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### Drive-Through Deliveries: Indiscriminate Postpartum Early Discharge Practices Presently Necessitate Legislation Mandating Minimum Inpatient Hospital Stays

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# "DRIVE-THROUGH DELIVERIES": INDISCRIMINATE POSTPARTUM EARLY DISCHARGE PRACTICES PRESENTLY NECESSITATE LEGISLATION MANDATING MINIMUM INPATIENT HOSPITAL STAYS

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## I. INTRODUCTION

"Drive-through deliveries," women delivering their babies and leaving the hospital only a few hours, rather than days, later are increasingly becoming the standard of care in the United States.<sup>1</sup> In fact, insurers around the country

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<sup>1</sup>"Drive-through deliveries" is a phrase, coined by the popular press, that refers to postpartum early discharge. "The practice of early discharge currently varies according to the region of the country. Though originally more prevalent in the West, it is increasingly becoming the standard of care throughout the country." *Mothers' and Newborns' Health Protection Act of 1995: Hearings on S. 969 Before the Comm. on Labor and Human Resources, 104th Cong., 1st Sess. 81 (1995)* [hereinafter *Hearings*] (prepared statement of Judith Frank, Chief of the Division of Neonatology and Associate Professor Department of Pediatrics, Dartmouth Medical School).

commonly discharge new mothers and their infants from the hospital less than twenty-four hours after a vaginal birth and within forty-eight hours after a cesarean section.<sup>2</sup> In California, for example, Kaiser Permanent, a large Health Maintenance Organization ("HMO"), at one point employed a policy to begin reviewing patients for discharge eight hours after birth.<sup>3</sup> Opinion concerning the safety of this practice varies widely. Proponents claim the practice is a safe, money-saving option, while opponents believe the practice may have harmful affects on newborns, especially concerning the diagnosis of serious illnesses undetectable before twenty-four hours of life.<sup>4</sup>

There is a cost crisis in health care and as competition among managed care organizations ("MCOs") grows, the urgency to cut costs and to gain market share becomes apparent.<sup>5</sup> Unfortunately, consumers are feeling the brunt of this competition through coverage limitations insurers find necessary in order to control costs.<sup>6</sup> While insurers claim limitations do not jeopardize the quality of care, cost-cutting techniques often force the discharge of patients earlier than current medical guidelines prescribe.<sup>7</sup> Traditionally, the decision concerning

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<sup>2</sup>Paula Braveman et al., *Early Discharge of Newborns and Mothers: A Critical Review of the Literature*, 96 PEDIATRICS 716, 716 (1995).

<sup>3</sup>Thomas W. Derry et al., *Post-Natal Care: Laws to Curb 'Drive-Through Deliveries' Gaining Momentum in State Legislatures*, 3 HEALTH CARE POL'Y REP. (BNA) D50 (Aug. 7, 1995).

<sup>4</sup>See *Hearings*, *supra* note 1, at 56-57 (prepared statement of Palma E. Formica, M.D., The American Medical Association); Mhairi G. MacDonald, *Hidden Risks: Early Discharge and Bilirubin Toxicity Due to Glucose 6-Phosphate Dehydrogenase Deficiency*, 96 PEDIATRICS 734 (1995).

<sup>5</sup>"Managed care" is a widely used term that generally includes strategies for cost containment through "management" of the care provided to patients. Cost containment is generally accomplished through strict observation of and control over doctors serving the MCO to be assured that no excess care is provided to the patient. Health Maintenance Organizations ("HMOs") and Preferred Providers Organizations ("PPOs") are examples of MCOs. MCOs are distinguishable from fee-for-service health providers which do not extensively monitor doctors' actions and expenses. Richard J. Arnould et al., *Competitive Reforms: Context and Scope*, in COMPETITIVE APPROACHES TO HEALTH CARE REFORM 3, 9 (Richard J. Arnould et al. eds., 1993).

<sup>6</sup>See Jerry Geisel, *Maternity Stay Backlash Grows; Bill Would Mandate Minimum Inpatient Stay*, BUS. INS., July 10, 1995, at 1; Christina Kent, *Bill Would Put the Brakes on 'Drive-Through Deliveries'*, AMERICAN MED. NEWS, Oct. 2, 1995, at 19; Jan Ziegler, *Drive-through Delivery: Bargain or Blunder? The Economics of Early Discharge of Mothers and Newborns Infants; Includes Related Information*, 13 BUS. & HEALTH 19 (Sept. 1995); Michael A. Farinella, *Managed Care Shakeout: Competitors Vie for Bigger Slice*, BEST'S REV. - LIFE-HEALTH INS. EDITION, Aug. 1, 1995, at 34.

<sup>7</sup>*Hearings*, *supra* note 1, at 33 (statement of Michael T. Mennuti, M.D., The American College of Obstetricians and Gynecologists). The current guidelines suggest that postpartum discharge should occur no earlier than forty-eight hours after a vaginal birth and ninety-six hours after a cesarean section. AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 91-116, (3rd ed. 1992) [hereinafter GUIDELINES].

discharge of the mother and newborn was determined jointly by the doctor and the mother.<sup>8</sup> Currently, the decision is often made by insurance personnel without medical training, according to insurance protocol.<sup>9</sup> Insurers claim to provide quality health care at the lowest possible cost;<sup>10</sup> however, many doctors believe early discharge calls the quality of postnatal care into question.<sup>11</sup>

The early discharge of mothers and newborns after childbirth has attracted the attention of politicians, researchers, doctors, and parents. The concerns about the safety of early discharge stem from the fact that numerous illnesses, such as jaundice, are not detectable in infants until at least twenty-four hours after birth.<sup>12</sup> While anecdotal evidence supports these fears, the potential consequences of early discharge are largely unknown.<sup>13</sup>

In response to complaints made by constituents, numerous state legislatures, as well as the federal government, have instituted protective laws and/or regulations for mothers and newborns.<sup>14</sup> Generally, the legislation mandates a minimum of forty-eight hours of inpatient care for a mother and her newborn after a vaginal birth and ninety-six hours of care after a cesarean section in order to prevent and deter wholesale early discharge until researchers are able to determine the safety of the practice.<sup>15</sup>

Mandated inpatient care, however, strikes a visceral chord. Opponents of the legislation believe the government should not involve itself in this matter and should allow insurers and physicians to determine a reasonable solution.<sup>16</sup> Additionally, opponents are concerned with the type of precedent this legislation establishes in the area of the government's involvement in the dissemination of healthcare.<sup>17</sup> Conversely, proponents of the legislation are concerned that early discharge is simply one example of the problems with the healthcare system and believe legislation is necessary to alleviate the current

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<sup>8</sup>*Hearings, supra* note 1, at 33 (statement of Michael T. Mennuti).

<sup>9</sup>*Id.*

<sup>10</sup>*Id.* at 63 (prepared statement of Sharon Levine, Pediatrician, Kaiser Permanent).

<sup>11</sup>*Id.* at 56-57 (prepared statement of Palma E. Formica).

<sup>12</sup>*Id.* at 34 (statement of Palma E. Formica); *see* Braveman et al., *supra* note 2, at 716.

<sup>13</sup>*Hearings, supra* note 1, at 30 (statement of Judith Frank). For an analysis of the literature, *see* Braveman et al., *supra* note 2.

<sup>14</sup>*See infra* part III.

<sup>15</sup>*See infra* part III.

<sup>16</sup>*Hearings, supra* note 1, at 39 (statement of Sharon Levine).

<sup>17</sup>Kent, *supra* note 6, at 19.

disconnect between insurers and doctors concerning what is to be considered appropriate care.<sup>18</sup>

This Note argues that legislation mandating minimum inpatient postpartum hospital stays is presently the best possible solution to the overreaching control MCOs have over doctors, the standard of care, and the length of hospital stays based on their willingness to cover treatment. Part II of this Note reviews the development of postpartum care during the twentieth century. This section also discusses the reasoning for the concerns regarding the early discharge of newborns and their mothers. Part III discusses the federal and state laws and regulations mandating minimum hospital stays. Part IV examines the available anecdotal and statistical evidence concerning the negative effects of early discharge on newborns and their mothers. Part V addresses the arguments for and against the legislation and proposes possible improvements. Part VI analyses whether and why legislation is the best solution to the current problem.

## II. CHANGES IN POSTPARTUM CARE DURING THE 20TH CENTURY

Most births in the early 20th century occurred in the home.<sup>19</sup> Hospital births became more common by the 1930s when antiseptic techniques and surgical anesthesia were routinely used in hospitals.<sup>20</sup> After World War II a trend of long hospital stays began to emerge with women and newborns remaining in the hospital for five or more days after a vaginal birth.<sup>21</sup> Similarly, the maternity stay after a cesarean section was one to two weeks.<sup>22</sup> In the early 1970s a transformation began with home births, midwives, and shorter hospital stays becoming popular.<sup>23</sup> These changes have been attributed to a "consumer demand to decrease medical interventions surrounding childbirth and provide a more family-centered birth experience."<sup>24</sup>

The decline in postpartum hospital stays has continued. As reported by the Centers for Disease Control and Prevention, the average length of maternity stays between 1970 and 1992 following a vaginal birth decreased from 3.9 to 2.1 days (46%) and following a cesarean section from 7.8 to 4 days (49%).<sup>25</sup> The

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<sup>18</sup>*Hearings, supra* note 1, at 35 (statement of Palma E. Formica).

<sup>19</sup>*Id.* at 64 (prepared statement of Sharon Levine).

<sup>20</sup>*Id.*

<sup>21</sup>*Id.*

<sup>22</sup>*Id.* at 53.

<sup>23</sup>*Hearings, supra* note 1, at 53 (prepared statement of Michael T. Mennuti).

<sup>24</sup>*Id.* at 53 (prepared statement of Michael T. Mennuti). Recall, this increase in home births, midwives and shorter hospital stays occurred at the height of the women's movement. One should not be surprised that women at this time were seeking greater control over childbirth and postpartum care.

<sup>25</sup>Centers for Disease Control, *Trends in Length of Stay for Hospital Deliveries - United States, 1970-1992*, 44 MORBIDITY & MORTALITY WKLY. REP. 335 (May 5, 1995). These

length of postpartum inpatient stays are steadily decreasing to lengths of twenty-four hours or less.<sup>26</sup> In a recent study by HCIA, Inc., researchers determined that in the Western region of the United States, 73% of women were discharged within twenty-four hours after birth, whereas only 10.2% of women in the Northeast were discharged within twenty-four hours after birth.<sup>27</sup> In the Midwest 30.1% of women were discharged within twenty-four hours after birth and in the South the figure was 37.0%.<sup>28</sup> The HCIA study also revealed an interesting correlation between a woman's insurance carrier and the length of her hospital stay, 57.7% of women with HMO coverage were discharged within twenty-four hours as compared to 35.9% of women with non-HMO coverage and 39.9% of women covered by Medicaid.<sup>29</sup>

#### *A. Explanations for the Present Decline in Hospital Stays*

In the 1970's, women wanting a more natural birthing process caused the trend toward earlier discharges.<sup>30</sup> In contrast, MCOs and third-party payers seeking to reduce costs have caused the current trend in early discharge.<sup>31</sup> This phenomena is not unique to postpartum early discharge. There has been a reduction in the amount and degree of care covered by insurers in all healthcare

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statistics do not distinguish between uncomplicated and complicated deliveries. Because the statistics include complicated deliveries, which increase the average length of stay, the average length of stay for uncomplicated deliveries is probably shorter than reported. *Hearings, supra* note 1, at 53 (prepared statement of Michael T. Mennuti).

