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NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT: PUTTING THE BRAKES ON DRIVE-THROUGH DELIVERIES

I. INTRODUCTION

Having a baby is one of the most joyous events in life. For nine long months, the anticipation builds. Finally, the day arrives and labor begins. After the excitement and exhaustion of delivery, mothers desperately need time to rest. First-time mothers particularly must learn to care for their infants, while others simply need time to recuperate physically and emotionally.

In 1970, the average hospital stay for a vaginal delivery was four days.1 Within the last three years, stays have declined from 48 hours to 24 hours.2 Some were even required to leave the hospital in as little as 8 hours after delivery.3 Women in labor were told to “wait in the hospital parking lot, as long as they can bear it, so that the clock doesn’t start ticking...”4

The initiation of “drive-through” deliveries led to a public outcry.6 As a result, state and federal legislators proposed bills mandating minimum maternity stays.7 Twenty-eight states passed bills,8 while

4. McCaughey, supra note 1, at A23.
5. The phrase “drive-through” delivery was coined by the media in response to the trend of releasing mothers and infants as quickly as possible after delivery. See Barbara Vobejda, “Moms and Babies” Prove to be Irresistible Force on Capitol Hill, WASH. POST, Sept. 20, 1996, at A17.
legislation was pending in others.\textsuperscript{9} All of this changed on September 26, 1996, when President Clinton signed a bill entitled "New Borns' and Mothers' Health Protection Act of 1996."\textsuperscript{10} The new law, which becomes effective January 1, 1998, requires insurance companies to cover forty-eight hours of care following a vaginal birth and ninety-six hours following a cesarean birth.\textsuperscript{11}

This Comment supports the necessity for ensuring appropriate maternity stays. Part II discusses the medical risks associated with early discharge. Parts III and IV address the arguments for and against mandating stays through legislation. Part V reviews the recently enacted law. Part VI focuses on alternatives to legislation.

II. THE MEDICAL RISKS ASSOCIATED WITH EARLY DISCHARGE

A. Statistical Risks

The risks associated with early discharges have been the topic of many studies.\textsuperscript{12} Still, the risks remain uncertain and debatable.\textsuperscript{13}


Although Senator Bradley from New Jersey sponsored the federal bill throughout 1995 and 1996, Senator Boxer of California was the first woman Senator to testify who had actually gone through labor and delivery. See 142 CONG. REC. S9908 (daily ed. Sept. 5, 1996) (statement of Sen. Boxer).

Senator Bradley was prompted to initiate the bill after he received 85,000 pieces of mail in response to an article in Good Housekeeping magazine. See 142 CONG. REC. at S9904; see also Thomas Monnay, Maternity Center Offers Enticement; Moms Get a Free Extra Day, SUN-SENTINEL FORT LAUDERDALE, Dec. 20, 1995, at 1. Senator Biden from Delaware also stated, "This issue was called to my attention by someone reading Good Housekeeping . . . ." 142 CONG. REC. S9904 (daily ed. Sept. 5, 1996).

\textsuperscript{11} Section 711(a)(1)(A) provides, in pertinent part: A group health plan, and a health insurance issuer offering group health insurance coverage, may not . . . restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or . . . following a cesarean section, to less than 96 hours . . . . Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-304, 110 Stat. 2935.

\textsuperscript{12} See Dorothy Brooten et al., A Randomized Trial of Early Hospital Discharge and Home Follow-Up of Women Having Cesarean Birth, 84 OBSTETRICS & GYNECOLOGY 832 (1994); Dorothy Brooten et al., A Randomized Clinical Trial of Early Hospital Discharge and Home Follow-Up of Very-Low-Birth-Weight Infants, 315 NEW ENG. J. MED. 934 (1986); Peg Jansson, Early Postpartum Discharge, 85 AM. J. NURSING 547 (1985); Ulla Waldenstrom et al., Early and Late Postpartum Discharge After Hospital Birth: Health of Mother and Infant in the Postpartum
It is, however, obvious that for mothers, shortened stays require them to absorb much information in a brief amount of time. For infants, physicians are unable to detect congenital heart defects, jaundice, dehydration, and streptococcal infections until a baby’s second or third day. Complications range from permanent brain damage to death.

Risks associated with childbirth have always existed. In the 19th century, there was the risk of puerperal fever, often associated with maternity hospitals. By the 1920s, deliveries in hospitals had become the fashion. Births in hospitals rose from five percent in 1900 to almost eighty percent in 1945. The first early discharge program, which was reported from Louisiana in 1943, suggested leaving at two to five days after birth.

Nevertheless, obstetrical training was still inadequate in teaching about safety and care of mothers and infants. All of this changed

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13. Mhairi G. MacDonald, Hidden Risks: Early Discharge and Bilirubin Toxicity Due to Glucose 6-Phosphate Dehydrogenase Deficiency, 96 PEDIATRICS 734, 734 (1995). MacDonald stated that the studies revealed that mortality rates were not significantly different between infants who were dismissed early and infants who were kept in an extra day. Id. MacDonald also said that the randomized studies that had been published had methodological problems including that the length of hospital stays varied, and that the timing of follow-up overlapped with the control infants. Id. In addition, the study sample sizes were usually small, with less than 100 infants per study. Id. See also Valerie M. Parisi & Bruce A. Meyer, To Stay or Not to Stay? That Is the Question, 333 NEW ENG. J. MED. 1635, 1636 (1995); Committee on Fetus Newborn, American Academy of Pediatrics, Criteria for Early Infant Discharge and Follow-Up Evaluation, 65 PEDIATRICS 651 (1980).


