SB

193

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 2/21/96 DATE TURNED INTO OFFICE: 3-12-96

The Finance Committee considered SENATE BILL NO. 193

"An Act requiring insurance coverage for certain costs of birth; and providing for an effective date."

and recommends:

[ ] be replaced with _____ CS _____ (_____)

[✓] adopt previous _____ CS SB 193 (LHC)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ _____ Committee

[ ] further referral to the _____ Committee

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical change
[ ] new: SCR*_____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
	✓	BOA Nay	✓		
	✓				
	✓				
Co-Chair:	✓	Co-Chair:	✓		
Co-Chair:		Co-Chair:			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
DCED	2/21/96	0	

PREVIOUS FISCAL NOTE(S):*

	Department	Date	Zero	Fiscal
#3	DHSS	1/19/96	0	
#1	DOA - All	1/15/96	0	

[ ] APPROPRIATION -- no fiscal note

*include fiscal notes accompanying Governor's bill

FISCAL NOTE

#1

STATE OF ALASKA

1996 LEGISLATIVE SESSION

BILL NO. SB 193

Revision Date:
Title: An Act requiring insurance coverage for certain costs of birth, and providing for an effective date.
Sponsor: Sato
Requestor:

Department Affected: All State Agencies
BRU: All State Agencies
Component: All State Agencies
COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES	104.0	250.0	250.0	250.0	250.0	250.0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	104.0	250.0	250.0	250.0	250.0	250.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts	10.7	25.8	25.8	25.8	25.8	25.8
1003 GF Match	2.9	7.0	7.0	7.0	7.0	7.0
1004 GF	64.9	155.8	155.8	155.8	155.8	155.8
1005 GF/Program Receipts	3.6	8.7	8.7	8.7	8.7	8.7
1037 GF/Mental Health	3.2	7.7	7.7	7.7	7.7	7.7
OTHER	18.7	45.0	45.0	45.0	45.0	45.0
TOTAL	104.0	250.0	250.0	250.0	250.0	250.0

Estimate of any current year (FY 96) cost: $ Zero

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This bill would mandate the minimum length of hospital stay that insurers would pay. The State's health plan pays for care that is medically necessary. That could mean an early discharge when everything is going smoothly or require an extended stay when needed.

This bill would become effective for the State employee plan on February 1, 1997. The potential increase for FY 1997 would be for five months only. The monthly per employee charge is estimated to be $1.78.

Prepared by: Robert F. Steinaker
Division: Retirement & Benefits
Phone: 465-4470
Date:

Approved by Commissioner: Mark Boyer
Agency: Department of Administration
Date: 2/14/96

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Rev 01/95

FISCAL NOTE

Copy to Larry 2/21/96 #1

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. SB 193

Revision Date:
Title: An Act requiring insurance coverage for certain costs of birth and providing for an effective date
Sponsor: Salo
Requestor:

Department Affected: All State Agencies
BRU: All State Agencies
Component: All State Agencies
COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES	0 0	0 0	0 0	0 0	0 0	0 0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0 0	0 0	0 0	0 0	0 0	0 0
CAPITAL EXPENDITURES	0 0	0 0	0 0	0 0	0 0	0 0
CHANGE IN REVENUES ( )	0 0	0 0	0 0	0 0	0 0	0 0

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts	0 0	0 0	0	0 0	0 0	0 0
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	0 0	0 0	0 0	0 0	0 0	0 0

Estimate of any current year (FY 96) cost: $ zero

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This bill would mandate the minimum length of hospital stay that insurers would pay. The State's health plan pays for care that is medically necessary. That could mean an early discharge when everything is going smoothly or require an extended stay when needed.

The State's premium cost is based on the experience of the plan. If extra days are paid that would otherwise not be covered, overall costs would increase and premiums would reflect that in the future. It is estimated that inpatient maternity costs could increase by 5-10%. In FY 1994 inpatient maternity costs were $2.5 million. This legislation could increase the health plan costs by $125,000 - $250,000

Prepared by: Robert F. Stanley Janet L. Parker Phone 465-4470
Division: Retirement & Benefits Date

Approved by Commissioner: Mark Boyer
Agency: Department of Administration Date 2/15/96

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1/16/96
S(L+C)

#2

FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. SB 193

Revision Date:
Title: Mandatory Ins for Costs of Birth
Sponsor: Senators Salo, Donley, Ellis
Requestor: Labor & Commerce Committee

Department: Commerce and Economic Development
BRU: Insurance
Component: Operations
COMPONENT SERIAL NO. #354