<sup>26</sup>Braveman et al., *supra* note 2, at 716. In fact, on January 1, 1995, Blue Cross and Blue Shield, the industry standard-setting company, instituted a policy covering hospital stays only up to 24 hours after a vaginal delivery and 48 hours after a cesarean section barring an emergency. Congressman Frank Pallone, Jr., Address at the Jersey Shore Medical Center Maternity Ward (Jan. 2, 1996).

<sup>27</sup>DAVE FOSTER & LINDA SCHNEIDER, HOSPITAL LENGTH OF STAY AND RE-ADMISSION RATES FOR NORMAL DELIVERIES AND NEWBORNS: RELATIONSHIP TO HOSPITAL PATIENT, AND PAYER CHARACTERISTICS 3 (1995).

<sup>28</sup>*Id.*

<sup>29</sup>*Id.* at 7.

<sup>30</sup>*Hearings, supra* note 1, at 80 (prepared statement of Judith Frank).

<sup>31</sup>*Id.* at 30 (statement of Judith Frank). In 1990, the United States spent \$666 billion on health care, double the amount the country spent on health care in 1982, less than ten years before. Howard M. Leichter, *The States and Health Care Policy: Taking the Lead, in HEALTH POLICY REFORM IN AMERICA INNOVATIONS FROM THE STATES* 13 (Howard M. Leichter ed., 1992).

The upsurge in cost-cutting measures is a result of the increase of MCOs in the market which evolved to be more cost effective than fee-for-service plans. In 1970, 90% of the people insured by private insurers in the United States were insured through fee-for-service providers; by 1991, that number plummeted to between 10% and 15%. Edward Hirshfeld, *The Case for Physician Direction in Health Plans*, 3 ANNAL HEALTH L. 81, 84 (1994) (citing DAVID E. VOGEL, *THE PHYSICIAN AND MANAGED CARE* 3 (1993)).

areas.<sup>32</sup> These cost-cutting measures are a response to fee-for-service insurance which provides cost-pass-through financing which has led to unnecessary medical care and increasing medical costs.<sup>33</sup>

The rise in health care costs has been attributed to a variety of factors including: 1) the rising cost of medical equipment; 2) the rising cost of medical tests; 3) the rising cost of hospital stays;<sup>34</sup> 4) tax-free health care packages for employers;<sup>35</sup> and 5) the work ethic of physicians. While all these factors add to excessive medical costs, insurers tend to focus their cost controlling efforts on the practices of physicians because,

[i]n a traditional health care relationship, the health plan has no control over expenditures, and the patient and physician have no incentive to control costs. The physician's focus is solely on healing patients: any treatment the physician orders that is within the realm of acceptable medical practice is a covered expense. The result has been unmanageable increases in health care expenditures.<sup>36</sup>

Physicians have contributed to increased health care costs because: 1) medical ethics dictate that physicians must provide all possible medical procedures; 2) malpractice laws reinforce medical ethics by creating a strict standard of care; and 3) fee-for-service insurance financing has not required

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<sup>32</sup>The following is an example of the effects of cost-cutting measures on inpatient hospital stays in the United States. "As little as two years ago, says Debra Garner of the Washington (D.C.) Hospital Center, the average heart patient undergoing by-pass surgery spent 14 to 16 days in the hospital. Now, these same patients go home in five to seven days." Ziegler, *supra* note 6, at 19.

<sup>33</sup>See Frances H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, LAW & CONTEMP. PROBS., Apr. 1988, at 195.

<sup>34</sup>See Thomas G. McGuire & John T. Montgomery, *Mandated Mental Health Benefits in Private Health Insurance*, 7 J. HEALTH POL., POLY. & L. 380, 389 (1982). The costs of medical equipment and tests cannot be controlled by insurers; these costs rise with inflation. *Id.* Consequently, insurers must attempt to control costs by controlling doctors' use of medical tests and equipment. *Id.*

<sup>35</sup>"Many companies provide complete first dollar coverage and a wide array of benefits as tax-free benefits to their employees. This takes away employees' incentives to act as consumers of health care." Henry N. Butler, *The Political Market for Mandated Health Care Benefits Under the Proposed National Health Security Act*, KAN. J.L. & PUB. POLY, Winter 1993/1994, at 113, 115 (citation omitted).

<sup>36</sup>Hirshfeld, *supra* note 31, at 84 (citations omitted). "[P]hysicians are the primary culprits of high health care costs. Physicians are perceived as having a financial interest in providing high-cost care, and as being unwilling to adopt a lower-cost practice, even if that lower-cost style results in a higher quality of care." *Id.* at 95.

In response to accusations that doctors are the reason health costs are soaring, the American Medical Association recognizes that there is a need for doctors to become more efficient and to streamline their practices. The AMA argues, however, that quality medicine cannot include insurance companies pressuring and second-guessing physicians' treatment decisions. *Hearings, supra* note 1, at 55 (prepared statement of Palma E. Formica).

physicians to reduce costs while preserving their medical ethics.<sup>37</sup> Because physicians must provide quality care to avoid malpractice liability and insurers want to control costs, a conflict of interest exists.<sup>38</sup> This conflict has led to a stalemate forcing MCOs to, as some would call it, infringe on the physician's right to determine what is medically best for his or her patient by pressuring physicians into discharging patients earlier than physicians believe to be appropriate.<sup>39</sup>

In order to "manage care," MCOs must determine ways to decrease the number of services physicians provide and perform. MCOs utilize three general mechanisms to control costs: 1) they eliminate unnecessary care; 2) they provide necessary care more efficiently; and 3) they offer preventive care.<sup>40</sup> In addition to these techniques, MCOs employ utilization review and financial incentives to control physicians.<sup>41</sup> Utilization review requires physicians to gain precertification prior to admitting a patient into a hospital or conducting any treatment by seeking approval from a MCO representative who has authority to approve or deny any treatment or length of stay.<sup>42</sup> The financial incentives include capitation payments, allowances, and target-utilization schemes.<sup>43</sup>

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<sup>37</sup>Hirshfeld, *supra* note 31, at 95. "The problem is not that physicians are giving patients care that has zero medical benefit; rather, it is that they are prescribing significant amounts of care that yields some positive health benefit to the individual patient but that is not cost-justified from society's point of view." Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons For Reformers from the Clash of Cultures*, 103 YALE L. J. 1297, 1300-01 (1994).

<sup>38</sup>Farinella, *supra* note 6, at 37.

In decision-making, physicians are only supposed to consider the medically applicable harms and benefits of a treatment cause of action; "judgments of cost-effectiveness are out-of-bounds." Frankel, *supra* note 37, at 1317. This approach directly contradicts the insurance companies' goals to reduce costs, and is one reason in favor of the current legislation. *Id.*

<sup>39</sup>Hearings, *supra* note 1, at 35 (statement of Palma E. Formica).

<sup>40</sup>Hirshfeld, *supra* note 31, at 85.

<sup>41</sup>Jim M. Perdue & Stephen R. Baxely, *Cutting Costs—Cutting Care: Can Texas Managed Health Care Systems and HMOs be Liable for the Medical Malpractice of Physicians?*, 27 ST. MARY'S L. J. 23, 47 (1995).

<sup>42</sup>*Id.*

<sup>43</sup>*Id.* at 48. Capitation payments are payments made to a physician on a monthly basis without regard to the amount of services the physician provides. If a physician is given an allowance, the physician is paid on a limited fee-for-service basis with a percentage of the fee withheld by the MCO. If the amount of the fees collected by the physician falls within the amount "allowed" by the insurer, the amount withheld will be paid to the physician at the end of the year. If the physician exceeds his/her allowance, the company keeps the withheld fees. In a target-utilization program a target amount of fees is set by the company and if the physician stays within that amount for the year, he/she is given a bonus. *Id.* at 48-49.



MCOs set stringent guidelines concerning the amount of inpatient time that is appropriate for all medical procedures in order to eliminate unnecessary care.<sup>44</sup> These guidelines have proven problematic because MCO personnel have interpreted them to be goals or rules instead of guidelines.<sup>45</sup> In general, the guidelines had been devised to be appropriate for the top ten best outcomes for any surgical procedure.<sup>46</sup> Now, these "optimal guidelines" are being applied to all patients without regard to the success of the particular procedure or that patient's individual healthcare needs.<sup>47</sup> The strict application of these guidelines has made insurers the medical decision-makers. Doctors are forced to seek MCO approval before conducting any treatment and patients are forced out of the hospital when insurers deny coverage.<sup>48</sup>

In defense of their actions, "[m]any in the managed care industry are quick to point out that they are 'only making benefits determinations' and the course of treatment or length of stay are solely within the judgment of the treating physician."<sup>49</sup> Technically, doctors do have the final decision-making power

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<sup>44</sup>See Greg Borzo, *R.I. Doctors Face 'Absurd' Inpatient Limits*, AM. MED. NEWS, Mar. 21, 1994, at 1.

<sup>45</sup>Farinella, *supra* note 6, at 38. "In their zeal to keep costs down, managed care companies reduce or 'ration' the health care they provide. One form of this rationing is to curtail the length of hospital stays for new mothers and babies following delivery. . . . These cost-driven measures completely ignore documented medical risks." *Hearings*, *supra* note 1, at 56 (prepared statement of Palma E. Formica).

<sup>46</sup>Farinella, *supra* note 6, at 38.

<sup>47</sup>*Id.*

<sup>48</sup>Hirshfeld, *supra* note 31, at 81. There are a number of adverse affects related to the non-physician authority and control developing in MCOs. The first is a less than optimal performance in terms of "value" achieved. The second is a loss of patient-centered values and ethics. The third is a transformation of the physician-patient relationship into an "arm's length business relationship." *Id.* at 91.

<sup>49</sup>Randal R. Munn, *Managed Care/Utilization Review Liability*, NEV. LAW, Aug. 1993, at 23, 25. At least one court has rejected this as legal fiction:

[The managed care company] makes much of the disclaimer that decisions about medical care are up to the beneficiary and his or her doctor. While that may be so, and while the disclaimer may support the conclusion that the relationship between [the managed care provider] and the beneficiary is not that of doctor-patient, it does not mean that [the managed care provider] does not make medical decisions or dispense medical advice. . . . By its very nature, a system of prospective decision making influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary, faced with the knowledge of specifically what the plan will or will not pay for, will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits. When [the managed care provider] makes a decision pursuant to [its administrative guidelines],

concerning the course of treatment or discharge of their patient. However, the MCOs do not reveal that doctors' decisions are often dictated by restrictions implemented by their MCO. In fact, companies retaliate against doctors whose medical judgment deviates too far from the company's guidelines.<sup>50</sup> Retaliation comes in the form of reduced compensation or deselection of the doctor from the health care plan.<sup>51</sup>

The health care industry needs to determine how to reduce costs while maintaining the present level of quality in the services it provides. The answer, however, is not removing doctors from the decision-making process although, many MCOs are effectively creating this result by enforcing stringent guidelines on doctors. While doctors may have contributed to the high cost of health care in the past, "[p]hysicians continue to be the best qualified to make medical decisions that maximize the value of health care services and embrace and resolve the challenge of finding ways to reduce costs without sacrificing coverage or quality."<sup>52</sup>

### *B. Attack on Postpartum Care*

Postpartum care is the area most noticeably affected by early discharge because childbirth is the most common reason for hospitalization in the United States. Consequently, postpartum care is the area most frequently targeted by insurers for cost-cutting measures.<sup>53</sup>

[I]nsurers looking for a place where a change of practice would bring significant savings—and child birth is the most common of all reasons for hospitalization, one that a large number of people on any general health plan can be expected to make use of—sought to impose such a

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it is making a medical recommendation which—because of the financial ramifications—is more likely to be followed.