15. Jaundice is a condition in which the infant is unable to excrete bilirubin, a yellow pigment that builds up in their blood and skin. ROSCOE N. GRAY, 4A GRAY'S ATTORNEYS' TEXTBOOK OF MEDICINE 227-8-11 (3d ed. 1989). Caused by the shifting of fetal hemoglobin to adult hemoglobin, jaundice does not show up until the infant is two to five days old. Id. The infant's immature liver is not able to metabolize the bilirubin. Id. As a result, it builds up in the blood stream. Id. The pigment then enters the brain and causes a disabling or fatal lesion. Id. This is called kernicterus and can be treated with blood transfusions and phototherapy (exposure to light). Id. Despite treatment, jaundice can lead to brain damage or even death. Id.

16. Boodman, supra note 2, at Z06.


18. See id. at 133.


21. See id.
after J. Whitridge Williams, a professor of obstetrics at Johns Hopkins University, published an evaluation of the atrocious level of training given to new obstetricians. Williams' evaluation called for drastic reforms, which later took place.

By the 1950s, hospital delivery was the norm. By the 1960s, essentially all births took place in a hospital. This led to a drastic reduction in the mortality rate of infants because of cleanliness, training, and observation.

In the 1970s, the average hospital stay after a vaginal birth was four or five days. After cesarean births, it was about one to two weeks. At the same time, however, more women were choosing to give birth at home. Recognizing this trend, Kaiser Permanente Medical Center in San Francisco introduced an early discharge policy where mothers in the Family Centered Perinatal Care Program could leave after twelve hours. For this early HMO, the initiative was economically sound and socially acceptable.

By the 1990s, these shorter stays had become the norm. Between 1970 and 1992, the median length of stay decreased by almost 50%. The safety of such practices became the topic of many studies. In one study, 24 to 36 hours seemed to be sufficient, although the readmission rate for infants discharged before 36 hours was 2.5 times higher than the...
rate for infants staying longer than 48 hours. In another study, those mothers required to leave in less than 48 hours showed a 50% increased risk of readmission to the hospital and a 70% increased risk of readmission to the emergency room.

The obvious problem with early discharge is that some illnesses for mothers and infants do not develop until days later. By leaving early, symptoms do not appear until the infant is at home. Coincidentally, medical complications which had become non-existent began to rise. For example, jaundice in the newborn, after becoming virtually eliminated decades ago, made a comeback. Jaundice, which is usually diagnosed and treated with special hospital lights on the second or third day, was beginning to go undetected.

Also on the rise was kernicterus, a rare and preventable complication of jaundice. Physicians say that until recently, they had not seen kernicterus in twenty-five years. However, one study linked the increase in jaundice and its related complications to early discharge. Dr. Augusto Sola, Professor of Pediatrics at University of California,

33. Of the readmissions, 60% were for jaundice, while 16% were for infections. See Paul D. Conrad et al., Safety of Newborn Discharge in Less than 36 Hours in an Indigent Population, 143 AM. J. DISEASES OF CHILDREN 98, 100 (1989).


35. It has been found that "tachypnea with infections or changes in behavior with jaundice may be too subtle for new families to detect until damage has been done." Parisi & Meyer, supra note 13, at 1636.

36. Because illnesses often do not develop until the second day, Senator Bradley argued that, "If the mother were in the hospital, [physicians] would be able to detect [illnesses] and deal with it." 142 CONG. REC. S9904 (daily ed. Sept. 5, 1996) (statement of Sen. Bradley).

37. McCaughey, supra note 1, at A23.

38. Senator Bradley noted, "[w]hat happens is the mother is pushed out of the hospital. In the second day jaundice is detected, or worse, a heart defect, and the mother is rushed back to the hospital at a much greater cost." 142 CONG. REC. S9904 (daily ed. Sept. 5, 1996).

39. Kernicterus is related to jaundice. See 4C GRAY, supra note 15, at 3249. It is a condition involving the nerve ganglia of the medulla, which connects the spinal cord with the base of the brain. Id. Mental disease occurs because of the destruction of coordinating nerve centers within the brain. Id. The infant may appear strong and vigorous at birth, but symptoms do not arise until several days later. Id. at 3252. Symptoms include jaundice; a listless, sleepy, flaccid condition or twitching; and sometimes convulsions. Id. at 3253. The infant is treated with a blood transfusion of magnitude proportions. Id. at 3257. The transfusion essentially needs to entirely replace the infant's current blood supply. See id. at 3248-63.

surveyed data from all hospitals in California. In 1992, California adopted an early discharge policy. Since that time, Dr. Sola saw "six otherwise healthy, full-term newborns rushed to his neonatal intensive care unit with permanent brain damage due to severe jaundice (bilirubin encephalopathy)." In addition, Dr. Sola found that in 1992 alone, "nine full-term newborns discharged early as healthy suffered irreversible brain damage because of severe jaundice."

Mental retardation is another risk associated with early discharge. Phenylketonuria, or PKU, is a metabolic disorder that can cause mental retardation if not treated. Fifty years ago, one percent of retarded people in institutions had suffered PKU. For decades, hospitals administered a simple test to detect the disorder. However, the PKU test is only effective if the infant has been eating for at least twenty-four hours. In fact, the test is the most accurate when the infant is three to five days old. Dr. Harry Ostrer, Director of Human Genetics at NYU Medical Center, believes infants were not being tested for PKU due to early discharge. For example, in Maryland, discharge of one third of the infants took place before the first day. Of those, eighteen percent did not return for PKU testing.

