas, but the long distances between patients and providers. "This is a good way to enhance medical services in our rural areas," said Arizona Sen. Robert Burns, an early supporter of telehealth in his state.

To paraphrase the National Library of Medicine, telepsychiatry is the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance. The major technological components include monitors, cameras, coder-decoders that transform the picture picked up by the video camera into a digital signal for transmission to the distant site, a desktop computer, microphones, speakers and other audiovisual interactive technologies such as videophones.

There are obstacles to setting up a telepsychiatry system, but supporters say it's a crucial means of reaching far-flung patients. "Telepsychiatry was born out of necessity," said Eugene Augusterfer, co-chair of the Washington, D.C.-based American Telehealth Association's mental health special interest group.

"Anyone would prefer face to face, but the overriding pro (of telepsychiatry) is that it provides access to patients who otherwise would have great difficulty getting to a psychiatrist, and it also gives them continuity of care, which is especially important for seriously ill patients," said Dr. Sara Gibson, medical director of the Northern Arizona Regional Behavioral Health Authority (NARBHA) in Flagstaff. The private, non-profit organization contracts with the Arizona Department of Health to provide behavioral health services through its videoconferencing system (NARBHAnet) to northern Arizona, which has a population of 600,000 spread out over 62,000 square miles.

"It's expensive to send a psychiatrist across the state to see a patient," said Ed Spencer, telepsychiatry coordinator at the South Carolina Department of Mental Health. "Our agency used to eat the driving time cost, because Medicaid only provides coverage for the service delivery. If agencies added up all of the driving time it takes to deliver a service across the state, there is no question that about every nine to 12 months the cost (of a telepsychiatry system) reclaims itself."

SATISFACTION DELIVERED

"Mental health professionals are resistant when initially confronted with the concept: how could something, if it's not face-to-face with a patient, work? Studies find that it works very well," Augusterfer said.

A comprehensive review of the literature by Dr. Donald Hilty, associate professor of clinical psychology at the University of California/Davis, and others for the Canadian Psychiatric Association's October 2003 *Bulletin*, found that cognitive-behavioral therapy for children with depression was as successful as telepsychiatry as in-person care. In other studies, patients expected a less satisfactory interaction than in a traditional physician-patient encounter, but overall satisfaction was very high – even when equipment problems occurred. The patients were pleased with the reduced travel time, less absence from work, reduced waiting time, and more patient choice and control.

[Telepsychiatry, p.6]

IN THIS ISSUE

HAPPY HOLIDAYS!

State Health Notes will take a breather for the holidays. Look for your next issue on December 27, 2004.

State Health Notes is supported in part by a grant from the Robert Wood Johnson Foundation.

PRIMARY CARE NEWS

States Make Advances in Providing Critical Prenatal Care

Prenatal care is one of the greatest public health achievements of the century, giving states a remarkable return on their investment. With a great body of research that bolsters the argument that prenatal care works, policymakers have played a key role in ensuring that as many expectant mothers as possible receive care – through Medicaid, the State Children's Health Insurance Program, health departments and other programs.

Despite the remarkable gains made during the past 25 years, the U.S. still lags behind other industrialized nations in the problems that prenatal care can help prevent: very low- and low-birth weight babies, neonatal and infant mortality, and maternal mortality.

Most women obtain prenatal care through private-practice physicians, hospital outpatient departments or health departments. Although Medicaid now pays for 40 percent of all births, fully 13.4 percent of women gave birth in 1999 with no insurance, greatly complicating their access to timely care. Even worse, of the roughly 4 million births in 2002, more than 140,000 were to women who received late or no prenatal care. In addition, although rates of smoking among pregnant women are half as high as 15 years ago, 11 percent were smokers in 2002.

Women with low-incomes, minorities (particularly African-Americans) and immigrants, teenagers and over-35 mothers, urban and rural, as well as those with mental illness and substance use disorders (including tobacco), are those for whom pregnancy carries higher risk. Key questions for states include the following:

Do mothers have access to an obstetrician? The medical malpractice insurance crisis has taken a heavy toll on the ranks of obstetricians. The American College of Obstetricians and Gynecologists estimates that the average obstetrician will be sued at least 2.5 times during his or her career. With such high litigation rates—and the highest defense costs among all medical specialties at over $34,000 per claim—the field has experienced a marked spike in premiums, causing many doctors to change their practices and some to stop delivering babies. As these problems have persisted, the number of medical graduates who choose obstetrics has dropped.