*Corcoran v. United Healthcare Inc.*, 965 F.2d 1321, 1331-32 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033.

<sup>50</sup>*Hearings*, *supra* note 1, at 57 (prepared statement of Palma E. Formica).

<sup>51</sup>*Id.* Doctors are at a disadvantage to the MCOs because doctors often depend on MCOs for patients and revenues. Farinella, *supra* note 6, at 37.

For Holly Roberts, an obstetrician-gynecologist in Red Bank, N.J., pressure from an insurer whose name she refuses to divulge peaked during a visit to her practice. "They came with a chart," she says, "and showed me where I was in getting patients out of the hospital. They said that they were keeping me in the system because of my low C-section rate, but that I had to get my patients out faster." The implication was clear: If she didn't comply she would be dropped from the plan. Now, simply to stay in practice, Roberts says, "I am getting my patients out faster."

Ziegler, *supra* note 6, at 19.

<sup>52</sup>Hirshfeld, *supra* note 31, at 92.

<sup>53</sup>Centers for Disease Control, *supra* note 25, at 335.

change even in cases where individual doctors had serious safety concerns.<sup>54</sup>

While relatively inexpensive compared to many other medical treatments, childbirth remains costly. In 1989, the average cost of a vaginal delivery was \$4,334 and the average cost of a cesarean-section was \$7,186.<sup>55</sup> In 1993, the cost of the average vaginal delivery rose to \$6,430 while the cost of the average cesarean-section rose to \$11,000.<sup>56</sup> Maternity beds average \$1000 per day and there are approximately four million births per year.<sup>57</sup> Consequently, for every day insurers shorten the average maternity stay, they save approximately \$4 billion a year.<sup>58</sup>

### *C. Concerns About Postpartum Early Discharge*

Postpartum early discharge is looked upon by many with distaste because at birth women and newborns are viewed as extremely vulnerable.<sup>59</sup> Early discharge is perceived as a tactic by insurers to take advantage of that vulnerability.<sup>60</sup> While this perception of early discharge has fueled the fire against the practice, more serious concerns plague doctors and researchers. The American Medical Association ("AMA"), the American Academy of Pediatrics ("AAP"), and the American College of Obstetricians and Gynecologists ("ACOG") have voiced their concerns about early postpartum discharge.<sup>61</sup> These concerns center on the fact that a twenty-four hour hospital stay is not long enough to detect many illnesses newborns may have nor to educate mothers in the areas of infant care and feeding particularly, if adequate follow-up care is not provided.

First, numerous health problems faced by newborns, such as dehydration and jaundice, do not appear until after the first 24 hours of life. Since many of these illnesses can only be detected by health professionals, early hospital discharge can cause these conditions to go undetected, leading to brain damage, strokes, or even death.

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<sup>54</sup>*Babies and HMOs*, WASH. POST, July 4, 1995, at A20.

<sup>55</sup>HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 1991 74 (1991).

<sup>56</sup>Geisel, *supra* note 6, at 22.

<sup>57</sup>*Hearings*, *supra* note 1, at 56 (prepared statement of Palma E. Formica); Centers for Disease Control, *supra* note 25, at 335.

<sup>58</sup>*Hearings*, *supra* note 1, at 56 (prepared statement of Palma E. Formica).

<sup>59</sup>*Id.* at 52 (prepared statement of Michael T. Mennuti).

<sup>60</sup>Insurers are viewed as "target[ing] mothers and newborns when they are most vulnerable." *Id.*

<sup>61</sup>*Id.* at 32 (statement of Michael T. Mennuti); *id.* at 34 (statement of Palma E. Formica); *Id.* at 76 (prepared statement of the American Academy of Pediatrics).

Second, the mother can also develop many serious health problems, including pelvic infections, breast infections, and hemorrhaging.

Third, a 24 hour stay does not provide sufficient opportunity for the mother to be taught basic infant care skills such as breastfeeding. This, combined with the fact that many mothers are simply too exhausted to care for their child 24 hours after delivery, often leads to newborns receiving inadequate care and nourishment during their crucial first few days of life.<sup>62</sup>

Inadequate newborn screening for phenylketonuria ("PKU"), a deficiency in the ability to metabolize protein which can lead to mental retardation if not detected and treated, is another serious concern.<sup>63</sup> The testing for PKU has become inadequate in recent years because the commonly used detection test is only reliable when performed no earlier than twenty-four hours after the newborn is first fed, which is usually four hours after birth.<sup>64</sup> Accordingly, early discharge creates a risk for a false-negative diagnosis of PKU because the sensitivity of the screening is decreased when conducted prior to twenty-four hours after the newborn's first feeding.<sup>65</sup> To avoid non-detection of affected newborns, the AAP recommends readministering the test between one and two weeks of age which rarely occurs because the majority of states do not mandate rescreening.<sup>66</sup>

A study conducted by Laura Sinai, M.D. found that twenty-four percent of newborns were discharged within twenty-four hours after birth.<sup>67</sup> In those states which do not mandate rescreening, only forty-eight percent of hospitals rescreen infants discharged within twenty-four hours of life.<sup>68</sup> Researchers are concerned that the incidence of mental retardation from PKU, which has been

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<sup>62</sup>141 CONG. REC. S9175 (daily ed. June 27, 1995) (statement of Sen. Bradley).

Additional concerns include noninitiation or premature cessation of breast-feeding, missed identification of congenital anomalies, decreased and incomplete immunization, increased rehospitalization, higher postneonatal mortality, decreased receipt of primary care, increased parental anxiety, decreased clinical postpartum observation, and increased maternal depression. Woddie Kessel et al., *Early Discharge: In the End, It Is Judgment*, 96 PEDIATRICS 739, 739 (1995).

<sup>63</sup>Laura N. Sinai et al., *Phenylketonuria Screening: Effect of Early Newborn Discharge*, 96 PEDIATRICS 605, 605 (1995). In the United States approximately 160-400 children per year are born with PKU. *Id.* The screening mechanism is essential because a clinical diagnosis of PKU cannot be made until about six months of age after significant mental retardation has already occurred. *Id.*

<sup>64</sup>*Id.*

<sup>65</sup>*Id.* at 607. Screening performed at 12 hours fails to diagnose 30% of infants with PKU, and screening between 12 and 24 hours fails to detect 10% of affected infants. *Id.*

<sup>66</sup>*Id.*

<sup>67</sup>*Id.*

<sup>68</sup>Sinai, et al., *supra* note 63, at 606.

basically averted in this country, will again increase as a result of early discharge.<sup>69</sup>

Discharge of the mother and newborn is not appropriate until both are medically stable, adequate parental education has occurred, and adequate neonatal screening has been completed.<sup>70</sup> In order to guide physicians in determining when discharge is appropriate, the AAP and ACOG have jointly developed minimum criteria and conditions that should be met prior to discharge.<sup>71</sup> Among the minimum criteria are the following: 1) the baby has urinated and passed one stool; 2) there is no evidence of jaundice in the first twenty-four hours of life; 3) the baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding; 4) the baby's vital signs are documented as being normal and stable for the twelve hours preceding discharge; and 5) a physician-directed source of care for mother and baby has been identified.<sup>72</sup> Because the criteria set forth in the *Guidelines for Perinatal Care* are extremely extensive, adequate fulfillment of the criteria within less than forty-eight hours after birth is extremely difficult.<sup>73</sup> The AAP and ACOG recommend that the postpartum hospital stay following an uncomplicated vaginal delivery be no less than forty-eight hours and the stay after a cesarean section be no less than ninety-six hours, both excluding the day of delivery.<sup>74</sup>

More important than the exact timing of the discharge is the fact that the decision to leave the hospital is made jointly by the physician and the mother, not by a removed third-party payer attempting to enforce strict time limits for hospital stays in order to control costs.<sup>75</sup> The AAP and ACOG admit that early discharge may be appropriate for some, possibly many, newborns and mothers. They caution, however, that the discharge decision must be left to the mother and her doctor who must consider the mother's medical condition, the condi-

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<sup>69</sup>The Maternal and Child Health Bureau ("MCHB") is seriously concerned about the increased inadequacies of newborn screening. It considers these increased inadequacies to be the most damaging after-effect of early discharge. As a result of the early discharge practices of MCOs, the MCHB believes the integrity of the National Newborn Screening Program for Genetic Disease has been destroyed. Seymour Charles & Brian Prystowsky, *Early Discharge, In the End: Maternal Abuse, Child Neglect, and Physician Harassment*, 96 PEDIATRICS 746, 746 (1995).

<sup>70</sup>Kessel et al., *supra* note 62, at 741.

<sup>71</sup>GUIDELINES, *supra* note 7, at 91-116.

<sup>72</sup>Hearings, *supra* note 1, at 76 (statement of the American Academy of Pediatrics). For the complete list of requirements, see GUIDELINES, *supra* note 7, at 108.

<sup>73</sup>Hearings, *supra* note 1, at 81 (prepared statement of Judith Frank).

<sup>74</sup>*Id.* at 32-33 (statement of Michael T. Mennuti); see generally GUIDELINES, *supra* note 7, at 105-08.

<sup>75</sup>Hearings, *supra* note 1, at 33 (statement of Michael T. Mennuti).

tion of the baby, medical risk factors, availability of support systems, and the mother's mental and physical ability to care for herself and the infant.<sup>76</sup>

### III. LAWS AND REGULATIONS MANDATING MINIMUM HOSPITAL STAYS

Because of the prevalence of early discharge practices across the country, numerous states have enacted laws and/or regulations which attempt to restrict early discharge practices.<sup>77</sup> As of September 1, 1996, twenty-nine states had enacted laws or regulations affecting postpartum hospital stays.<sup>78</sup> There have also been ten states that considered, but did not enact, a mandatory maternity stay bill.<sup>79</sup> Additionally, the federal government has passed a law mandating postpartum minimum hospital stays which is aimed at compensating for deficiencies encountered in state legislation and which applies to those health plans not controlled by state statute.<sup>80</sup>

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<sup>76</sup>*Id.* at 54 (prepared statement of Michael T. Mennuti).

<sup>77</sup>Farinella, *supra* note 6, at 37. Early discharge is a politically poignant area. "No one wants to be *against* providing services to pregnant women and infants." Leichter, *supra* note 31, at 50.

<sup>78</sup>*Maternity Care: Appropriate Follow-Up Services Critical with Short Hospital Stays, Report to the Honorable Ron Wyden, U.S. Senate, GAO/HEHS-96-207* (Sept. 1996) (hereinafter "*Maternity Care*").

Twenty-four of the state laws have been categorized into three types:

I - Laws that specify a minimum number of hours that are required to be provided during postpartum hospital stays.

II - Laws that require insurers to provide coverage for the length of stay mandated by the attending physician.

III - Laws requiring insurers to provide coverage for an amount of care in accordance with the guidelines issued by the ACOG and AAP.

The following states having enacted type I laws: Alaska (eff. 6/3/96), Georgia (eff. 7/1/96), Iowa (eff. 7/1/96), Kansas (eff. 4/1/96), Kentucky (eff. 7/15/96), Maryland (eff. 7/1/96), Massachusetts (eff. 2/19/96), Minnesota (eff. 3/20/96), Missouri (eff. 8/28/96), New Jersey (eff. 6/28/95), New York (eff. 1/1/97), North Carolina (eff. 10/1/95), Oklahoma (eff. 7/1/97), Pennsylvania (eff. 8/31/96)

The following states having enacted type II laws: Alabama (eff. 10/1/96), Maine (eff. 4/5/96), New Hampshire (eff. 1/1/97), Ohio (eff. 7/18/96), South Carolina (eff. 10/1/96), Washington (eff. 6/9/96)

The following states having enacted type III laws: Florida (eff. 10/1/96), Indiana (eff. 7/1/96), Tennessee (eff. 5/13/96), Virginia (eff. 7/1/96)

*Nonpension Welfare Benefits: States Enact Minimum Maternity Stay Laws, Congress may Follow, WGL EMPLOYEE BENEFITS ALERT*, July 31, 1996.