As a result of such alarming statistics, Dartmouth Medical School conducted a study to determine the risk of hospital readmission and emergency room visits within the first two weeks of life. The findings were startling. For infants discharged in less than 48 hours, "there was a 50% increased risk of readmission and a 70% increased risk for

41. See McCaughey, supra note 1, at A23.
42. Id.
43. Id.
44. Id.
45. PKU is a liver ailment that can lead to mental retardation, underactive thyroid, sickle cell anemia, and jaundice if not detected. Michael M. Mazzocco et. al., Cognition and Tyrosine Supplementation Among School-Aged Children with Phenylketonuria, 146 AM. J. OF DISEASES OF CHILDREN 1261 (1992). See also Robert L. Brunner et al., Early Treated Phenylketonuria: Neuropsychologic Consequence, 102 J. PEDIATRICS 831 (1983).
46. McCaughey, supra note 1, at A23.
47. Id. at A24.
48. Id.
50. See id.
51. McCaughey, supra note 1, at A23.
52. Id.
53. Id.
emergency room admissions."

Other studies were just as revealing. One study found that infants discharged early were twenty-five times more likely to have missed screenings for congenital disorders than those who stayed the extra day. Still another study showed that cesarean section infants sent home within twenty-four hours are three times more likely to develop problems that require them to return to the hospital. Of these, readmission of 4.3% of the infants was due to serious health problems.

Also found within this study was a discrepancy in insurance coverage. This is reason to believe that early discharge correlates strongly with economic scarcity; not with the comfort and health of home. Within 24 hours after delivery, hospitals sent home patients who belonged to health maintenance organizations (HMOs) more often than those covered by commercial insurance or Medicaid. As will be discussed later, this link between early discharges and HMOs is not surprising. Indeed, HMOs were one of the biggest opponents of mandatory stays, stating there is no statistical data on risks associated with early discharge.

B. Personal Risks

Despite HMOs' disbelief in statistical proof, personal risks are plentiful in anecdote. For instance, mother-to-be Allison Bissar desperately tried not to enter the hospital until after midnight because she knew her insurance company covered only twenty-four hours of care. "I'd been in labor all day, 'she said, 'and the contractions were so bad I was gritting my teeth.' Twenty-three hours after delivery, while she was still bleeding heavily, nurses rushed her to leave because her insurance refused to pay for another day.

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55. Id. See also Physicians Blame Insurance Profits for Trend in Early Hospital Releases, 3 Health Care Pol'y Rep. (BNA) No. 37, at 1441-42 (Sept. 18, 1995) [hereinafter Physician's Blame Insurance Profits].


58. Id.

59. Id. at 1319.

60. Company Profits, supra note 7, at 2065.

61. Id.


63. Id.
For Johannah Donoghue, postdelivery care was just as traumatic. Hospital officials could not confirm her payment authorization because her insurance company was closed for the business day. Thus, seventy-two hours after having an emergency cesarean section, Johannah was turned out of the hospital near midnight, heavily sedated and in a wheelchair. Unfortunately for her, permission to stay an extra day came in the mail a few days later.  

In another case, a home nurse detected nearly fatal infectious symptoms in a mother and her infant. The insurance company had ordered the mother to leave early without considering such important factors as her age, premature baby, and lack of family support at home.

More serious cases concern infants, including that of Shannon McCloskey. Baby Shannon was discharged approximately twenty-seven hours after birth. Eight hours later, she began having seizures and ended up in the emergency room. After diagnosing her with streptococcus, the physician said that she would have died if the parents had arrived at the hospital 15 minutes later.

Brantley Dunn was one month premature and born via cesarean section. He was released thirty-six hours after birth. Within twenty minutes of arriving home, Brantley stopped breathing. He was rushed to the hospital and placed in the neonatal intensive care unit.

Other cases include a Virginia infant who suffered brain damage and a Cincinnati infant who had his leg amputated. Both cases were due to complications of dehydration. Both could have been prevented with longer hospital stays.

An even more tragic case involved infant Michelina Bauman. Michelina was discharged twenty-eight hours after her birth. When she began showing signs of streptococcus a day later, her parents repeatedly called their HMO's home nurse care program. Tragically, the nurse finally called one day after Michelina's death. The Baumans believe that their daughter would still be alive if she had been in the hospital

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64. See Lloyd, supra note 32, at A1.
66. Id.
68. Id.
70. Id.
71. Id.
72. Id.
Leigh Fallon feels the same way about her baby boy. Leigh's son was delivered by an emergency cesarean section after two days of exhaustive labor with extensive complications. Under pressure from their insurance company, Leigh and her son were discharged 72 hours later, even though Leigh had a high fever and her son had jaundice and a heart murmur. A few days later, the baby was rushed to the hospital for emergency heart surgery. He died.

III. THE PROONENTS' ARGUMENTS FOR MANDATING MINIMUM STAYS

A. Insurance Companies are the Problem

Because of the rise in medical complications and deaths, health care providers, hospital administrators, and parents began urging legislators to intervene. Proponents for mandating minimum maternity stays believe that patients are not being forced to leave by the hospitals, but by insurance carriers who refuse to pay for longer stays. They argue that since obstetrical delivery is the most frequent cause of hospitalization, shorter hospital stays are appealing to insurers.

Indeed, if the mother was ready to leave, insurance companies did not allow them to stay if the infant was having complications. Likewise, infants were sent home without their mothers if the mother was having complications.