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 96) cost: $ 0.0

POSITIONS

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)
No fiscal impact.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: 1/11/96

Approved by Commissioner: William L. Hensley
Agency: Commerce and Economic Development
Date: 1-11-96

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#3

FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. SB 193

Revision Date:
Dept. Affected: Health and Social Services
Title: An Act requiring insurance coverage for certain costs of birth; efd
BRU: Medical Assistance
Component: Medicaid Services
Sponsor: Salo
COMPONENT SERIAL NO. 2077
Requestor: Salo
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This legislation does not affect the Medicaid Program at this time, but passage of these requirements could affect the program in the future when the division enters into managed care contracts. Medicaid provides health care coverage for medically necessary services to eligible women from the date when pregnancy is determined until two months following the termination of the pregnancy. Children born to Medicaid-eligible women are automatically eligible for Medicaid for the first year of life. A requirement that insurance carriers provide post partum coverage could realize savings for the Medicaid Program because health care providers are required to bill other third party resources a recipient may have prior to billing Medicaid.

Prepared by: Nancy Welker
Phone: 465-3355
Division: Medical Assistance
Date: 01/12/96

Approved by Com: Karen Perdue, Commissioner
Date: 1/15/96
Agency: Department of Health & Social Services

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FISCAL NOTE

No. 1

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Bill Version: CS SB 193(L&C)

(S) Publish Date: 2-21-96

Revision Date:
Title: An Act requiring insurance coverage for certain costs of birth; and providing for an effective date
Sponsor: Salo
Requestor:

Department Affected: All State Agencies
BRU: All State Agencies
Component: All State Agencies

COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES	104.0	250.0	250.0	250.0	250.0	250.0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	104.0	250.0	250.0	250.0	250.0	250.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts	10.7	25.8	25.8	25.8	25.8	25.8
1003 GF Match	2.9	7.0	7.0	7.0	7.0	7.0
1004 GF	64.9	155.8	155.8	155.8	155.8	155.8
1005 GF/Program Receipts	3.6	8.7	8.7	8.7	8.7	8.7
1037 GF/Mental Health	3.2	7.7	7.7	7.7	7.7	7.7
OTHER	18.7	45.0	45.0	45.0	45.0	45.0
TOTAL	104.0	250.0	250.0	250.0	250.0	250.0

Estimate of any current year (FY 96) cost: $ Zero

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This bill would mandate the minimum length of hospital stay that insurers would pay. The State's health plan pays for care that is medically necessary. That could mean an early discharge when everything is going smoothly or require an extended stay when needed.

This bill would become effective for the State employee plan on February 1, 1997. The potential increase for FY 1997 would be for five months only. The monthly per employee charge is estimated to be $1.78.

Never printed and replaced by a zero fiscal note #1

Prepared by Robert F. Stahnke
Division Retirement & Benefits
Phone 465-4470
Date

Approved by Commissioner Mark Boyer
Agency Department of Administration
Date

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FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Bill Version: CS SB193 (L&C)
(S) Publish Date: 2-21-96

( ) Date:
T.. -n Act requiring insurance coverage for certain costs of birth and providing for an effective date
Sponsor: Salo
Requestor:

Department Affected: All State Agencies
BRU: All State Agencies
Component: All State Agencies
COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	0.	0.0	0.0	0.0
1003 GF Match						
1004 GF						
GF/Program Receipts						
GF/Mental Health						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 96) cost: $ zero

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

This bill would mandate the minimum length of hospital stay that insurers would pay. The State's health plan pays for care that is medically necessary. That could mean an early discharge when everything is going smoothly or require an extended stay when needed.

The State's premium cost is based on the experience of the plan. If extra days are paid that would otherwise not be covered, overall costs would increase and premiums would reflect that in the future. It is estimated that inpatient maternity costs could increase by 5-10%. In FY 1994 inpatient maternity costs were $2.5 million. This legislation could increase the health plan costs by $125,000 - $250,000.

Prepared by: Robert F. Stanaker for Janet C. Parker Phone: 465-4479
Division: Retirement & Benefits Date:

Approved by Commissioner: Mark Boyer
Agency: Department of Administration Date:

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Rev. 11/95

FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. CS SB 193(L&C)

Revision Date:
Title: Mandatory Ins for Costs of Birth

Department: Commerce and Economic Development
BRU: Insurance
Component: Operations

Sponsor: Senators Salo, Donley, Ellis
Requestor: Senate Finance Committee

COMPONENT SERIAL NO. #354

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	00	00	00	00	00	00
CAPITAL EXPENDITURES						
CHANGE IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	00	00	00	00	00	00

Estimate of any current year (FY 96) cost: $ 00

POSITIONS

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)
No fiscal impact.