Connecticut (eff. 5/24/96), Illinois (eff. 9/15/96), New Mexico (eff. 3/1/96), Rhode Island (eff. 9/1/96), and South Dakota (eff. 7/1/96) are the additional five states having enacted legislation or regulations. *Maternity Care*, GAO/HEHS-96-207.

<sup>79</sup>Arizona, California, Colorado, Hawaii, Mississippi, Nebraska, Utah, Vermont, West Virginia, and Wisconsin have declined to enact such legislation. See *Maternity Care*, *supra* note 78, at 16.

<sup>80</sup>The Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 100 Stat. 2874 (effective Jan. 1, 1998).

### A. State Legislation

In response to complaints from dissatisfied patients, child advocacy groups, and the Maryland Academy of Pediatrics, on May 25, 1995 the Maryland Legislature passed the Mothers' and Infants' Health Security Act.<sup>81</sup> This made Maryland the first state to pass legislation regulating postpartum hospital stays. The statute became effective on October 1, 1995.<sup>82</sup> On May 14, 1996 the Governor of Maryland signed into law two Bills that completely overhauled the first law.<sup>83</sup> One of the Bills passed in May of 1996, Senate Bill 433, was an attempt by the Maryland legislature to remedy faults in the original legislation.<sup>84</sup>

The original Maryland law required insurers to cover a minimum postpartum stay "in accordance with the medical criteria outlined in the most current version of the 'Guidelines for Perinatal Care' prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists."<sup>85</sup> Insurers had the option, however, to provide for a shorter hospital stay if the newborn was medically stable according to the *Guidelines for Perinatal Care* and the insurer provided a home visit by a nurse shortly after discharge.<sup>86</sup> Because insurers were furiously taking advantage of their ability to discharge women early, even absent the woman's consent, the Maryland legislature sought to close this loophole by amending the law with Senate Bill 433 to provide that the decision regarding length of stay is to be made by the mother after conferring with her physician.

The current Maryland legislation mandates an inpatient stay of forty-eight hours after a vaginal birth and ninety-six hours after a cesarean section unless the attending physician determines that less time for recovery is needed.<sup>87</sup> If the mother and newborn are discharged prior to the minimum time provided for in the statute, the health care provider must arrange for a home health care visit by a qualified nurse within twenty-four hours after discharge.<sup>88</sup> If the mother and newborn remain in the hospital the full time allotted in the statute,

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<sup>81</sup>Md. H.B. 888, Leg. Sess. (1995) (enacted) (codified at MD. CODE ANN., HEALTH-GEN. § 19-1305.4 (1995)). The Maryland legislation was also prompted by a spike in inadequate PKU testing which increased from 5% in 1989 to 30% in 1993. Derry et al., *supra* note 3, at D50.

<sup>82</sup>Md. H.B. 888.

<sup>83</sup>Md. S.B. 433, Legis. Sess. (1996) (enacted); Md. H.B. 1271 Legis. Sess. (1996) (enacted) (both codified in MD. CODE ANN., HEALTH-GEN. § 19-1305.4 (1996)).

<sup>84</sup>Karen Riley, *Maryland Lawmakers Ok Hmo Reforms*, THE WASHINGTON TIMES, April 10, 1996, at B7.

<sup>85</sup>Md. H.B. 888. As of January 1996 the minimums are 48 and 96 hours for vaginal and cesarean section deliveries, respectively.

<sup>86</sup>*Id.*

<sup>87</sup>MD. CODE ANN., HEALTH-GEN. § 19-1305.4(c) (1996).

<sup>88</sup>MD. CODE ANN., HEALTH-GEN. § 19-1305.4(d) (1996).

the attending physician may order a home health care visit if necessary however it need not be automatically provided by the insurer.<sup>89</sup>

New Jersey became the next state to enact protective legislation for mothers and newborns on June 27, 1995.<sup>90</sup> Similar to Maryland, the New Jersey legislation came in response to complaints from constituents.<sup>91</sup> The New Jersey law states that providers of maternity benefits must cover a minimum of forty-eight hours of inpatient care after a vaginal birth and a minimum of ninety-six hours of inpatient care after a cesarean section.<sup>92</sup> Under the law, an insurance contract that provides coverage in the home shall not be required to provide inpatient care unless inpatient care is determined to be medically necessary by the attending physician or is requested by the mother.<sup>93</sup> The law also has strict notice provisions to ensure all new mothers are made aware of this law by their insurers.<sup>94</sup>

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<sup>89</sup>*Id.*

<sup>90</sup>N.J. A.B. 2224, 206th Leg., 2nd Annual Sess. (1994) (enacted) (N.J. P.L. 1995 c. 138 (C. 17:48-61, et al.)) (codified at 1995 N.J. STAT. ANN. §§ 17:48a-7k; 17:48E-35.9; 17B:26.2.1k; 17B:27-46.1k; 17B:27A-7.1; 17B:27A-19.2; 26:2J-4.9 (West 1995)).

<sup>91</sup>According to staff developing the New Jersey legislation, the genesis of the bill was constituents' concerns expressed to the Assembly, specifically Assembly Democratic Leader, Doria. Interview with Benjamin A. Dworkin, Assistant Director of Research New Jersey General Assembly Democratic Office (Mar. 18, 1996).

<sup>92</sup>N.J. A.B. 2224(1)(a). The law states in pertinent part:

Every individual or group contract that provides maternity benefits and is delivered, issued, executed or renewed in this State . . . after the effective date of this act shall provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newly born child in a health care facility . . . .

<sup>93</sup>N.J. A.B. 2224(1)(b). The law states in pertinent part:

Notwithstanding the provision of subsection a. of this section, a hospital service corporation contract that provides coverage for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours and 96 hours, respectively, of inpatient care unless such inpatient care is determined to be medically necessary by the attending physician or is requested by the mother.

The fact that the mother may override the insurer's decision to provide in-home care makes this bill one of the most favorable in terms of the rights of mothers. Both the New York and Kentucky laws have similar provisions.

<sup>94</sup>N.J. A.B. 2224(1)(c). The law states in pertinent part:

Every hospital service corporation shall provide notice to policy holders regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health . . . . The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the policy holder; (2) the yearly informational packet sent to the policyholder; or (3) January 1, 1996.

Providing notice to the consumer, while not a focus of this Note, is a concern of the



The New Jersey and Maryland statutes provide examples of statutes that mandate a specific minimum postpartum hospital stay that must be observed by all insurers. In contrast, the Maine statute simply requires insurers to provide coverage for the amount of time dictated by the attending physician.<sup>95</sup>

Further, other states have attempted to enhance the general hospital stay requirement. For example, physicians who contract with HMOs often experience a substantial amount of pressure from HMOs to reduce the amount of inpatient time consequently, many states have enacted additional requirements to ensure that insurers are not improperly influencing physicians to discharge new mothers early.<sup>96</sup> Many states also forbid insurers from offering gifts to mothers who choose early discharge.<sup>97</sup> Florida is an example of the third general type of legislation which requires insurers to provide coverage that is in accordance with the *Guidelines for Perinatal Care* as issued by the ACOG and AAP.<sup>98</sup>

### B. Problems with State Legislation

While the above-mentioned state laws are progressive in their intent, they have not been wholly successful in achieving their stated purpose. For example, the New Jersey legislation does not apply to many insurers, thus, leaving many women and children without protection from early discharge.<sup>99</sup> The law does not cover women on Medicaid. Also, because the law is a New Jersey state law, it has no binding effect on out-of-state insurers and insurance

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AMA, AAP, and ACOG because the organizations believe lack of public awareness concerning patient rights has contributed to the prevalence of early discharge. *Hearings*, *supra* note 1, at 55 (prepared statement of Palma E. Formica). By being assured that women know their rights, insurers will be less able to convince them they must leave early when in reality they may stay.

<sup>95</sup>Me. ALS. 615, Legis. Sess. (1996) (enacted) (codified at Me. Rev. Stat. Ann. tit. 24, § 2318-A, 4234-B, 2834-A, 2743-A (West 1996)).

<sup>96</sup>In Massachusetts, HMOs are forbidden to terminate services, reduce capitation payments, or penalize a physician for failing to discharge a mother early. *Maternity Care*, *supra* note 78, at 18. The New Mexico regulations prohibit the offering of financial incentives or disincentives to physicians to encourage early discharge. *Id.*

<sup>97</sup>The Missouri and Ohio laws prohibit insurers from offering gifts to mothers if they choose early discharge.

<sup>98</sup>Fl. S.B. 1860, Legis. Sess. (1996) (enacted) (codified at FLA. STAT. ch. 627.6406 (1996)).

<sup>99</sup>While many women are not protected by the legislation, one report has found that in New Jersey the average length of stay for women giving birth in 1994 was 1.4 days which increased to 1.9 days during the last three months of 1995, after the implementation of the law mandating minimum hospital stays. Paul H.B. Shin, *Birth Certificate Made Easy On-line*, COURIER NEWS, Feb. 9, 1996, at A1, A7. These statistics may be deceiving because they include both vaginal and cesarean section deliveries and the normal hospital stay after a cesarean section is, on average, longer than the normal hospital stay after a vaginal delivery.

contracts entered into outside the state of New Jersey.<sup>100</sup> Because the law does not apply to out-of-state insurers, women insured through employers in New York and Pennsylvania that contract with out-of-state insurers are not protected by the law.<sup>101</sup> This exemption is extremely problematic because tens of thousands of New Jersey residents are insured through insurers located out-of-state.<sup>102</sup>

Another problem common to all state legislation regulating health insurance is the Employee Retirement Income Security Act ("ERISA") which prevents states from passing laws regulating employee benefit plans, including health insurance plans.<sup>103</sup> Any state law regulating companies that self-insure will be pre-empted by ERISA.<sup>104</sup> ERISA has the effect of excluding all companies that self-insure from being bound by state legislation requiring minimum hospital stays.<sup>105</sup>

New York has partially remedied this difficulty by imposing minimum postpartum stay requirements directly on hospitals in addition to insurers.<sup>106</sup> This ensures that women have access to adequate care regardless of their insurer or whether they have no insurance at all. The problem with this tactic is while hospitals are being forced to keep new mothers, insurers are refusing to pay for the treatment. In New Jersey, for example, there is evidence that insurers are beginning to reimburse hospitals for childbirth costs on a per-case, as opposed to the standard per-diem, basis.<sup>107</sup> This enables insurers to offset the costs related to the postpartum minimum hospital stay legislation by burdening the hospitals with the costs of additional hospital days.<sup>108</sup>

The federal government has passed legislation in an attempt to alleviate some of the problems with ERISA preemption.<sup>109</sup> Federal legislation is vital to

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<sup>100</sup>In other words, this law applies only to those insurance contracts entered into in the state of New Jersey even if the insurer is part of a National "chain" with offices located in New Jersey.

<sup>101</sup>Pallone, *supra* note 26; Art Weissman, *Not all Moms get 2-day Stay for Childbirth*, ASBURY PARK PRESS, Aug. 3, 1995, at A1.