Do mothers have access to culturally competent care? With African-Americans experiencing poorer outcomes rates – nearly double those of white and Hispanic Americans – a marked disparity still exists in prenatal care. Research consistently points to the need for culturally competent care. Immigrant populations also have special needs. For example, recent research indicates that Indian immigrants – among the more well-educated immigrant populations – have startlingly poorer outcomes than whites.

Do mothers have access to care in the appropriate setting? Teenage mothers frequently begin care later in a pregnancy, resulting in poorer outcomes. Recent research highlighted success in lowering the rate of low-birthweight babies among teens through prenatal care at school-based health centers.

Do mothers have access to appropriate, high-quality care? Due to geographic isolation, rural mothers face the problem of access to quality care. A study conducted by the Georgia Department of Health found that almost 25 percent of very low-birthweight neonatal deaths in the state between 1994 and 1996 could have been avoided had mothers received care with better technology.

Do mothers have access to mental health and substance cessation/abstinence programs? Research shows that both mental health and substance use disorders are factors in birth weight and mortality for infants and mothers. However, mothers often hide these stigmatized conditions from providers. Reluctance to admit problems outright, lack of funds to enroll in counseling, and fear of criminal prosecution and/or of losing custody of their child prevent many women from seeking care.

THE RIGHT CARE IN RHODE ISLAND

States are taking a variety of innovative approaches to improving women's access to prenatal care. In Rhode Island, RIte Care – the state's Medicaid managed-care program – has not only improved health outcomes but produced cost savings. Healthier births mean fewer emergency room visits, shorter hospital stays and early treatment for chronic conditions.

RIte Care tackles many barriers, such as disorganized delivery systems that may have low capacity and low cultural competency. To help ensure access, the state maintains a toll-free information line that connects women with counselors who enroll them in prenatal programs. To encourage physicians to participate, it offers increased reimbursement to prenatal and obstetrical providers. Health plans must reach out to all members of childbearing age, and providers are required to see enrollees within three weeks of a positive pregnancy test. To help women get to their appointments, RIte Care offers bus passes and cab vouchers.

RIte Care's proactive approach to investing in high-quality care for expectant mothers has achieved considerable results. Re-

[Prenatal Care, p.5]

Improvements in Access to Care and Infant Health

Improvements in Access to Care	1993 (pre-RIte care)	2000 (post-RIte care)
Pregnant Medicaid beneficiaries receiving adequate prenatal care	56 percent	73 percent
Percentage of female Medicaid beneficiaries who began prenatal care in the first trimester	77 percent	84 percent
Improvements in Infant Health	**1993 (pre-RIte care)**	**1995 (post-RIte care)**
Incidence of low-birthweight babies in Providence	10 percent	5 percent
Percentage of infants who had their first physician visit within the first two weeks	54 percent	70 percent
Percentage of infants who waited less than two weeks for specialty care	44 percent	71 percent

Source: Sharon Silow-Carroll. *Building Quality into RIte Care: How Rhode Island is Improving Health Care for its Low-Income Populations.* Washington D.C.: Economic and Social Research Institute, January 2003.

HIGHLIGHTS

HEALTH INSURANCE

SCHIP Funding Update

At the final minute of the final day of federal FY 2004, $1.1 billion in unspent funds for the State Children's Health Insurance Program (SCHIP) reverted to the U.S. Treasury. Congress did not act, as it had in past threats of reversion, to keep the funds in the program (FYI *SHN #430*). During the election recess, a bicameral and bipartisan collection of congressional staff discussed ways to restore the funds to the program. Unfortunately for states needing redistributed funds, the discussions did not result in any congressional actions during the lame-duck session that will conclude the 108th Congress. One hurdle that arose in the path of restoration was negotiators' insistence on finding offsets in the federal budget. Restoration also was not included in the Bush administration's proposed budget for FY 2005. Nevertheless, sponsors and allies of the restoration bills in the 108th Congress hope to revive the issue. U.S. Senate Finance Committee Chairman Charles E. Grassley is committed to working on a way to restore funds in the 109th Congress, which convenes in January 2005.