Prepared by: Joan Brown, Administrative Officer Phone 465-2597
Division: Insurance Date: 2/26/96

Approved by Commissioner: William L. Hensley Date: 2-26-96
Agency: Commerce and Economic Development

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No. 2

FISCAL NOTE

Bill Version: CS SB 193(L&C)

(S) Publi Date: 2-21-96

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Revision Date:
Title: Mandatory Ins for Costs of Birth
Sponsor: Senators Salo, Donley, Ellis
Requestor: Labor & Commerce Committee

Department: Commerce and Economic Development
BRU: Insurance
Component: Operations
COMPONENT SERIAL NO. #354

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 96) cost: $ 0.0

POSITIONS

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)
No fiscal impact.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: 1/11/96

Approved by Commissioner: William L. Hensley
Agency: Commerce and Economic Development
Date: 1-11-96

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FISCAL NOTE

No. 3

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Bill Version: CS SB 193(L&C)
(S) Publish Date: 2-21-96

evision Date:
itle: An Act requiring insurance coverage for certain costs of birth: efd
Sponsor: Salo
Requestor: Salo

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Services
COMPONENT SERIAL NO. 2077
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This legislation does not affect the Medicaid Program at this time, but passage of these requirements could affect the program in the future when the division enters into managed care contracts. Medicaid provides health care coverage for medically necessary services to eligible women from the date when pregnancy is determined until two months following the termination of the pregnancy. Children born to Medicaid-eligible women are automatically eligible for Medicaid for the first year of life. A requirement that insurance carriers provide post partum coverage could realize savings for the Medicaid Program because health care providers are required to bill other third party resources a recipient may have prior to billing Medicaid.

Prepared by: Nancy Weller
Division: Medical Assistance
Phone: 465-3355
Date: 01/12/96

Approved by Com: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 1/15/96

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101

Senator Judith E. Salo

Alaska State Legislature

FEB 22 1996

MEMORANDUM

TO: Senator Rick Halford, Co-Chair
Senate Finance Committee
Senator Steve Frank, Co-Chair
Senate Finance Committee

FROM: Senator Judith E. Salo

DATE: February 21, 1996

SUBJECT: Hearing Request,

I respectfully request a hearing on Senate Bill 193, "An Act requiring insurance coverage for certain costs of birth". This legislation will require insurers to cover hospitalization and medical costs for the mother and newborn for a period of time up to 48 hours for a normal vaginal birth and 96 hours for a cesarean delivery.

The need for this legislation has been brought about by the growing practice of health insurers requiring mothers and infants to leave the hospital 24 hours after a normal birth (12 hours in some states) and seventy two hours after a cesarean section. Many doctors don't believe this to be a sufficient amount of time for recovery, observation, or basic infant care skills. This legislation does not require a mother and newborn to stay in the hospital. In fact they can leave prior to the stated times in the legislation if in consultation with their doctor they agree it is not medically necessary to stay longer.

Thank you for your consideration.

South Anchorage • Lower Hillside • Ocean View • Klatt • Kenai • Nikiski • Kalifornsky Beach

❑ During Session: State Capitol • Juneau, AK 99801 • (907) 465-4940 • (907) 465-3766 FAX
❑ Interim Anchorage: 716 W 4th, Suite 450 • Anchorage, AK 99501 • (907) 258-8183 • (907) 258-5571 FAX
❑ Interim Kenai: 125 Mainstreet Loop • Kenai, AK 99611 • (907) 283-7996

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/8/96 FURTHER:

Date of 5-Day Notice: Feb 8 1996
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: Feb. 20, 1996

The Labor & Commerce Committee considered SENATE BILL NO. 193

"An Act requiring insurance coverage for certain costs of birth; and providing for an effective date."

FN: 0 FN

and recommends:

[X] be replaced with ____ CS SB193 (L&C)

[ ] adopt previous ____ CS ____ ( )

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ____ Committee

[ ] further referral to the ____ Committee

Senate Bill:
[X] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR'____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
		John Logan	✓		
Judith E Salo	✓				
CHAIR: Tim Kelly	✓				

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal
← Dept. of Admin	2/14/96	X	104.0
← DCED	1/11/96	X	

SB & CS

[ ] APPROPRIATION -- no fiscal note

*Include fiscal notes accompanying Governor's bill

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 26, 1996

Senator Steve Frank, Co-Chair
Senator Rick Halford, Co-Chair
Finance Committee
Alaska State Senate
Capitol Building
Juneau AK 99801

Re: Support, SB 193
Insurance Cost of Birth

Dear Co-Chair and members of the Senate Finance Committee:

ASHNHA, representing community hospitals & nursing homes across Alaska asks your support of SB 193, requiring health insurance coverage for obstetrical care.