<sup>102</sup>Weissman, *supra* note 101, at A1.

<sup>103</sup>See 29 U.S.C. § 1144(a) (1995).

<sup>104</sup>*Id.* Self-insured employers tend to be larger employers such as AT&T and General Motors that find it more cost effective to provide insurance for their employees rather than contracting with a third party insurer. Forty percent to fifty percent of people insured in the United States are employed by self-insured companies. Kent, *supra* note 6, at 19.

<sup>105</sup>Weissman, *supra* note 101, at A1; Pallone, *supra* note 26.

<sup>106</sup>N.Y. Sess. Laws Ch. 56 (McKinney 1996) (enacted). (Codified in N.Y. Pub. Health § 2803-n (McKinney 1996).)

<sup>107</sup>S. Res. 8, 207th Leg., 1996 N.J. 1st Sess.

<sup>108</sup>*Id.*

<sup>109</sup>Pub. L. No. 104-204, 110 Stat. 2874 (codified as amended at 29 U.S.C. § 1191 (1996)).

the success of any general attempt to regulate insurance coverage because the federal government can regulate self-insured companies without being preempted by ERISA.<sup>110</sup> Additionally, the federal legislation will be effective in all states, thus, alleviating the lack of coverage for women insured by out-of-state insurers.<sup>111</sup>

### C. Federal Legislation

In response to some of the short-comings of the state legislation, the Newborns' and Mothers' Health Protection Act of 1996 was signed into law by President Clinton on September 26, 1996.<sup>112</sup> The Bill that precipitated this law was introduced on June 27, 1995 by Senator Bradley as S.B. 969, the Newborns' and Mothers' Health Protection Act of 1995. The Bill, as introduced, was modeled closely after the New Jersey legislation.<sup>113</sup>

The Newborns' and Mothers' Health Protection Act of 1996, as enacted, amends ERISA with the following additions.<sup>114</sup> A health insurance provider may not restrict the benefits of an insured following a vaginal childbirth to less than forty-eight hours and following a cesarean section to less than ninety-six hours.<sup>115</sup> The law provides an exception to this provision if the attending physician, in consultation with the mother, determines that a shorter length of stay is appropriate.<sup>116</sup>

The federal legislation also prohibits insurers from denying a new mother insurance coverage in order to avoid the requirements of the law.<sup>117</sup> Insurers are also prohibited from providing payments or rebates to mothers or attending

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<sup>110</sup>Pallone, *supra* note 26.

<sup>111</sup>*Id.*; *Hearings*, *supra* note 1, at 53 (prepared statement of Michael T. Mennuti).

<sup>112</sup>Pub. L. No. 104-204, 110 Stat. 2874 (codified as amended at 29 U.S.C. § 1191 (1996)). The Newborn's and Mothers' Health Protection Act of 1996 was attached to a House of Representatives Bill making appropriations for the Departments of Veterans Affairs and Housing and Urban Development (1996 HR 3666).

<sup>113</sup>S. 969; N.J. S.B. 2224.

<sup>114</sup>The legislation amends part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (added by section 101(a) of the Health Insurance Portability and Accountability Act of 1996). The legislation also makes the same amendments to Title XXVII of the Public Health Service Act (as added by section 102 of the Health Insurance Portability and Accountability Act of 1996) and to part B of title XXVII of the Public Health Service Act (as added by section 111 of the Health Insurance Portability and Accountability Act of 1996).

<sup>115</sup>Pub. L. No. 104-204, 110 Stat. 2874 (codified as amended at 29 U.S.C. § 1191 (1996)), Title VI, Sec. 603(a).

<sup>116</sup>*Id.*

<sup>117</sup>Pub. L. No. 104-204, 110 Stat. 2874 (codified as amended at 29 U.S.C. § 1191 (1996)), Title VI, Sec. 603(b).

physicians to encourage early discharge.<sup>118</sup> Further, insurers are forbidden from penalizing attending physicians for complying with the legislation.<sup>119</sup> Finally, insurers may not restrict the benefits offered to a mother during the mandatory hospital stay.<sup>120</sup>

Because more than half of the states have enacted legislation mandating minimum postpartum hospital stays, the law indicates that it will be preempted by those states with laws or regulations that: (1) mandate greater protection; (2) require insurers to provide coverage for at least forty-eight hours following a vaginal birth and ninety-six hours following a cesarean section; (3) require insurers to provide coverage in accordance with the *Guidelines for Perinatal Care*; or (4) leave the determination for length of stay to the attending physician in accordance with the mother.<sup>121</sup> The federal law does not preempt state laws that provide an option for follow-up care in the home. In essence, the federal law applies to all self-insured plans and to all health insurance plans in those states that have not enacted legislation.

The states are charged with the enforcement of the federal law with respect to private insurers and HMOs.<sup>122</sup> States are permitted to enforce noncompliance with the law using any and all appropriate penalties.<sup>123</sup> Self-insured plans are subject to the penalties set forth in section 502, 504, 506, and 510 of ERISA and will be monitored by the Secretary of Labor.<sup>124</sup>

The law also requires that the Department of Health and Human Services establish an advisory group by December 25, 1996 which is to examine the length of postpartum hospital stay issues.<sup>125</sup> The advisory group is to develop a consensus on the appropriateness of the statutory provisions and author a report to the Department of Health and Human Services summarizing their findings.<sup>126</sup> The Department of Health and Human Services is charged with advising Congress through several reports concerning the findings of the advisory group.<sup>127</sup> The Department of Health and Human Services must submit an initial report to Congress in March of 1998, an interim report in Sep-

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<sup>118</sup>*Id.*

<sup>119</sup>*Id.*

<sup>120</sup>*Id.*

<sup>121</sup>*Id.* at Sec. 603(f).

<sup>122</sup>104th Cong., 2nd Sess., S. Rpt. 326 (1996).

<sup>123</sup>*Id.*

<sup>124</sup>*Id.*

<sup>125</sup>Pub. L. No. 104-204, 110 Stat. 2874 (codified as amended at 29 U.S.C. § 1191 (1996)), Title VI, Sec. 606.

<sup>126</sup>*Id.*

<sup>127</sup>*Id.*

tember of 1999 and a final report by September of 2001.<sup>128</sup> The reports must include a summary of the study conducted by the advisory group, a summary of the best postpartum practices in use, recommendations for improvement in all facets of pre- and postpartum care, and a summary of whether the recommended improvements are best suited to implementation through federal government, state government, and/or the private health care sector.<sup>129</sup>

While the law is generally beneficial to mothers and newborns, it does have one severe shortcoming - postnatal care. Unlike original Bill 969 introduced in the Senate, the legislation signed into law does not include a provision that requires insurers to provide home care services for mothers who consent to early discharge.<sup>130</sup> By removing this integral provision from the legislation, the Congress has severely undercut the effectiveness of this law. The failure to include such a provision may lead women to stay in the hospital needlessly for fear that something may go wrong thus, needlessly increasing their health care costs. This may also lead to increased problems for mothers and newborns who leave the hospital according to the early discharge mandate of an insurer but who are not actually ready for release.

#### IV. EVIDENCE CONCERNING THE APPROPRIATENESS OF EARLY DISCHARGE

##### *A. Anecdotal Evidence*

Anecdotal evidence, accounts of women whose children were injured as a result of early discharge, has fueled the fire in support of legislation mandating minimum inpatient care for mothers and newborns. The following are summaries of three women's accounts of their birthing experience as previously presented to the Senate Labor and Human Resources Committee during hearings concerning Senate Bill 969 on September 12, 1995.

In her testimony, Virginia Fallon spoke of the traumatic birth of her son, Jesse.<sup>131</sup> After numerous hours of labor and various attempts to extract the baby vaginally, Ms. Fallon was forced to give birth through an emergency cesarean section when doctors determined the baby was experiencing tachychardia.<sup>132</sup> After birth, Jesse had difficulty breathing and was placed in intensive care.<sup>133</sup> Ms. Fallon had contracted a fever.<sup>134</sup> Ms. Fallon was

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<sup>128</sup>*Id.*

<sup>129</sup>*Id.*

<sup>130</sup>See S. 969, Sec. 2(B)(1) which stated:

[A] health plan that provides coverage for post-delivery care provided to a mother and her newly born child in the home shall not be required to provide coverage of in-patient care under subsection (A) unless such in-patient care is determined to be medically necessary by the attending physician or is requested by the mother.

<sup>131</sup>*Hearings, supra* note 1, at 17 (statement of Virginia Leigh Fallon).

<sup>132</sup>*Id.*

<sup>133</sup>*Id.* at 18.

exhausted, unable to sleep, and delusional from the excessive amount of pain medication she was prescribed.<sup>135</sup> Ms. Fallon also had difficulty feeding Jesse who had developed jaundice.<sup>136</sup> Even though Ms. Fallon was in an extremely precarious state and having difficulty feeding Jesse who was jaundiced and had a heart murmur, she was discharged seventy-two hours after the birth.<sup>137</sup> A few days later, Jesse began to have trouble breathing so the couple took Jesse to the emergency room where he was put on life support and open heart surgery was performed.<sup>138</sup> Jesse died three days and \$80,000 later.<sup>139</sup>

Karen L. Davies also testified before the Committee. Ms. Davies' insurance company required the discharge of she and her daughter, Maria, twenty-four hours after birth against the advice of Ms. Davies' physician.<sup>140</sup> Maria was three weeks premature, yet the insurance company refused to grant her an additional day in the hospital despite Ms. Davies' difficulty waking and feeding Maria.<sup>141</sup> After discharge, Maria contracted severe jaundice and had to be rehospitalized for a number of days. During Maria's rehospitalization Ms. Davies feared Maria would have neurological damage as a result of the severe jaundice.<sup>142</sup> Maria did not suffer neurological damage; however, Ms. Davies is convinced that had another day in the hospital been covered by her insurer, doctors would have discovered the jaundice in time to prevent rehospitalization.<sup>143</sup> Ms. Davies believes her hospital stay was predetermined by her insurance company before her daughter was born.<sup>144</sup>

Michelle Bauman also spoke before the Senate Labor and Human Resources Committee. The hospital discharged Ms. Bauman and her daughter twenty-eight hours after birth.<sup>145</sup> Twenty-eight hours was not a sufficient amount of time for doctors to determine that the baby had streptococcus.<sup>146</sup>

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<sup>134</sup>*Id.* at 17.

<sup>135</sup>*Id.* at 18.

<sup>136</sup>*Hearings, supra* note 1, at 18 (statement of Virginia Leigh Fallon).

<sup>137</sup>*Id.*

<sup>138</sup>*Id.* at 19.

<sup>139</sup>*Id.*

<sup>140</sup>*Id.* at 77 (prepared statement of Karen Davies).

<sup>141</sup>*Hearings, supra* note 1, at 78 (prepared statement of Karen Davies). Ms. Davies was 39, had no support system at home, and Maria was her first child. None of these factors appear to have been taken into account by the insurer when making the discharge determination. *Id.*

<sup>142</sup>*Id.* at 16 (statement of Karen Davies).

<sup>143</sup>*Id.*

<sup>144</sup>*Id.*

<sup>145</sup>*Id.*

<sup>146</sup>*Hearings, supra* note 1, at 19 (statement of Michelle Bauman).