Texans Ask for Action

Texas business leaders are asking their state legislators to take steps to reform the health-care system in the state – in their words, STAT! A new report from the Texas Association of Business recommends a series of legislative reforms, including:

- The expansion of consumer child health plans, low-cost coverage that is free of state-mandated benefits;
- Creation of exclusive provider organizations that would offer no out-of-network coverage except in emergencies or in areas without network providers; and
- Allowing managed-care companies to impose limitations on time and cost of services.

"The Texas health insurance crisis is no longer just a problem of the unemployed and the working poor," said TAB President Bill Hammond. "Because of escalating health-care costs, it is a problem for everyone, regardless of income." He said that Texas leads the nation in the number of state-mandated benefits – 65 are currently on the books. In 2003, lawmakers approved the consumer choice health plans that limit the number of costly mandates. According to the National Academy of Sciences, Texas leads the U.S. in terms of percentage of population that is uninsured — 26 percent. California is a distant second with 12 percent uninsured. Rep. Arlene Wohlgemuth offered praise for the business community's initiatives. "For far too long, Texas has mandated health insurance out of reach of most employers," she said. "Offering alternatives that allow consumers to purchase lower-cost plans was the right step for the Texas Legislature. We should expand on the initiative." The TAB also recommends:

- Adoption of a new, more enforceable health-care fraud statute modeled after the Texas Deceptive Trade Practices Act;
- Creation of a Consumer Right-to-Know Act that would empower consumers by giving them information needed to make educated decisions regarding the cost and quality of health-care services; and
- Allowing data pertaining to medical errors to be obtained by the public while protecting patient privacy rights. Go to: www.tabcc.org

HOSPITALS

Reimbursing Hospitals

Wyoming is examining various solutions to a problem that could shut down some of its hospitals: the failure to be reimbursed for catastrophic (long-term major illnesses) and trauma (life-threatening injuries) care, writes the *Casper Star-Tribune*. The problem – which cost Wyoming hospitals nearly $10 million in FY 2004 — is critical, according to a study performed for the Wyoming Healthcare Commission by Chicago-based Navigant Consulting Inc. "Unlike many other states, all hospitals (in Wyoming) are sole community providers," the study notes. "If a Wyoming hospital fails, there is no hospital to provide services." Using models created by other states, the study suggested three possible options for Wyoming:

- Create a bad debt fund for hospitals, and every year, place a set amount into it. Reimburse hospitals for inpatient trauma and catastrophic care, once costs exceed a predetermined amount. Base payments on a percentage of costs or on a first-come, first-served claim application system.
- Reimburse hospitals for a percentage of their uncompensated care with adjustments to favor those with a high proportion of trauma care.
- Provide a catastrophic care pool for uninsured Wyoming residents. The pool would pay for catastrophic care that exceeded a limit, of say, $10,000 per patient.

The study outlined a number of funding sources for a hospital uncompensated care fund. California, Illinois, Pennsylvania, Mississippi and Washington use traffic and legal fines to pay for unreimbursed medical costs, the study said. Fines for criminal acts that can result in the need for trauma care – such as driving under the influence of alcohol or illegally discharging a firearm – go to the hospital fund. Other states, such as Maryland, have increased automobile registration and drivers' licensing fees, and a portion of that money goes to the funds.

PRESCRIPTION DRUGS

Giving More to Those with Less

Three out of four Medicare beneficiaries who sign up for the new Part D prescription drug benefit will have the same or lower out-of-pocket costs in 2006, according to a new study from the Kaiser Family Foundation. But the other one in four will have higher out-of-pocket costs, unless they get coverage from another source.

"This analysis shows that the prescription drug law will provide the most help to seniors with low incomes and very high drug bills, just as Congress intended," said Drew Altman, president of the Kaiser foundation. "Congress faced budget constraints and had to make tradeoff decisions; the question is whether the law they passed will meet seniors' expectations." Low-income people who sign up for the Part D drug plans and get

special subsidies (about 8.7 million people) will pay about 83 percent less for their prescription drugs than they would have without a benefit. Those who do not receive the low-income subsidies (20.3 million) will pay only about 28 percent less for their prescription drugs. "Most are projected to get helped, and some will get helped more than others, but in any single year we would expect one in four to spend more out of pocket under Part D than they would have under the prior system," said Jim Mays, the reports lead author and president of the Actuarial Research Corp., which performed the study for Kaiser. For more, go to: www.kff.org

Meanwhile, a new poll shows that only 20 percent of seniors say they have even a "fair" amount of knowledge about Medicare Part D and other changes that are taking place in Medicare. After the new prescription drug and preventive care benefits (for cardiovascular and diabetes screening) were described to 1,200 Americans aged 55 and older, approval of the 2003 Medicare Modernization Act jumped from 35 percent to 62 percent. Of those who are enrolled in the discount card program now in place, 61 percent were satisfied, and 16 percent dissatisfied. The poll was announced by Medicare Today, a national public education campaign being conducted by nearly 100 organizations, including AARP, the Healthcare Leadership Council and the National Council on Aging.