Proponents also maintain that insurance companies pressure physicians to limit hospital stays. Physicians agree, saying, "The insurance company tells the hospital not 'when' to discharge [mothers], but how many days it will pay for." In some cases, physicians were forced to lie to get coverage for their patients. "They'll say the mother has an infection. That's worth an extra 24 hours. The flu, even better."
A study conducted by the General Accounting Office found that "a significant number of plans offer doctors alternative financial incentives for early discharge and significant penalties for keeping young mothers and babies in the hospital longer than the plans would like."82 Indeed, Kaiser Permanente, a nonprofit health plan, encouraged its physicians and nurses to usher new mothers out as quickly as possible.83 Physicians were told to say that hospital food does not taste good and that more visitors could be had at home, or that sleeping in their own bed would be better.84

In addition, insurance companies required physicians to code everything placing certain symptoms or treatments in various categories, which was impossible at times.85 Physicians had to search to find a diagnosis that fit the reimbursement codes.86 Still, insurance companies would balk at paying for an extra day if the reason was not serious enough. Physicians explain, "it's hard to convince an insurance company that the mother's need for rest and education is enough criteria to keep them for another 24 hours."87 Indeed, one HMO refused to pay for a woman whose physician described her as exhausted and unable to move.88 The HMO representative remarked, "Well, she should have gone to a hotel. It would have been a lot cheaper."89

With such statements, physicians became troubled. If they requested too many services, it would affect their medical and financial "profile" with an insurer.90 Physicians were placed in a difficult situation; by advocating for their patients, they were simultaneously advocating for their own economic ruin.91

To help physicians help patients, the American Academy of Pediatrics (AAP) and the American College of Obstetricians and

83. See AnnaL supra note 25, at 1648.
84. Id.
86. Felice J. Freyer, Panel to Consider a Bill Requiring 2 Days in Hospital After Childbirth, PROVIDENCE J.—BULL., Jan. 24, 1996, at 1A (citations omitted).
87. Patrick Howington, Hospital to Give New Moms 2nd Day of Care-Free, COURIER.—J. (Louisville) Dec. 15, 1995, at 1A (citations omitted).
89. Id.
91. Freyer, supra note 86, at 1A.
Gynecologists (ACOG) began revising the guidelines for early discharge, which encouraged physicians to release mothers only after a complete examination. In addition, mothers should not have any psychiatric, surgical, or medical problems before release. The guidelines also suggested that mothers be instructed on caring for their infants as well as themselves.

The guidelines also recommended that mothers reject early discharge if they were not ready. There was, however, no guarantee that insurance companies would pay for the second day. If insurance companies refused to pay, mothers were forced to accept early discharge our responsibility for the costs. Thus, proponents explained that mandating stays through legislation, not new guidelines, was the only way to hold insurance companies accountable.

B. State Legislation as a Solution

State legislators began to address these concerns. New Jersey was the first to adopt a minimum maternity stay statute. Subsequently, several states modeled their statutes after this version. Approved on June 28, 1995, the New Jersey statute, states in pertinent part:

Every individual or group contract that provides benefits and is delivered, issued, executed or renewed in this State...

92. AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, Guidelines for Perinatal Care, in AM. ACAD. PEDIATRICS (Roger K. Freeman & Ronald L. Poland, eds., 3d ed. 1992) [hereinafter GUIDELINES]. See also AMERICAN ACADEMY OF PEDIATRICS, COMMITTEE ON FETUS AND NEWBORN, Hospital Stay for Healthy Term Newborns, 96 PEDIATRICS 788 (1995).

93. The new guidelines require physicians not to release mothers early unless they have been examined by their physicians and have no psychiatric, surgical, or medical problems. Possible problems could include excessive bleeding or fever, which is a sign of sepsis, a potentially life-threatening bacterial infection, or third- or fourth-degree lacerations as a result of an episiotomy, which is an incision made to facilitate delivery. See GUIDELINES, supra note 92, at 91-111.

94. Id.

95. Care instructions are extensive. If a mother is planning to nurse, she should have instruction in breast-feeding and have someone verify that she is doing it correctly. She should also know how to reach a lactation consultant by phone. Id.

Moreover, she should have instruction in bathing her baby and caring for the umbilical cord and circumcision site. She must also be able to recognize early signs of illness in her baby, such as decreased feeding, color change, lethargy, breathing difficulties, or the loss of more than five percent to ten percent of the baby's weight. She should have someone at home to help care for both herself and the baby. Additionally, babies should not be released early unless they are delivered at term and have had a normal physical exam. Babies must also have urinated, passed stool, had screening tests, and be fed every two hours. Id.

approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this act shall provide coverage for a minimum of 48 hours of in-patient care following a vaginal delivery and a minimum of 96 hours of in-patient care following a cesarean section for a mother and her newly born child in a health care facility . . . .

Massachusetts was the fourth state to set minimum hospital stays. The State Department of Public Health has 120 days to promulgate regulations on early discharge and post-delivery care. Medical, women's, and children's groups in Massachusetts supported the legislation, insurers and HMOs opposed it.

At the signing ceremony, the Governor of Massachusetts declared, "This bill leaves the decision of when to leave the hospital in the hands of the real experts—the patient and her doctor." The new law, which applies to Medicaid recipients, forbids insurers from penalizing doctors or nurses who comply with its provisions. Thus, physicians in Massachusetts will no longer have to fight with insurance companies to keep mothers hospitalized an extra day.

Legislators in Indiana were taking notice as well. One state representative agreed that technological advances may make shorter hospital stays possible for some medical procedures. Upon filing a bill with the state, however, this same legislator emphasized, "[t]he way you have a baby never changes."