*Streptococcus* is a treatable condition; however, because the baby was not diagnosed with the ailment prior to discharge from the hospital, the baby died shortly after discharge.<sup>147</sup> When Ms. Bauman realized her daughter was sick, she placed a call to her HMO to have a nurse visit her home.<sup>148</sup> Unaware of the birth, the HMO told the Baumans a representative would call back to schedule an appointment.<sup>149</sup> By the time the HMO returned the call a day later, the baby was dead.<sup>150</sup>

Ms. Davies experienced a breakdown in the home care system similar to that experienced by Ms. Bauman. Ms. Davies nor the first nurse who saw her baby during a home visit were able to detect the severity of Maria's jaundice. Detection took a second nurse who needed to make a call to the pediatrician to determine the severity of the ailment.<sup>151</sup> Insurers claim that home care is a safe and effective alternative to inpatient treatment, but, as the above examples illustrate, this may not, in fact, be correct.

These are only three of the many instances being reported concerning difficulties related to early discharge. Unfortunately, while these accounts are disturbing, they are not "scientific proof" that early discharge has a negative impact on a significant number of mothers and/or newborns to justify elimination of the practice. Scientific research is necessary to validate such a conclusion.

### *B. Statistical Evidence*

While anecdotal evidence is compelling, statistical evidence is necessary to provide a more accurate picture of the magnitude of the problems stemming from early discharge. Early discharge is currently defined as discharge within ninety-six hours after a cesarean birth and within forty-eight hours after a vaginal birth with very early discharge occurring within twenty-four hours after a vaginal birth.<sup>152</sup> In the 1980s early discharge was defined as discharge between five and seven days.<sup>153</sup> Because studies conducted prior to the 1990s used drastically different measures of early discharge, only three recent studies of early discharge practices will be discussed, one of which conducted an analysis of the findings of earlier studies.

First, a large-scale study of 1.4 million newborns conducted by HCIA, Inc., a private data analysis firm, found that the readmission rate for all newborns was 1.7%, with the readmission rate for newborns delivered vaginally being

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<sup>147</sup>*Id.*

<sup>148</sup>*Id.* at 20.

<sup>149</sup>*Id.*

<sup>150</sup>*Id.* at 20 (statement of Michelle Bauman).

<sup>151</sup>*Hearings*, *supra* note 1, at 16 (statement of Karen Davies).

<sup>152</sup>GUIDELINES, *supra* note 7, at 105-08.

<sup>153</sup>Kessel et al., *supra* note 62, at 739.

1.8%, and the rate for those delivered by cesarean section being 1.3%.<sup>154</sup> The study did not reveal any statistically significant differences in the rates of readmission for newborns delivered vaginally and released within twenty-four hours as compared to those with longer hospital stays.<sup>155</sup>

The study did find, however, that newborns delivered by cesarean section and discharged within twenty-four hours after birth were 3.3 times more likely to be readmitted into the hospital than similar newborns discharged between two and seven days.<sup>156</sup> Specifically, the readmission rate for cesarean section newborns discharged within twenty-four hours was 4.3%.<sup>157</sup> The most common reasons for readmission were perinatal infections and problems stemming from low birth weight.<sup>158</sup>

The significance of the results of the HCIA, Inc. study, however, have been called into question.<sup>159</sup> While the cesarean section readmission rates appear significant, the actual number of readmissions was extremely small.<sup>160</sup> An expert from Kaiser Permanente considers this sample to be too small to be statistically stable and therefore not an accurate measure of the effect early discharge has on infants born through cesarean section.<sup>161</sup>

The second significant study was conducted in 1993 by Dr. Judith Frank, Chief of Neonatology at Dartmouth Medical School.<sup>162</sup> Dr. Frank's study indicated an increased risk for readmission and emergency room visits within the first two weeks of life for infants discharged less than forty-eight hours after birth.<sup>163</sup>

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<sup>154</sup>FOSTER & SCHNEIDER, *supra* note 27, at 4.

<sup>155</sup>*Id.*

<sup>156</sup>*Id.* Only 3% of the cesarean section babies were discharged this early. *Id.*

<sup>157</sup>*Id.*

<sup>158</sup>*Id.* "[T]here is a suggestion of somewhat higher re-admission rates with longer stays for newborns delivered vaginally." *Id.* The re-admission rate for vaginally delivered newborns discharged within one day was 1.7%, within two days was 1.9%, within three days was 2.0%, within four days was 2.4%, within five days was 1.5%, within six days was 2.5%, and within seven days was 1.4%. *Id.* "[T]his may reflect a situation in which medical problems that require longer stays for treatment and that may later require re-admission for further treatment arise after delivery. As this association was not statistically significant, random chance can not be ruled out as a possible explanation." *Id.*

<sup>159</sup>Hearings, *supra* note 1, at 67 (prepared statement of Sharon Levine).

<sup>160</sup>*Id.* Only ten of every 240 newborns were readmitted. This represents 0.0075% of the 32,000 cesarean sections examined. *Id.*

<sup>161</sup>*Id.*

<sup>162</sup>*Id.* at 30 (statement of Judith Frank). Dr. Frank studied 15,000 births in the state of New Hampshire.

<sup>163</sup>*Id.* at 30-31 (statement of Judith Frank).



Dr. Frank defined early discharge as discharge less than forty-eight hours after birth.<sup>164</sup> Twenty-four percent of the infants in the study were discharged within forty-eight hours after birth.<sup>165</sup> The risk for readmission for the infants discharged early was fifty percent greater than for those infants discharged later than forty-eight hours after birth.<sup>166</sup> Similarly, the risk for emergency room visits for the infants discharged early was seventy percent greater than their counterparts who had longer hospital stays.<sup>167</sup>

While the percentages in this study appear extremely high, the actual number of readmissions and emergency room visits for infants discharged early were quite small: 1.61% of infants discharged early were readmitted compared to 1.09% of infants not discharged early.<sup>168</sup> Similarly, 2.04% of infants discharged early required emergency room treatment, while 1.17% of infants who were not discharged early required such treatment.<sup>169</sup>

Dr. Frank also conducted a cost-benefit analysis of early discharge practices to determine whether they were cost effective despite the increased number of hospital readmissions and emergency room visits by newborns discharged early. Infants discharged early who require readmission incurred total hospital charges of approximately \$183,000 in 1993.<sup>170</sup> The total charge for all mothers and infants in New Hampshire for an extra day in the hospital over the course of the year was approximately \$7,466,000.<sup>171</sup> The savings from early discharge thus constitutes approximately \$7,283,000 per year.<sup>172</sup> Dr. Frank concluded that early discharge is clearly cost effective; however, she cautioned that in order to ensure optimal care for mothers and newborns, all infants should receive a home-care visit if discharged early.<sup>173</sup>

Dr. Frank's study, however, appears to be flawed.<sup>174</sup> The study does not differentiate between cesarean section and vaginal deliveries.<sup>175</sup> Newborns

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<sup>164</sup>*Hearings, supra* note 1, at 30.

<sup>165</sup>*Id.*

<sup>166</sup>*Id.*

<sup>167</sup>*Id.* at 30-31.

<sup>168</sup>*Id.* at 31 (statement of Judith Frank).

<sup>169</sup>*Hearings, supra* note 1, at 31.

Consistent with the concerns of the AAP and ACOG, the most frequent cause for readmission in the study was jaundice (51%), followed by infectious disease (22%), and gastrointestinal problems (9%). Infectious disease (28.4%) was the leading cause for emergency room treatment, followed by gastrointestinal problems (23%), and jaundice (8.9%). *Id.* at 81 (prepared statement of Judith Frank).

<sup>170</sup>*Id.* at 31 (statement of Judith Frank).

<sup>171</sup>*Id.*

<sup>172</sup>*Id.* at 31 (statement of Judith Frank).

<sup>173</sup>*Id.*

<sup>174</sup>*Hearings, supra* note 1, at 67 (prepared statement of Sharon Levine).

delivered through cesarean section have an average length of stay of over two days and have thirty percent fewer readmissions than newborns delivered vaginally.<sup>176</sup> As a result, the higher readmission rates for the early discharge group in Frank's study may be attributable to the fact that the majority of the cesarean section births were in the longer stay category thus reducing the readmission percentages for that group.<sup>177</sup>

The third significant study was conducted by Dr. Paula Braveman who analyzed all the published literature on the subject of early discharge as of 1995.<sup>178</sup> In her analysis, Braveman groups studies according to post-discharge practice: 1) studies examining early discharge outcomes without routine additional visits before a two week "well baby visit"; 2) studies of early discharge followed by a clinic or office-based follow-up occurring one to three days after discharge; and 3) studies examining early discharge followed by a home visit.<sup>179</sup>

After completing her analysis of the available research on early discharge not followed by routine additional visits, Braveman concluded that "[t]he literature contains no sound evidence to support the safety of discharge before 48 hours in the absence of compensatory follow-up services."<sup>180</sup> Of the studies analyzing early discharge followed by a clinic-based follow-up one to three days after discharge, Braveman concluded "[t]he literature does not provide reliable information on neonatal or maternal consequences of early discharge with instructions to return for office- or clinic-based post discharge follow-up for the general population."<sup>181</sup> Braveman does note, however, that studies have shown elevated rates of non-attendance at clinic-based follow-up in low-income populations.<sup>182</sup> Finally, in studies of early discharge followed by a home visit, Braveman concluded that this practice "may be safe for newborns in carefully selected and prepared populations determined to be medically, psychosocially, and economically at low risk; carefully screened women who desire early discharge and receive intensive home follow-up may have improved maternal well-being and adjustment."<sup>183</sup> Braveman adds that the

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<sup>175</sup>*Id.*

<sup>176</sup>*Id.*

<sup>177</sup>*Id.* at 67 (prepared statement of Sharon Levine).

<sup>178</sup>Braveman et al., *supra* note 2, at 716. The studies conducted by Dr. Frank and HCIA, Inc. were not included in Dr. Braveman's analysis.

<sup>179</sup>*Id.*

<sup>180</sup>*Id.* at 721.

<sup>181</sup>*Id.* at 722

<sup>182</sup>*Id.* For a study concerning early discharge in an indigent population, see Paul D. Conrad et al., *Safety of Newborn Discharge in Less Than 36 Hours in an Indigent Population*, 143 AM. J. DIS. CHILD 98 (1989).

<sup>183</sup>Braveman et al., *supra* note 2, at 724.

optimal number of home visits has yet to be determined; however, she does note that no successful study has used less than two home visits.<sup>184</sup>

Braveman determined that the body of studies available are too inconsistent and inaccurate to make a determination about the safety of early discharge. Studies concluding that early discharge

was safe either where applied under highly restricted circumstances, had important methodological flaws, or were too small to detect clinically significant effects on important outcomes. Most studies are flawed by lack of appropriate comparison groups, limited outcome measures, and/or inadequate description of participation criteria, protocols, or loss to follow-up.<sup>185</sup>

Braveman also concluded that there is minimal scientific basis for the claim that early discharge is safe in the absence of careful predischARGE screening preparation and intensive and repeated in-home follow-up care.<sup>186</sup> Braveman warns that adverse impacts as a result of early discharge were observed in some studies, and while those studies may not be statistically reliable, they should not be ignored either.<sup>187</sup> Another researcher has noted that "[f]ailing to prove that shorter hospital stays are unsafe especially in the face of numerous methodological flaws is not the same as proving they are safe."<sup>188</sup>

The medical consequences for early discharge are largely unknown. There is sufficient anecdotal evidence linking early discharge to infant rehospitalization and even death;<sup>189</sup> however, there is insufficient scientific evidence detailing the potential consequences of early discharge.<sup>190</sup> Without knowledge about how early discharge affects all women and newborns, "[t]he recent trend toward shorter stays could be the equivalent of a large, uncontrolled, uninformed experiment on newborns and their mothers."<sup>191</sup> Until further research is conducted, early discharge should not be utilized absent mother and physician agreement that early discharge is an appropriate measure for the particular mother and infant involved.