SUBSTANCE ABUSE

The Younger the Drinker, the Higher the Risk

A new study confirms what anecdotes have conveyed: that women are becoming more like men in their drinking habits, and youthful drinkers have a greater risk of becoming adult problem drinkers. After conducting a national telephone survey of 2,276 adults, researchers at the State University of New York at Buffalo's Research Institute on Addictions, found that the likelihood of alcohol abuse or dependence later in life increases by 12 percent for each year of decrease in the age at first drink for both men and women. Women reported taking their first drink at about age 18, while men started to drink at about 16. Supporting the view that women are becoming more like men in their drinking habits, the study showed that the age at first drink was more similar for young men and women than for older age groupings by gender. "We believe that these findings strengthen the argument for identifying individuals who begin drinking at young ages and targeting them for possible prevention efforts," said James York, lead investigator on the study, published in the journal *Alcoholism: Clinical and Experimental Research.*

WEST VIRGINIA LAW SEEKS FEDERAL DRUG DISCOUNTS

A groundbreaking resolution passed unanimously by both houses of the West Virginia Legislature could lower the cost of prescription drugs for all West Virginians, and be replicated by other states.

Passed during a special two-day session in late November, the resolution creates a new cabinet-level office, the Pharmaceutical Advocate, to negotiate prescription drug prices for public programs, including state employees, Medicaid, Workers Compensation and the Children's Health Insurance Program. As a benchmark, the Advocate would use the Federal Supply Schedule, which the federal government uses to negotiate lower prices for its veterans homes, prisons and other low-income programs.

If the program works, West Virginia could save enormous amounts of money. On average, federal supply prices are about 42 percent of retail. Those prices are 18 cents per pill lower than the prices the West Virginia Public Employee Insurance Agency pays, and 35 cents per pill lower than what Medicaid pays.

Once the program is up and running, any private entity, including senior service organizations and agencies and even pharmacies, could join and get the lower prices, said House Speaker Bob Kiss, who initiated the legislation. "The long-run intention is for all citizens of the state to benefit from the initiative, not only those who acquire their drugs through the state insurance systems," he said.

The Advocate, whose office would be located within the recently formed West Virginia Pharmaceutical Cost Management Council, would develop a common preferred drug list and prior authorization process for all pharmaceutical purchases for state agencies. The Advocate also could contract with prescription drug wholesale firms or act as wholesaler to local pharmacies, once drug prices are negotiated with the manufacturers.

"We're treading on new ground with this proposal, but we believe it has great merit," Kiss said. "This legislation would be only the beginning, providing the framework for implementation." The program's success is largely contingent upon joining together with other states to ensure sufficient leverage, Kiss added. "Several state leadership members we have contacted already have expressed interest. It's a problem that touches every state, and I believe many others would come on board." West Virginia may join with other multi-state purchasing alliances, and/or other states may join West Virginia in its strategy.

"We definitely could not force the pharmaceutical industry to give us the discounts, but we spend a lot through Medicaid and state employees (so we have significant negotiating power)," said Stacey Ruckle, spokeswoman for the House of Delegates. "We've been called the mouse that roared, and you could say we are."

Prescription drugs are the single largest cost of the state's Medicaid program, which pays more than $370 million a year for the 300,000 beneficiaries in the program.

Prenatal Care, from p. 2

searchers credit improvements to the targeted interventions that increased the number of obstetric providers serving Medicaid patients and, consequently, eased the burden on community health centers and hospital clinics.

A January 2004 report ranked Rhode Island first in the nation with the lowest percentage of births to women who received late or no prenatal care at only 1.1 percent, less than one-third of the national average of 3.7 percent.