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97. Id.
99. The regulations were to be drawn up by representatives from the Massachusetts Nurses Association, Massachusetts Medical Society, Massachusetts Hospital Association, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, Massachusetts Association of Health Maintenance Organizations, Blue Cross/Blue Shield, and other health organizations. Massachusetts to Require Insurers to Pay for Minimum Maternity Stays, [July-Dec.] Pens. & Ben. Rep. (BNA) No. 47, at 2601 (Nov. 28, 1995) [hereinafter Massachusetts Requires Insurers].
102. Id.
103. Massachusetts Requires Insurers, supra note 99, at 2601 (citations omitted).
106. Howington, supra note 87, at 1A (citations omitted).
New Yorkers agreed. The New York Public Interest Research Group supported legislation, saying the early discharge policy “[gave] new meaning to HMO—‘Heave Mothers Out.’”

Regardless of the states’ interests in mandating minimum maternity stays, there was still concern for those whose employers are self-insured. A 1978 federal law exempts self-funded insurance plans from state regulation. States, therefore, cannot mandate self-funded insurers to pay for longer stays. Additionally, state legislation could not protect those who must cross state lines to get health care, or those under the Employee Retirement Income Security Act (ERISA). Accordingly, in Connecticut, “lawmakers [w]ere seeking a way to compel longer hospital stays for all women after giving birth, without raising ERISA preemption issues or leaving patients covered by self-insured plans outside the mandate.” If the Connecticut legislation had addressed only insurance carriers, coverage would exclude over 50% of its population. Thus, 50% of mothers would not have been protected in Connecticut.


108. Deborah Barfield, Rare Move on 2-Day Stays for New Moms, NEWSDAY, Jan. 9, 1996, at A21.

109. State laws do not extend to those insurance companies and employers which are based out of the state. State laws also do not cover self-funded insurance plans. Closing a Loophole; Federal Law Needed to Protect the Newborn, ASBURY PARK PRESS, Dec. 27, 1995, at A10.

110. Id.


Senator Bradley addressed the fact that state laws do not affect a large segment of the insured population that would be covered by federal law. “For example, we need a Federal law to get at the so-called ERISA plans, the self-insured plans, the plans of large companies like Boeing, IBM, 3M, Dupont, and others. They would not be affected by a State law because they are self-insuring ERISA, controlled by Federal law.” 142 CONG. REC. S9904 (daily ed. Sept. 5, 1996) (statement of Sen. Bradley).

Senator Chafee from Rhode Island was initially against the federal bill. He changed his mind after Senator Bradley spoke about ERISA. Chafee stated that “because ERISA applies to those corporations that have interstate health care plans, that the ERISA law prevents the State government . . . from getting involved with the plans that are covered by the ERISA statute.” 142 CONG. REC. S9910 (daily ed. Sept. 5, 1996).


113. Id.
The same problem arose in Kansas, where only 40% of the companies would be subjected to state regulation, leaving 60% unprotected.\textsuperscript{114} The figures were the same in Minnesota.\textsuperscript{115} In Delaware, only 15% would be affected by state law, leaving 85% unprotected.\textsuperscript{116}

IV. THE OPPONENTS' ARGUMENTS AGAINST MANDATING MINIMUM STAYS

Originally, insurance companies, HMOs, and some business groups\textsuperscript{117} disagreed. These groups made up the bulk to opponents of state and federal legislation. The opponents argued that governmental remedies would give physicians and patients too much decision-making power, and would set a precedent "for wide-ranging regulation of medical practices—or simply . . . force insurers to cut compensation elsewhere."\textsuperscript{118} Opponents now fret that Congress will begin mandating lengths of stay for other procedures as well.\textsuperscript{119}

Those opposed to legislative solutions hypothesize that new laws will drive up premiums.\textsuperscript{120} They deem all of this "a troubling attempt by government to dictate medical standards."\textsuperscript{121}

Accordingly, opponents claim that legislators have over-stepped their boundaries. One opponent, Jady DeGiralomo, President of the Ohio HMO Association, argued that "dispensing medical advice is out of bounds for a . . . legislature."\textsuperscript{122} DeGiralomo said the early-discharge system worked because it was the physicians who decided the length of stays for their patients, not the insurance companies. DeGiralomo declared, "[I]n all aspects of the health-care system, physicians [were] being asked to consider whether an additional day or two [would] contribute to the patient's health."\textsuperscript{123}

\textsuperscript{115} Id.
\textsuperscript{117} The business groups include the California Chamber of Commerce, National Federation of Independent Business, the Association of California Life Insurance Co., and the California Association of HMOs. Calif. Assembly Panel to Take Up Bill Mandating Minimum Childbirth Coverage, 3 Health Care Pol'y Rep. (BNA) No. 38, at 1501 (Sept. 25, 1995).
\textsuperscript{118} Hammonds, supra note 6, at 40.
\textsuperscript{119} Senate Delays May be Tied to Portability Requirements in Insurance Reform Measure, DAILY REP. FOR EXECUTIVES, Dec. 15, 1995, at 241.
\textsuperscript{120} Wong, supra note 101, at 28.
\textsuperscript{121} Id.
\textsuperscript{123} Id.
Others argue the consequences of early discharge are largely unknown.124 For example, the chief medical officer at one health plan claimed, "There is virtually no clinical evidence that there's a technical medical necessity for an acute medical stay of more than 24 hours."125

Some claim early discharge is medically sound. Permanente Medical Group agrees. It urged discharge to start as early as eight hours after delivery.126 In one Los Angeles hospital operated by Permanente, an eight-hour pilot project was already in place.127 Permanente says the project reduced costs and allowed them "to remain competitive in a fluid marketplace and thus retain our jobs and attract more patients."128 Furthermore, Permanente claims that 60% of new mothers plan to leave the hospital after twenty-four hours anyway.129 Permanente argues that mandating longer stays goes against the patients' desires.130

Group Health Association of America (GHAA) also claims that early discharge is safe. GHAA is a Washington-based trade association that represents most of the nation's HMOs.131 The group surmises that an early discharge avoids exposure "to unnecessary risks of hospitalization, such as infection."132 GHAA also finds the statutory standards inflexible133 and believes that a "cookie-cutter approach" to the issue is unwise.134 Obviously, GHAA's focus is cost-oriented: "To freeze standards of care into statute through legislation [would] impede progress towards the dual goals of quality improvement and cost effectiveness."135 Moreover, GHAA officials assert that "legislators should not dispense medical care, nor should they create barriers to cost-effective care."136 Instead, GHAA declares that the focus should be on the quality and comprehensiveness of prenatal and follow-up care.137

Others say that ensuring the safety of mother and infants through.