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<sup>184</sup>*Id.*

<sup>185</sup>*Id.*

<sup>186</sup>*Id.*

<sup>187</sup>*Id.*

<sup>188</sup>Kessel et al., *supra* note 62, at 741.

<sup>189</sup>See *Hearings*, *supra* note 1, at 17 (statement of Virginia Leigh Fallon); *Id.* at 15 (statement of Karen Davies); *Id.* at 19 (statement of Michelle Bauman).

<sup>190</sup>Braveman requests that additional research in the area is conducted before a determination on the safety of early discharge is made. Braveman et al., *supra* note 2, at 724.

<sup>191</sup>*Hearings*, *supra* note 1, at 10 (statement of Sen. Bradley) (quoting the ACOG).

#### V. DEBATE SURROUNDING THE LEGISLATION MANDATING MINIMUM POSTPARTUM HOSPITAL STAYS

The debate surrounding the legislation mandating inpatient postpartum coverage has two sides, those groups opposed to the legislation, generally traditional insurers and MCOs, and those persons in favor of the legislation, generally doctors, nurses, and parents. The arguments in opposition to the legislation center on the amount of money early discharge saves the health care industry and on the costs of implementing the legislation. While the arguments in favor of the legislation focus on the possible negative effects early discharge may have on the health of mothers and newborns.<sup>192</sup>

Proponents of the legislation generally believe the legislation will re-empower doctors by keeping insurance companies out of the healthcare decision-making process. In response, opponents claim that the government is attempting to "legislate medical care"<sup>193</sup> by creating an inflexible standard that will create a false sense of security for women and doctors without actually allowing women and doctors to make discharge decisions.<sup>194</sup> Proponents object to this analysis citing that the legislation merely regulates insurance coverage based upon the industry leading guidelines.<sup>195</sup>

Proponents claim that legislation will enable doctors to make medically sound decisions that are not influenced by economics; consequently, there will be less chance of injury or illness due to inappropriate early discharge.<sup>196</sup> The incidence of PKU has appeared to increase with the implementation of early discharge practices and the legislation should help decrease the false-negative readings often obtained from infants tested too early by ensuring that the test is not conducted until the proper time.<sup>197</sup> Cases of severe jaundice should also be reduced as a result of the legislation. Opponents respond with fears of an increased likelihood of infants contracting illnesses at the hospital the longer they remain there.<sup>198</sup>

During the hearings for Senate Bill 969, the AMA representative noted,

[t]he AMA has long opposed congressional intervention into a physician's decision-making. However, in the postpartum context, we believe that S 969 is necessary to stem the tide of insurers who are

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<sup>192</sup>These arguments were presented to the Senate Labor and Human Resources Committee on September 12, 1995. See generally *Hearings*, *supra* note 1.

<sup>193</sup>*Hearings*, *supra* note 1, at 33 (statement of Michael T. Mennuti).

<sup>194</sup>*Id.* at 41 (statement of Sharon Levine).

<sup>195</sup>*Id.* at 33 (statement of Michael T. Mennuti).

<sup>196</sup>*Id.* at 34 (statement of Palma E. Formica).

<sup>197</sup>Sinai et al., *supra* note 63, at 608.

<sup>198</sup>*Hearings*, *supra* note 1, at 65 (prepared statement of Sharon Levine).

replacing the physician's judgment of what is best for the patient with what is the cheapest way to pay for health care.<sup>199</sup>

In support of the federal legislation, the AMA representative in attendance at the Senate hearings added that the legislation is a fair and equitable solution to the intrinsic problems in early discharge. The legislation is narrow enough to only affect those plans offering maternity benefits.<sup>200</sup> It is flexible in that it does not establish an inflexible term for inpatient stays for every delivery.<sup>201</sup> Instead, the legislation recognizes that not all mother and infant dyads require a full forty-eight hours in the hospital by permitting early discharge when the mother and physician determine it is appropriate.<sup>202</sup>

Additionally, proponents of the legislation recognize that birth is a natural process and that women have been accomplishing it successfully for thousands of years without a forty-eight hour minimum hospital stay; however, they also recognize that America, today, is quite different than in the past. Most importantly, the family support system previously prevalent is no longer available to many American women.<sup>203</sup> It is this family support system that often operated in place of the hospital and physician after the discharge of the mother and newborn. Further, the American people have not replaced the diminishing family system with community support structures for pregnancy and child birth.<sup>204</sup> In fact, decreased postpartum stays have occurred simultaneously with the loss of the family support system.<sup>205</sup>

While these arguments are persuasive, the proponents of the legislation seem to "hang their hat" on the fact that there is a great deal of evidence that indicates early discharge is not appropriate for mothers and infants indiscriminately. MCOs must be presented with the burden of demonstrating that early discharge is a safe practice for the majority of women and newborns. "The burden of proof should be based on 'first do no harm.' Evidence of safety and efficacy are essential before practice changes are advocated."<sup>206</sup> Not having specific statistics indicating that early discharge is unsafe is not sufficient to conclude the practice is safe.<sup>207</sup>

While MCOs have not demonstrated that early discharge is safe, they have presented a number of strong arguments against mandating inpatient hospital

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<sup>199</sup>*Id.* at 56 (prepared statement of Palma E. Formica).

<sup>200</sup>*Id.* at 57.

<sup>201</sup>*Id.*

<sup>202</sup>*Id.*

<sup>203</sup>*Hearings, supra* note 1, at 22 (statement of Kathleen Fitzgerald, President, Rhode Island Medical Women's Association).

<sup>204</sup>*Id.*

<sup>205</sup>*Id.*

<sup>206</sup>Kessel et al., *supra* note 62, at 741 (citation omitted).

<sup>207</sup>*Id.*

stays. Group Health Association of America, the leading national association for HMOs, stresses that the focus in this debate should not be on the length of hospital stay but on the quality of care provided to each woman and how it meets her specific health care needs.<sup>208</sup> Opponents strongly stress that it is important to recognize that prenatal, perinatal, and neonatal care are all equally important in producing healthy babies.<sup>209</sup> The approach that needs to be taken must address and attempt to reevaluate each phase.

Additionally, opponents claim that legislating medical criteria is foolish because medical standards frequently change as new scientific developments occur. For example, laparoscopic cholecystectomies have replaced abdominal surgery for gall bladder removal making a three to five day inpatient recovery into an outpatient procedure.<sup>210</sup> Opponents claim that to "freeze standards of care into statute through legislation will impede progress towards the dual goals of quality improvement and cost effectiveness."<sup>211</sup> Opponents are concerned that the legislation may have difficulty keeping the standards in accordance with the *Guidelines for Perinatal Care* which are revised every three to five years. Similarly, the present state of the art for PKU testing is not adequate for use with early discharge; however, a new test may be developed in the future eliminating the present problem. Opponents are also extremely concerned about the precedent-setting effect this legislation may have. They believe it is the start of a "slippery slope" and question in what areas the legislature will mandate guidelines next.<sup>212</sup>

Finally, while the AMA and other groups support the legislation, they have raised some suggestions for improvement and alternatives to the minimum hospital stays. The AMA suggests a less costly option, a step-down unit in the hospital where meals are available but where the available nursing care will not be as extensive as that available in maternity wards.<sup>213</sup> This step-down unit option would provide for "inpatient" care at a lower cost to insurers.<sup>214</sup> Adding a provision to the federal law providing home healthcare for mothers who choose early discharge may decrease costs associated with hospital stays because more women may choose early discharge relying on the home care that will be provided as an alternative to staying in the hospital an additional day.

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<sup>208</sup>*Hearings, supra* note 1, at 59 (prepared statement of Richard Marshall, Group Health Association of America, Inc.).

<sup>209</sup>*Id.* at 68 (prepared statement of Sharon Levine).

<sup>210</sup>*Id.*

<sup>211</sup>*Id.*

<sup>212</sup>Derry et al., *supra* note 3, at D50.

<sup>213</sup>*Id.* at 81 (prepared statement of Judith Frank).

<sup>214</sup>*Id.*

Another option is to pass laws mandating PKU rescreening for infants discharged early.<sup>215</sup> In the alternative, the test for PKU could be made more sensitive by lowering the cut-off level at which further testing is determined to be necessary thus making the test more suitable for use with early discharge.<sup>216</sup> Both, however, are more cost effective than maintaining the present system because they may be more cost effective in the long run when the cost of litigation and the cost of caring for a severely affected child are considered.<sup>217</sup>

## VI. IMPLICATIONS FOR THE HEALTH CARE INDUSTRY

Competition in the health care industry is fierce. With the emergence of MCOs, insurers are constantly looking for ways to reduce costs in order to provide lower premiums to individuals.<sup>218</sup> By providing lower premiums, insurers expect to gain more clients and greater market share.<sup>219</sup> Prior to the current wave of MCOs, competition in the healthcare market was not extremely fierce.<sup>220</sup> Companies that contracted with third-party insurers for fee-for-service insurance did not "shop around" in order to get the best deal on their insurance package.<sup>221</sup> With the onset of MCOs, however, the competition to offer the highest quality services at the lowest possible cost has brought fierce competition to the market.<sup>222</sup> Employers now "shop around" for the best healthcare deal.<sup>223</sup>

This competitive atmosphere has made onlookers cautious of the possible ramifications this fierce competition may have on the industry. One concern is that the strongest MCOs will gain excessive power by pricing the smaller insurers out of the market, thus creating a monopolistic situation similar to that requiring regulation in public utilities area.<sup>224</sup> Another concern is that the fierceness of the competition will force the ethical and professional norms

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<sup>215</sup>Sinai et al., *supra* note 63, at 608.

<sup>216</sup>*Id.*

<sup>217</sup>*Id.*

<sup>218</sup>See *Hearings*, *supra* note 1, at 80 (prepared statement of Judith Frank); Geisel, *supra* note 6, at 1.

<sup>219</sup>Farinella, *supra* note 6, at 34.

<sup>220</sup>Miller, *supra* note 33, at 195.

<sup>221</sup>*Id.*

<sup>222</sup>Farinella, *supra* note 6, at 34.

<sup>223</sup>*Id.*

<sup>224</sup>See Thomas P. Weil, *Managed Health Care: A Utility-Style Monopoly?*, PUB. UTIL. FORT., Feb. 1, 1995, at 14, 14. "The nation's health alliances are already segmenting the marketplace. Hospitals and physicians are forming powerful oligopolies in almost every metropolitan area. Huge managed-care plans create monopolies that force out weaker firms and stifle competition." *Id.* These alliances lower the incentive for providing quality care. *Id.*

experienced with fee-for-service medicine to give way to medicine driven by financial incentive causing the quality of care to suffer greatly.<sup>225</sup> In other words, the competition will favor those who can provide the lowest possible cost without regard to the quality of service.<sup>226</sup> This fear has been realized by the inappropriate use of early discharge because many women and newborns are not receiving adequate postpartum care.<sup>227</sup> Consequently, state and federal government regulation can be viewed as a valid corrective measure because market forces are not regulating competition.<sup>228</sup>

Ideally, competition in the insurance market should be advantageous, lowering prices while sustaining the quality of care.<sup>229</sup> Because insurance plans differ in terms of the amounts and levels of coverage, competition can be advantageous because buyers of insurance can choose the plan that accommodates their specific needs and competition forces insurers to be innovative in their development of insurance plans and benefits.<sup>230</sup> This idealistic portrayal, unfortunately, is not reality.