GOING DOOR TO DOOR

Another technique that some states are using to reach out to high-risk, pregnant women are community health workers (CHWs). Known by a variety of names – lay health workers, promotoras, outreach educators, peer health educators and community health outreach workers – CHWs work to improve pregnancy outcomes by educating women about basic prenatal services and bringing them into the health-care system.

In some places, CHWs go door-to-door to identify pregnant women and develop relationships with them during their pregnancies. They assist women and their families with applications for Medicaid, WIC and other programs and offer informal counseling and basic education on topics such as substance abuse, HIV transmission, breastfeeding and lead poisoning prevention.

An estimated 12,000 CHWs serve in programs across the U.S. As states begin to recognize the integral role these health workers can play in linking services and improving health outcomes, many state legislatures may consider the formal credentialing of CHWs. By setting standards for certified CHWs, states can ensure that these workers have a minimum knowledge base and can provide them with a defined set of services and level of credibility within the health community.

Several states already have begun discussing credentialing, and two states – Ohio and Texas – have passed legislation requiring certification of CHWs. After establishing a temporary committee to examine educational requirements for promotoras and community health workers, the Texas Legislature passed legislation in 2001 that required the Department of Health to develop a CHW training and certification program. In doing so, Texas became the first state to formally credential CHWs.

The Ohio Legislature followed suit in 2003, creating a CHW credentialing program under the state Board of Nursing. In Ohio, CHWs work one-on-one with pregnant women before and after the child is born to make sure that they keep appointments and understand the importance of checkups and childhood screenings. The credentialing program will help Ohio provide standardized training for CHWs while encouraging them to advance their careers.

There may be drawbacks to credentialing. Such requirements create a barrier for people trying to enter the field, and training may distance CHWs from the neighbors they help. Furthermore, CHWs provide such a broad array of services that developing a defined set of skills or knowledge base may be difficult. However, states can expect to hear more about credentialing of CHWs as they seek to identify effective ways of reaching pregnant, at-risk women.✦

Adapted from an NCSL "State Health Lawmakers' Digest" written by GM, MH and ABS.

Telepsychiatry, from cover

More recently, a study in the October 2004 *American Journal of Psychiatry* found that a videolink is as effective in treating depression as face-to-face consultation. The study enrolled 119 veterans with depression in a randomized, controlled trial of eight therapy sessions over six months. Fifty-nine patients were treated using videoconferencing equipment, and 60 were treated in person. Forty-nine percent of the patients in the videoconferencing group and 43 percent of those in the in-person group showed over 50 percent improvement, according to accepted psychiatric measures.

STUMBLING OVER THE MONEY

One of the most serious obstacles to integrating telemedicine into mental health practices is the lack of consistent and comprehensive reimbursement policies, said Mark Langdon, a partner with Arent Fox in Washington, DC. Over the years, Congress has gradually removed some of the obstacles to Medicare reimbursement, until today, Medicare pays for various telepsychiatric services, including individual psychotherapy.

Advances also have been made at the state level. At least 27 states provide Medicaid reimbursement for telehealth services, as one of their optional services. Behavioral health is the fastest area of expansion within those services. States use many factors to determine the scope of coverage for telemedicine, such as the quality of equipment, type of services to be provided and location of providers (e.g., remote rural sites).

Meanwhile, the private sector is catching on. In a study by AMD Telemedicine Inc., Lowell, Massachusetts, some 38 programs in 25 states receive reimbursement from private payers. "While the market assumption is that private payers do not reimburse for telemedicine, in reality over 100 private payers currently reimburse for telemedicine," according to the CTL report.

Five states – including Louisiana, California, Oklahoma, Texas and Kentucky – have enacted laws requiring that services provided via telemedicine must be reimbursed if the same service would be reimbursed if provided in person, according to a 2003 report by the Center for Telemedicine Law (CTL), a non-profit group devoted to the advancement of telemedicine. And even in the absence of a definitive policy, some insurers and Medic-

[Telepsychiatry, p.6]

Telepsychiatry, from p. 5

aid agencies will pay for telemedicine services as long as the rationale for using telemedicine is justified to the agency's satisfaction.

HIGH START-UP COSTS

Cost is the biggest obstacle to starting a new telehealth system. In 1996, the Arizona Legislature paved the way for the establishment of NARBHAnet by providing a grant of $250,000 per year for three years from the state tobacco tax funds. NARBHA added another $91,000 a year from its end-of-the-year reserve fund.