124. Id.
125. Hammonds, supra note 6, at 40 (quotations omitted).
126. Company Profits, supra note 7, at 2065.
128. Id.
129. Company Profits, supra note 7, at 2065.
130. Id.
132. See Boodman, supra note 2, at Z6.
132. Id.
133. Company Profits, supra note 7, at 2065.
134. Boodman, supra note 2, at Z06.
135. Company Profits, supra note 7, at 2065.
136. O'Malley, supra note 122, at 19.
137. Id.
legislation is misguided. They argue that legislation "does not take a comprehensive, cost-benefit approach to society's health care needs." Since insurance companies made up the bulk of opponents, they decided to work with the authors of the bills. The California Association of HMOs worked with the author of the California version of the bill. This association agreed with setting guidelines, but is still proposing more studies to determine appropriate lengths of stays.

In Rhode Island, the three major health insurers helped craft a version of their bill. The insurers were not fighting legislation because they saw it as a social issue, not a medical issue.

In Maryland, the Medical and Chirurgical Faculty of Maryland, a leading physicians group, and the Maryland Association of Health Maintenance Organizations formed an alliance to amend Maryland's existing law. The two groups created a document outlining "principles of agreement" in sixteen different managed care issues.

V. CONGRESS STEPS IN WITH A NEW LAW

As previously noted, proponents saw legislation as the only way to protect all mothers. On September 12, 1995, physicians representing the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) addressed the Senate Labor and Human Resources Committee to propose legislation mandating
lengths of stay for childbirth. If passed, the act would be mandatory for all states.

The original proposal, after two revisions, became law. The law now requires health insurers to permit new mothers and their infants to remain in the hospital for a minimum of 48 hours after a vaginal birth and 96 hours after a cesarean delivery. Shorter stays, however, are permissible if neither the mother nor health care provider objects. What the law does not do is require a mother and infant to stay a fixed time. Nor does it require that a mother deliver in a hospital. It also does not preempt state laws or regulations which already provide as much or more protection.

The AMA supports the new law. AMA officials state that managed care companies were taking cost-effectiveness too far. By focusing on the reduced costs of shorter stays, the health and safety of mothers and infants was being glossed over by insurance companies.

The ACOG also supports the new law. ACOG has had guidelines since 1983 for longer lengths of stay. Recently insurance companies cut the length of stays to shorter intervals. ACOG officials called the early discharge a "large, uncontrolled, uninformed experiment."

The American Academy of Pediatrics (AAP) also recommended a second day for the mother's sake. A spokesperson stated, "There are clearly some babies who, from a medical standpoint, seem like they're OK to go home, but perhaps the mothers are not ready for the volume of items that they're required to do in taking care of the baby." Therefore, the AAP believes a longer stay will enable mothers to learn how to properly feed and care for their infants.

149. Id.
152. Id. at § 711(a)(2).
154. Company Profits, supra note 7, at 2065.
155. Id.
156. Id.
158. Gordon, supra note 90, at B1 (citations omitted).
159. Howington, supra note 87, at 1A.
All the proponents agree that increases in serious and sometimes fatal complications accompanied the decline in postnatal hospital stays. For the safety of all mothers and infants, the law requires the decision to stay up to the health care provider and patient, not the insurance company.

VI. WHAT THE FUTURE HOLDS

The emphasis on mandating maternity stays "is like motherhood, apple pie and the Fourth of July." Despite the arguments for and against such legislation, the heart of the matter is the health and safety of mothers and infants. Arguably, there should be laws when "economic experiments" harm citizens. Perhaps there should even be laws when insurance companies refuse to be flexible in covering longer periods of stay. Realistically, lawmakers may not be able to "set one standard when no evidence exists that one measure is best for all." It may not be possible for legislators to know today what will be appropriate lengths of stay for the future.

Although the new law offers a nationwide guarantee that the health and welfare of newborns and mothers will be the primary focus of decisions, the Act stops short of mandating minimum periods of stay. Therefore, other options adopted by health care providers still have some validity. Additionally, the Act does not close the book on examining the need for more stringent safeguards.