This type of governmental regulation of the health care industry is not unique. Another example is state-mandated benefits statutes.<sup>231</sup>

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<sup>225</sup>Thomas L. Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 CONN. L. REV. 605, 605 (1989).

<sup>226</sup>To the contrary, many are not worried about the quality of care being reduced by competition because in the near future purchasers of insurance will have available to them information about the quality of care provided by different MCOs. Quality is assumed to be essential for MCOs to remain in competition. Hirshfeld, *supra* note 31, at 94. This theory, however, is problematic because the quality of postpartum care is decreasing and this "consumer protection" information is not yet available to allow consumers to "police" insurers themselves.

<sup>227</sup>*Babies and HMOs*, *supra* note 54, at A20. "[T]here is a very fine line between eliminating unnecessary care and reducing access to care which is truly required." *Hearings*, *supra* note 1, at 52 (prepared statement of Sen. Bradley).

<sup>228</sup>Others would argue that managed care has been successful at maintaining quality while at the same time reducing costs. See generally *Parker Hannifin's Health Benefits Program: Self-Management*, MANAGED CARE Q., Autumn 1993, at 1 (evaluating several managed care initiatives and their successes).

<sup>229</sup>"The marketers imagine a world in which health care providers jockey to satisfy consumers (and their agents, such as corporate benefits managers). They see providers who prosper because they offer better care at lower cost; in this world the market - the consumers - will discipline the others." James A. Morone, *The Ironic Flaw in Health Care Competition: The Politics of Markets*, COMPETITIVE APPROACHES TO HEALTH CARE REFORM 207 (Richard J. Arnould et al. eds. 1993).

<sup>230</sup>David Dranove, *The Case for Competitive Reform in Health Care*, in COMPETITIVE APPROACHES TO HEALTH CARE REFORM 76 (Richard J. Arnould, et al., eds. 1993). Competition is also viewed as advantageous because it keeps cost reduction a primary goal of insurers.

<sup>231</sup>Mandated benefits laws require that insurers to include specific benefits in all health insurance policies. Albert E. Trentalance, *Mandated Benefits: A Misguided Effort*, PHYSICIAN EXEC., March 1994, at 35, 35.



State-mandated benefits statutes require a minimum level of health care benefits to be included in insurance policies. Examples of the benefits currently mandated in most states are mental health benefits, pap smears, and mammograms.<sup>232</sup> These mandates are similar to the legislation at issue because each mandate regulates the insurance industry by requiring that insurers provide some level of coverage.<sup>233</sup> The two are different, however, because mandated-benefits statutes require that an insurer provide coverage for an illness or treatment not previously covered, while the legislation at issue requires insurers who already cover maternity benefits to specifically cover a minimum level of care.

Mandated-benefits statutes are necessary when insurers refuse to provide, or price at an excessive cost, insurance benefits for health care needs the government feels every individual should have. Ideally, insurers should set premiums in accordance with the amount of insurance used by each buyer and buyers should be well-informed about available policies, thus weighing the benefits and detriments of the purchase of a particular insurance plan.<sup>234</sup> Were the system to operate in this manner, government intervention and regulation would not be necessary.<sup>235</sup> The market, however, does not always operate ideally. An examination of mental health benefits provides a good example of market inadequacies.

The market is flawed for a number of reasons. First, buyers are ignorant about the benefits of certain insurance options, such as mental health benefits.<sup>236</sup> Second, insurers do not set premiums at the cost of insurance.<sup>237</sup> Premiums, instead, are set according to a person's status as a good or bad risk.<sup>238</sup> Persons who are good risks pay too much in premiums because they tend not to use the available coverage and persons who are bad risks tend to pay too little in premiums because they tend to over use the available coverage.<sup>239</sup> Consequently, good risks avoid plans that offer coverage, such as mental health benefits, if they do not believe they need such coverage, in order to save money.<sup>240</sup> Insurers who offer coverage to bad risks increase the rates of

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<sup>232</sup>See e.g., N.J. STAT. ANN. § 17:48-6I (West 1995).

<sup>233</sup>"Mandates may reflect a general belief in a state that all should have the ability to pay for a minimum level of mental health services (whether or not they would choose to do so)." McGuire & Montgomery, *supra* note 34, at 382.

<sup>234</sup>*Id.*

<sup>235</sup>*Id.*

<sup>236</sup>*Id.*

<sup>237</sup>*Id.*

<sup>238</sup>McGuire & Montgomery, *supra* note 34, at 382.

<sup>239</sup>*Id.* at 383. This process of setting premiums based on risk factors is called adverse selection. *Id.*

<sup>240</sup>Coverage for newborns from the time of birth is commonly mandated; it is a significant financial risk, against which many are willing to insure. "The problem is that

the coverage in order to offset the lack of good risks buying insurance and bringing down the cost of premiums.<sup>241</sup> The cost of mental health coverage then becomes excessive thus making it available to very few people.<sup>242</sup>

Mandated-benefits legislation serves to regulate the system so that all buyers have the opportunity to receive a minimum level of coverage for a particular health care service.<sup>243</sup> Because the market falls prey to offering coverage based on a person's status as a good or bad risk, insurers cannot offer specialty coverage without falling victim to market dynamics. Mandated-benefits statutes are a form of government intervention that serve to reduce the amount of competition in the market by forcing all insurers to provide a minimum amount of coverage.<sup>244</sup> Insurers can no longer seek to lower coverage and appeal to only good risks.<sup>245</sup> In an ideal market, all persons would be able to buy the amount of coverage appropriate for them. The legislation attempts to mimic that result by forcing all persons to buy a minimum level of coverage for those specialty benefits believed to be essential or important.<sup>246</sup>

Unfortunately, mandated-benefits statutes have not been wholly successful. Mandates have caused many employers who previously used third-party insurers to become self-insured in order to avoid the high cost of third-party insurance that has partially resulted from the excessive use of mandated benefits by the states.<sup>247</sup> Employers choose self-insurance because ERISA preempts state mandated benefits laws from applying to self-insured plans.<sup>248</sup>

Additionally, one-quarter of persons who currently cannot afford health insurance would be able to afford it but for mandated benefits adding to the cost of health care.<sup>249</sup> Consequently, a large number of individuals are not pro-

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many people who are going to have children plan for it in time to select the most favorable coverage." Those people planning to have children will go with an insurer offering such coverage, and those people not planning to have children will not. *Id.* at 384.

<sup>241</sup>*Id.* at 383.

<sup>242</sup>*Id.*

<sup>243</sup> See McGuire & Montgomery, *supra* note 34, at 382.

<sup>244</sup>*Id.* at 385.

<sup>245</sup> Mandated benefits may contribute to a monopolistic environment because smaller insurers who were successful when they could offer lower rates to good risks may not be able to sustain clients when forced to raise premiums.

<sup>246</sup> Mandated benefits are not always the ideal solution, however, because we cannot be sure that the amount of benefits mandated by the government is sufficient. McGuire & Montgomery, *supra* note 34, at 385.

<sup>247</sup> Trentalance, *supra* note 231, at 35.

<sup>248</sup>*Id.*

<sup>249</sup> Butler, *supra* note 35, at 115 (citing John Goodman of the National Center for Policy Analysis).

ted by mandated benefits legislation.<sup>250</sup> The increased costs associated with mandated benefits have also been accused of being the impetus for many MCOs to contract with cheaper, less qualified doctors in attempts to counteract rising costs.<sup>251</sup>

However, mandated benefits which require certain preventive techniques, such as mammograms, can be viewed as cost effective because early detection of cancer should save insurers money in reduced treatments over the long term. Similarly, legislation mandating minimum maternity hospital stays is valuable because mother and infant health care has the effect of offsetting health care costs in other areas.<sup>252</sup> While the legislation may cost insurers more money up front, over the long term this preventive care should reduce costs.<sup>253</sup>

Aside from the similarities the mandated benefits legislation has to the legislation mandating minimum postpartum hospital stays is the precedent setting effect it may have on future legislation regulating "medical care."<sup>254</sup> In response to this criticism of the legislation, Senator Bradley has noted, "[i]f we are balanced legislators, that we can do this self-evident act . . . and not lurch into intervention in a doctor's practice."<sup>255</sup> Mother and infant health care, however, is a barometer of the health of the country.<sup>256</sup> When vulnerable women and newborns are not receiving adequate medical treatment, this inadequacy is often reflective of the medical treatment offered to others.<sup>257</sup> Extensive government regulation of the industry may become the only answer if insurers do not find ways to effectively implement cost containment measures without jeopardizing the quality of care doctors are able to provide.

The legislation presumes medical standards will remain static and that forty-eight hours will always be the appropriate minimum hospital stay for postpartum inpatient care. This presumption demonstrates the disadvantage of legislating medical care. However, because insurers are removing medical decision-making from doctors and giving it to insurance personnel, doctors will be limited in their ability to make advancements in medical technology to determine whether early discharge is appropriate. "Historically, creative initiatives in advances in medical care have come primarily from physicians

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<sup>250</sup>*Id.*

<sup>251</sup>Trentalance, *supra* note 231, at 35. By contracting with less qualified doctors, insurers are jeopardizing the standard of care. *Id.*

<sup>252</sup>*Id.*

<sup>253</sup>*Id.* "Healthy babies have a better chance of becoming healthy children." *Id.*

<sup>254</sup>Hearings, *supra* note 1, at 68 (prepared statement of Sharon Levine).

<sup>255</sup>*Id.* at 9 (statement of Sen. Bradley).

<sup>256</sup>Saundra K. Schneider, *Improving the Quality of Maternal and Child Health Care in the United States: State-Level Initiatives and Leadership*, in HEALTH POLICY REFORM IN AMERICA INNOVATIONS FROM THE STATES 49 (Howard M. Leichter ed., 1992).

<sup>257</sup>*Id.*

and other scientists, not administrators who have no medical training."<sup>258</sup> Consequently, regulation may be more effective if it requires MCOs to give doctors decision-making authority concerning coverage decisions.<sup>259</sup> This authority may give doctors the incentive to devise, under their own initiative, ways to reduce costs without jeopardizing the quality of care.<sup>260</sup>

## VII. CONCLUSION

As a result of the present cost-cutting frenzy brought about by MCOs, early discharge of mothers and newborns after birth has become the standard of care in this country. While statistical evidence concerning the validity of early discharge is inconclusive, there is sufficient anecdotal evidence suggesting that there are definite negative effects associated with early discharge. Therefore, early discharge should not be the standard of care in this country until researchers determine its appropriateness.

Currently, researchers believe early discharge may be safe if adequate follow-up care is provided. Consequently, early discharge, as presently conducted, is inappropriate because insurers have not given doctors enough time to adjust to the stringent discharge criteria and to develop post-discharge programs necessary to provide adequate follow-up care.

The state laws that have been passed mandating minimum postpartum hospital stays have not been wholly effective. In fact, they have been limited because large numbers of women are not protected due to ERISA preemption and other loopholes in the state legislation. As a result of these deficiencies, federal legislation is necessary to ensure that women are protected from inappropriate early discharge practices.

The present disagreement over appropriate postpartum care should not be a conflict between insurers and doctors but a joint effort to develop a more cost-effective postpartum program that focuses on the individual traits of each mother and infant dyad. Unfortunately, such a collaborative effort has not taken place and legislative action has become necessary. While legislation is not the perfect solution, until researchers determine that early discharge following childbirth is safe for both the mother and newborn, legislation is currently the best medium through which society can ensure that women and newborns receive adequate postpartum care.

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<sup>258</sup>Hirshfeld, *supra* note 31, at 92.

<sup>259</sup>*Id.* at 99.

<sup>260</sup>*Id.*