"We felt it was that important to our ability to provide care," said Sue Morley, NARBHA's director of administrative services. In all, first year start-up costs totaled more than $1 million, said Morley. This included hub and endpoint equipment, building wiring, equipment maintenance contracts, telecommunications lines and staff costs. Although the program was helped with funding from the state during its early years, it hasn't received any specific telemedicine money from the state for the past few years, said Morley. The costs of both telemedicine equipment and telecommunications lines have declined significantly since NARBHAnet's inception, so NARBHA and its member clinics are now able to fund NARBHAnet independently.

Arizona's Medicaid program has covered the services provided via NARBHAnet since the network's start. "We met with our state Medicaid office early on," Morley said. "Our Medicaid program in Arizona has always been capitated, and they were supportive about our program from day one."

NARBHAnet has grown from six sites in 1996 to 17 today (12 rural clinic sites and five video rooms at NARBHA's Flagstaff headquarters). Five psychiatrists and one psychiatric nurse practitioner provided approximately 7,000 member visits in FY 2003-2004, an increase from the 841 provided in 1997, NARBHAnet's first full year of operation. Members go to one of the 12 clinic sites, where the TV monitors and camera equipment are located. The centers have social workers, counselors and case managers. Besides clinical and psychiatric work, NARBHAnet is used for consultations, office meetings and training.

NARBHAnet, like most telemedicine programs, has high equipment and line costs: In 1998-1999, NARBHA spent $778,994 on its then-14 sites for operations, telecommunication, salaries, depreciation and maintenance. Of that, approximately $131,000 was ultimately reimbursed by the Universal Service Fund program. (A surcharge on phone bills, the Universal Service Fund reimburses rural schools and health care clinics for the difference in cost between urban and rural phone lines.) "Rural lines are so much more expensive than those in urban areas," said Morley.

She pointed out that there are enormous savings in costs and time for that period. Those include: 6,572 hours and 347,039 miles of staff travel, and $107,582 of potential staff travel reimbursement.

SOUTH CAROLINA'S NEW GROUND

In 1994, the South Carolina Department of Mental Health launched a telepsychiatry program. It was initially started to accommodate the hard of hearing/deafness community, since the state was fortunate enough to employ a psychiatrist who knew American Sign Language. It has since grown beyond the 600 hard of hearing/deafness persons plus their family members to accommodate an additional 350 hearing persons with mental health problems per year. Some 70 percent of South Carolina is deemed rural.

The mental health department partnered with the state Medicaid agency in 1994 to help split the initial start up costs of $275,000, said Spencer. "Every state should work closely with their Medicaid agency to negotiate billable services using telepsychiatry," he stressed. In November, the mental health department rolled out new equipment to its 20 sites, and this time the department paid 100 percent of the costs. Due to lower technology costs, the department spent about the same amount of money as it had in 1994.

Better yet, the quality of technology has grown, so the department can do more with the new equipment, said Spencer. The new equipment also will allow the department to broadcast to all of the sites, and to include up to seven people at each site. The old system could only broadcast from one individual site to another. "This will open the door for us to hold consumer education programs on topics such as new emerging medications, or provide orientations regarding our mental health services," said Spencer. South Carolina's state Medicaid agency has approval for five different reimbursement categories of telepsychiatric services. With the new system, there is a potential to receive reimbursement for another dozen or so.

The program also has saved on line costs over the past two years by tapping into high-speed data lines already leased by the facilities for other purposes. In past years, the program had to pay $12.50 per hour, per site, per session for high-speed phone lines. "The idea of using the same lines already leased for video and voice is a distinct value," said Spencer. ✦

By Therese Droste, a freelance writer in Washington, D.C.

STATE HEALTH *NOTES*
FORUM FOR STATE HEALTH POLICY LEADERSHIP

Published biweekly (24 issues/yr.) by the FORUM FOR STATE HEALTH POLICY LEADERSHIP, an information and research center at the National Conference of State Legislatures in Washington, DC.