A. Hospitals Providing a Second-Day Free

This section will discuss options not addressed by the Act, as well as

160. Id.
161. In Burditt v. U.S. Dept. of Health and Human Services, 934 F.2d 1362, 1370-73 (5th Cir. 1991), the court held that physicians are allowed to use their judgment in emergency labor situations to decide if the benefits of transferring the mother to another hospital outweigh the increased risk.
163. See O'Malley, supra note 122, at 19.
164. Parents Push for Longer Hospital Stays for Newborns, supra note 40, at A5.
165. To codify one standard of care for everyone assumes that this standard will be appropriate in the future. "Indeed, in a world of rapidly changing technology, it is easy to imagine that, even if leaving the hospital prior to two days postpartum is unsafe in 1996, it may not be unsafe in the future." Massachusetts Requires, supra note 138, at 2118.
166. Prior to the passage of the new law, though, Congress had already successfully codified some aspects of labor and delivery, despite this argument. For example, the Emergency Medical Treatment and Active Labor Act requires hospitals to admit women in labor when transfer to another hospital is dangerous. 42 U.S.C.A. § 1395dd (West 1987), amended by 42 U.S.C.A. § 1395dd (West Supp. 1991).
steps Congress has taken to further research this still-developing issue. One alternative removed from legislation is for hospitals to offer a second day free.\textsuperscript{166} If the fixed costs for the room and staff are discounted,\textsuperscript{167} the cost for providing care for a second day amounts to between $50 to $100.\textsuperscript{168}

Several hospitals are already providing this service.\textsuperscript{169} Tacoma General Hospital in Washington absorbs the extra costs. The hospital allows every new mother to stay up to forty-eight hours following a vaginal delivery.\textsuperscript{170} During the extra day, new mothers "have the opportunity to learn what to expect about their baby’s feeding, crying, diapering, immunizations, health signs and safety."\textsuperscript{171} Also during this time, mothers learn how to care for themselves.\textsuperscript{172} Furthermore, the hospital promises minimal interruptions so that mothers can rest before going home.\textsuperscript{173} For mothers who decide to leave early, a nurse visits the home within two days.\textsuperscript{174}

Another hospital, Bon Secours in Detroit, introduced a free second-day “Rest & Reassurance” policy.\textsuperscript{175} In addition to this policy, accommodations are available for mothers who are discharged, but whose infants are required to stay. The hospital absorbs the cost if the insurance company refuses to pay.\textsuperscript{176}

University Medical Center in Stony Brook, New York, also offers a second day free. If the insurers do not pay for the extra day, “the hospital will absorb the estimated $300 in added cost.”\textsuperscript{177} Representatives state, “the additional costs absorbed by the hospital seemed trivial in comparison with concern about the potential medical consequences of

\begin{itemize}
  \item \textsuperscript{166} See Howington, supra note 87 at 1A.
  \item \textsuperscript{167} Testifying for the Massachusetts bill, Deborah Socolar, a Boston University researcher, said the staff would be paid whether or not the room was occupied. Kong, supra note 104, at 20.
  \item \textsuperscript{168} \textit{Id}.
  \item \textsuperscript{169} Howington, supra note 87, at 1A.
  \item \textsuperscript{170} \textit{Tacoma General Hospital Puts Mom and Baby First}, BUS. WIRE, Dec. 11, 1995.
  \item \textsuperscript{171} \textit{Id}.
  \item \textsuperscript{172} Mothers will learn about hormonal changes, family planning, and exercise. \textit{Id}.
  \item \textsuperscript{173} \textit{Id}.
  \item \textsuperscript{174} During the home visit, a registered nurse “will teach the new parents about issues and concerns regarding their newborn, help them determine what additional information and resources they need and provide basic examinations for both the infant and the mother.” \textit{Id}.
  \item \textsuperscript{175} \textit{Bon Secours Confronts National Birthcare Issue Offers New Moms Second Day Free}, PR NEWSWIRE, Jan. 23, 1996 [hereinafter \textit{Bon Secours}].
  \item \textsuperscript{176} \textit{Id}.
  \item \textsuperscript{177} See Annas, supra note 25, at 1650. Annas stated that the actual cost of the additional day is actually around $100. \textit{Id}.
\end{itemize}
shorter stays covered by insurers.”

Two Illinois hospitals likewise provide a second day for mothers who request it. Moreover, Chicago's Cook County Hospital offers a forty-eight hour stay for indigents. Chicago city council members are also targeting hospitals rather than insurers. A proposal by two Chicago council members would require hospitals to sign affidavits verifying that they base maternity discharge policies on the AAP's recommendations. Hospitals' license renewal and free water from the city would hinge on the guarantee of longer maternity stays for new mothers. Council members think that “if a hospital is licensed to do business in the City of Chicago, it has a moral and legal obligation to the people that it serves that it will follow professionally acceptable standards of care.”

As a condition of maintaining their licenses, Massachusetts' hospitals are required to make longer stays available. Hence, rather than wait for legislation, hospitals have taken the matter into their own hands by offering a second day free of charge if necessary.

B. Home Health Care Systems

Another option is to increase the home health care network. Currently, hospitals, health care providers, and other medical personnel are liable for death or injury to infants caused by improper postdelivery diagnosis and care. In addition, hospitals, health care providers, and other medical personnel are liable for death or injury to mothers or infants caused by inadequate attendance or monitoring during and after pregnancy, labor, and delivery. However, this liability ends once the patient leaves the hospital. Therefore, focusing on the length of stays

178. See Parisi & Meyer, supra note 13, at 1637.
179. LaGrange Memorial Hospital and St. Joseph Medical Center, Joliet, provide a second day free of cost for new mothers. Chicago Officials, supra note 76, at 1859.
180. Id.
182. Id.
183. Chicago Officials, supra note 76, at 1859 (citations omitted).
184. Langan, supra note 8, at 130.
186. Jay M. Zitter, Annotation, Liability of Hospital, Physician, or Other Medical Personnel for Death or Injury to Mother or Child Caused by Inadequate Attendance or Monitoring of Patient During and After Pregnancy, Labor, and Delivery, 3 A.L.R.5th 146 (1995).
may be too narrow. Instead, home health care may be the vital link between the hospital and home.