For more information about Forum projects, visit our web site at: www.ncsl.org/programs/health/forum

RESEARCH & EDITORIAL STAFF
Dick Merritt — Forum Director
Christina Kent — Managing Editor
Anna C. Spencer — Associate Editor
Contributors: Allison Colker, Donna Folkemer, Shelly Gehshan, Michelle Herman, Kala Ladenheim, Tara Lubin, Greg Martin, Diana Hinton Noel

EDITORIAL INQUIRIES

Christina Kent, Managing Editor
Tel: 202-624-5400 • Fax: 202-737-1069
email: christina.kent@ncsl.org

CUSTOMER SERVICE & SUBSCRIPTIONS
NCSL, 7700 East First Place, Denver, CO 80230
Tel: 303-364-7700 • Fax: 303-364-7800

TRACKING *TRENDS*

From NCSL's HEALTH POLICY TRACKING SERVICE

Hospital Billing Practices and the Uninsured: Emerging Legislative Response

Hospitals increasingly are seeking to obtain payment from patients prior to discharge in order to reduce bad debt and to increase their profit margins. This policy places a financial burden upon low- or middle-income uninsured individuals. Moreover, there appears to be a discrepancy between the amount that hospitals charge uninsured patients and private insurers, Medicare and Medicaid for medical care -- only the uninsured pay the full price. Should uninsured patients fail to pay their bills, the hospitals may initiate debt collection practices that critics assert are abusive.

In 2004, lawmakers considered legislation aimed at curbing abusive practices. However, no legislation was enacted this year. In Alabama, HB 805 would prohibit hospitals from charging uninsured individuals more than the amount Medicare would pay for the same service. The Georgia General Assembly considered two bills – HB 533 and HB 1573 – that would prohibit hospitals from charging an uninsured patient more than the average rate charged to managed-care plans. In Illinois, SB 2579 would require hospitals to develop "assistance to the uninsured" policies and would limit debt collection activities.

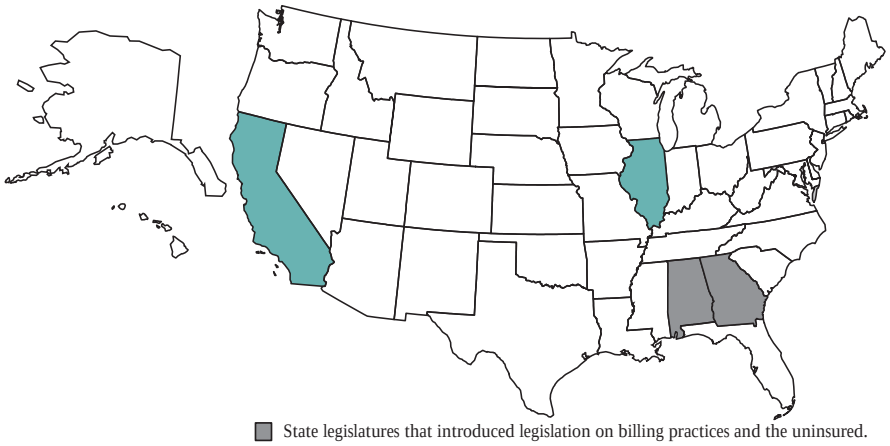
California Gov. Arnold Schwarzenegger (R) vetoed legislation, SB 379, that would have required hospitals to provide discounted care to low-income individuals and prohibited a number of aggressive debt collection tactics. In his veto message, the governor expressed sympathy for uninsured patients who struggle with expensive hospital bills. However, he said that he wanted to give the voluntary charity care and collection guidelines adopted by the hospital industry more time to work before imposing state mandates. The California Healthcare Association pledged that every hospital in the state would be complying with the guidelines by the end of 2004.

Hospital officials note that they have discount programs for uninsured patients. However, in an interview with the Health Policy Tracking Service, Georgia Rep. Austin Scott, sponsor of HB 1533 and HB 1573, asserted that state action was needed to ensure that all hospitals do not charge the uninsured inflated prices. In fact, he said, the inspiration for his bills came from a discussion with a proactive member of the hospital industry who voluntarily instituted a discount policy. Scott intends to introduce the legislation again in 2005, and he expects livelier debate because the issue is heating up.

Nationwide, at least 48 class action lawsuits have been filed against more than 400 nonprofit hospitals. The lawsuits claim that hospitals retain millions of dollars annually because of their tax-exempt status; in return, the hospitals should provide charity care. Instead, the lawsuits say, they charge uninsured patients full price and harass them when they're unable to pay. The lawsuits also argue that hospitals violate the Emergency Medical Treatment and Labor Act by requiring patients, prior to treatment, to sign a contract agreeing to pay in full for unspecified medical charges that are set by the hospital at its sole discretion.

The American Hospital Association asserts that the lawsuits do not focus on the underlying problems of the health-care system: emergency departments caring for a growing number of indigent patients, a record number of Americans who lack insurance, and Medicaid and Medicare payments that have not kept pace with hospital costs. *AM*

For more information on this topic call (703) 531-1213 or e-mail info@hpts.org



State legislatures that introduced legislation on billing practices and the uninsured.

States where legislation passed the chamber of origin.

Source: NCSL Health Policy Tracking Service, November 2004.

FOR YOUR *INFORMATION*

Nevada Promotes Good Oral Health

Of all the preventive oral health care measures that are available, probably nothing gives more "bang for the buck" than fluoridation. Fluoridation is inexpensive, safe and especially effective for children, whose still-growing teeth are vulnerable to caries (or decay) and bad hygiene habits.

Fluoridation is the process of adding the naturally occurring element fluorine to drinking water to prevent decay. It's estimated that for every dollar spent on fluoridation, up to $50 in dental bills may be saved. Unfortunately, as of 2002, only 66 percent of U.S. residents served by public water supplies had fluoridated water.

In 1999, Nevada set out to make a real difference in the oral health of its children and adults. The state Legislature approved a one-time redirection of the Maternal and Child Health Block Grant to establish a two-year oral health initiative. Soon after, the Legislature also enacted legislation requiring counties with populations of more than 400,000 to fluoridate their water supplies.

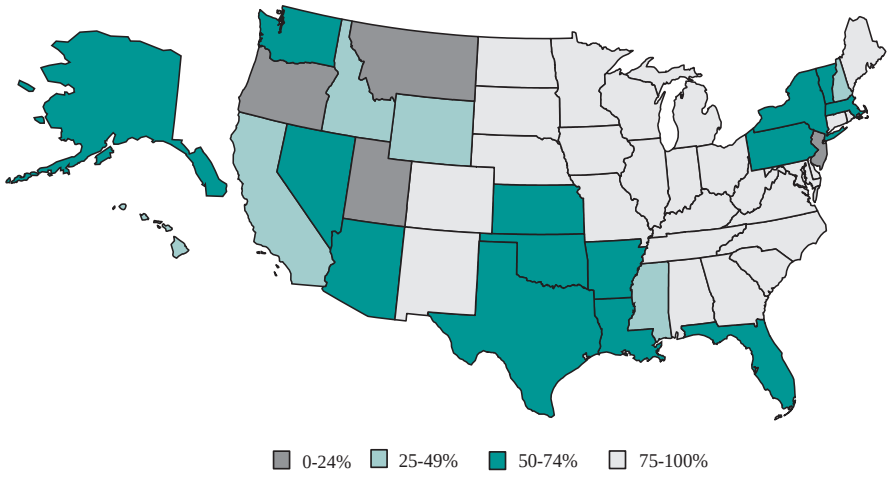
That meant that Clark County, which contains Las Vegas and two-thirds of the state's population, was required to initiate optimal flouridation. In March 2000, the county's community water suppliers brought fluoridation levels in the county from zero to 69 percent. In November 2000, Clark County residents voted to continue fluoridation. The residents were pro-flouridation in part because a dental care coalition had worked very hard to educate them about the benefits of fluoride, said Christine Forsch, oral health program manager of Nevada.

The fluoridation equipment is funded by the Centers for Disease Control and Prevention, and the minimal costs of the fluoride (about 50 cents per person, per year) are subsidized by the water authorities.

In order to track the effects of fluoridation, this past year the state compared the rate of caries in Head Start children aged three to five in Clark County, with children in Washoe County, whose water supply is not fluoridated. Half the children in Clark had tooth decay, compared to 65 percent of those in Washoe – a significant difference.

Nevada hopes to meet the Healthy People 2010 target of 75 percent fluoridation. "One of the things I tell people is that not everybody becomes diabetic, not everybody is obese, not everybody smokes, but everybody has teeth, or had teeth, so it is a concern for everyone," Forsch said. "There's not a person alive for whom oral health isn't relevant." *TR*

Fluoridation Statistics 2000: Status of Water Fluoridation by State
Percentage of state population served by public water systems receiving fluoridated water, 2001



Source: 2000 Water Fluoridation Reporting System (CDC website).

National Conference of State Legislatures
444 North Capitol Street, NW, Suite 515
Washington, D.C. 20001