Both proponents and opponents of legislation agree that appropriate care for mothers and infants after delivery is essential. With most women working outside the home, postpartum care may be just as important as prenatal care.\textsuperscript{187} In fact, medical professionals claim that many of the health problems associated with early discharge are avoidable if insurance companies automatically send home health nurses to mothers.\textsuperscript{188}

Some hospitals already absorb the cost of visits to new mothers. Bon Secours Hospital in Detroit calls its program “Birth Care Home Advantage.”\textsuperscript{189} When visiting a mother and infant at home, the nurse “evaluates the health care needs of both the mother and baby while helping to facilitate the transition from hospital to home.”\textsuperscript{190}

The cost-effective service of home care did increase in 1995.\textsuperscript{191} Moreover, “[t]he increasing availability of this service, coupled with insurance companies’ willingness to cover the service” may be a better option than mandating minimum stays.\textsuperscript{192}

\section*{C. Different Methods of Payment}

There is a downside for hospitals absorbing all of these costs. Some hospital executives predict, “[e]ating the cost on one procedure could encourage HMOs to cut back on others.”\textsuperscript{193} Instead, a different method of payment may be an option. Currently, insurers are starting to compensate hospitals on a flat-fee basis for certain procedures.\textsuperscript{194} Perhaps maternity stays should be on a flat-fee rate, regardless of the length of stay. Even though providers would have to take on the additional financial risk of giving care, they would still have decision-making power.

\begin{thebibliography}{99}
\bibitem{}Gordon, supra note 90, at B1.
\bibitem{}\textit{Bon Secours}, supra note 175.
\bibitem{}Id.
\bibitem{}Id.
\bibitem{}Id.
\bibitem{}Id.
\bibitem{}Id.
\bibitem{}Bon Secours, supra note 175.
\bibitem{}Id.
\bibitem{}Id.
\bibitem{}The National Medical Expenditures Survey stated that the home health care industry grew from \$11.6 billion in 1987 to \$29.9 billion in 1994. Pamela Lemkin, \textit{Cost vs. Care; Cost of Continuum of Care}, INDEP. LIVING PROVIDER, Nov. 1995, at 44.
\bibitem{}Id.
\bibitem{}Hammonds, supra note 6, at 40.
\bibitem{}Medicare already has a flat-fee basis for many procedures. The flat-fee takes the place of the more common method of negotiating per diem rates. \textit{Id.}
\end{thebibliography}
D. Advisory Panel Established by the Act

In enacting the Newborns' and Mothers' Health Protection Act of 1996, Congress also recognized the paucity of conclusive research in this area. To ensure that the sweeping mandate of the Act is carried out to its fullest extent, Congress has seen fit to call for the establishment of an advisory panel to study and recommend the appropriate manner to effectuate the new law.\textsuperscript{195}

This advisory panel is to be composed of representatives of health care practitioners, health plans, hospitals, employers, states, and consumers.\textsuperscript{196} It is to address patient care, quality assurance, consumer issues, and other research.\textsuperscript{197} More importantly, this advisory panel has been instructed its primary point of reference is that childbirth is but one part of a "continuum of experience that includes prepregnancy, pregnancy and prenatal care, labor and delivery, the immediate postpartum period, and a longer period of adjustment for the newborn, the mother, and the family . . . ."\textsuperscript{198} Additionally, in recognition of the arguments of the opponents of such legislation, Congress has also recognized that "health care practices across this continuum are changing in response to health care financing and delivery system changes, science and clinical research, and patient preferences . . . ."\textsuperscript{199}

This advisory panel is, therefore, to conduct a study of the following areas:

(A) the factors affecting the continuum of care with respect to maternal and child health care, including outcomes following childbirth;
(B) the factors determining the length of hospital stay following childbirth;
(C) the diversity of negative or positive outcomes affecting mothers, infants and families;
(D) the manner in which post natal care has changed over time and the manner in which that care has adapted or related to changes in the length of hospital stay, taking into account—
   (i) the types of post natal care available and the extent to which such care is accessed; and

\textsuperscript{196} Id. § 606(b)(2)(B)(ii), 110 Stat. 2943.
\textsuperscript{197} Id. § 606(b)(2)(B)(i), 110 Stat. 2943.
\textsuperscript{198} Id. § 606(a)(1), 110 Stat. 2942.
\textsuperscript{199} Id. § 606(a)(2), 110 Stat. 2942.
(ii) the challenges associated with providing postnatal care to all populations, including vulnerable populations, and solution for overcoming these challenges; and

(E) the financial incentives that may—
   (i) impact the health of newborns and mothers; and
   (ii) influence the clinical decision making of health care providers. 200

The establishment of the advisory panel indicates that the debate in this area has not been laid to rest by the enactment of the Newborns' and Mothers' Health Protection Act of 1996. Those with an interest at stake can be sure that this controversial issue will continue to develop.

VII. CONCLUSION

As this Comment has shown, recent changes in medical technology and the manner in which insurance companies cover maternity stays has led to increased concern over the health and welfare of newborns and their mothers. Dissatisfied with the insurance companies' and hospitals' handling of this sensitive issue, states, and finally the federal government, have stepped in to protect a vulnerable segment of our society. Now that the dangers associated with shortened delivery stays have been brought to the fore, more research will certainly be conducted to test the validity of these concerns. Alternatives to minimum periods of stays and the establishment of an advisory panel to conduct an in-depth study of this area indicate that a conclusive solution has yet to be achieved. Nevertheless, the adoption of the Newborns' and Mothers' Health Protection Act of 1996 is an excellent first step in this still-developing area. New mothers can breathe a sigh of relief now that Congress has properly placed the focus of childbirth, not on an insurance company's bottom line, but on the health and safety of the mother and child.

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200. Id. § 606(c)(1)(A)-(D), 110 Stat. 2943-44.