A debate is currently underway nationally on the issue of appropriate length of hospital stay for a mother and her newborn following delivery. Statistics show the average length of stay for all hospital deliveries nationwide in 1970 was 4.1 days. By 1992, the average had decreased to 2.6 days.

In Alaska, hospital administrators feel SB 193 is needed legislation even though the trend has been to release obstetrical patients and their newborns within 24 hours.

The cost of an additional day of obstetrical care can run from $600 to a $1,000.00. This can be a major cost impact to a young family and should be covered, when medically necessary, by health insurance.

Sincerely,

Harlan R. Knudson
President/CEO

[illegible] Seward Street, #11 • Juneau, AK 99801 • (907) 586-1790 • Fax (907) 463-[illegible]

Senator Judith E. Salo

Alaska State Legislature

Sponsor Statement

Senate Bill 193

I have introduced Senate Bill 193 to ensure that newborn babies and their mothers receive adequate health care in the critical first few days after birth. Complications that might jeopardize the health of the mother or child are best dealt with if there is an adequate postpartum hospitalization period. Birth is traumatic for both the child and the mother. That period of trauma is best handled in a controlled care environment.

It is now becoming common for health insurers to require mothers and their babies to leave the hospital 24 hours after an uncomplicated vaginal delivery and 72 hours after a cesarean section. In some states it is being reduced to 12 hours. In many cases the mother and infant receive no follow up care at home. The American Medical Association has dubbed theses practices "drive through deliveries."

Sending a newborn and mother home within 24 hours could pose severe health risks. National medical organizations, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Medical Association have all stated that the trend toward shorter hospital stays is placing the health of many newborns and mothers at risk.

Senate Bill 193 will put a stop to these practices and require that health insurers allow new mothers and infants to remain in the hospital up to 48 hours for a vaginal birth and 96 hours for a cesarean section. Keep in mind that it does not require patients to stay in the hospital for the full time if the patient and physician agree to a shorter stay. This decision, as many in regard to medical care, is best made by the patient and physician.

South Anchorage • Lower Hillside • Ocean View • Klatt • Kenai • Nikiski • Kalifornsky Beach

❑ During Session [redacted] • (907) 465-3766 FAX

❑ Interim Anchorage: 71[redacted] 8-8183 • (907) 258-5571 FAX

❑ Interim [redacted] 907) 283-7996

OB-GYN ASSOCIATES
GEORGE STRANSKY, MD, FACOG
Diplomate, American Board of Obstetrics and Gynecology
LYNN HARTZ, RN, MSN, ANP
Advanced Nurse Practitioner

4231 Lake Otis Parkway, Anchorage, Alaska 99508-2293
(907) 562-2999, Fax (907) 561-1757

January 17, 1996

To: Senator Judith E. Salo, Alaska State Legislature
From: George Stransky, MD, Chairman, Department of Obstetrics and Gynecology, Providence
Re: Senate Bill No. 193

Dear Senator Salo:
From my medical standpoint, your Senate Bill No. 193 is sound and the time intervals are reasonable. It seems to protect the family while not placing undo hardship on insurance coverage.

Such a bill would have seemed unnecessary only a few years ago. However in recent years, insurers continue to push the envelope as intimidation and innuendo in their dealings with their policy holders. I repeatedly feel that insurance firms are not clear about their intent and coverage when a policy is sold, that insurance firms make decisions with flow charts and statistics without the same level of expertise in an individual case as medical personnel dealing with a given situation, and that review organizations seem like poorly disguised cost control points.

If your bill is not voted into law, I would encourage pressure to remain on insurance companies for full disclosure of benefits or full responsibility of risks involved in childbirth.

Thank you for caring.

George Stransky, MD, FACOG
Chair, Department of Obstetrics and Gynecology, Providence Alaska Medical Center
Associate Professor, University of Washington School of Medicine
Adjunct Facility, University of Alaska Anchorage

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 14, 1996

Senator Tim Kelly, Chair
Labor & Commerce Committee
Alaska State Senate
Capitol Building
Juneau AK 99801

Re: Support, SB 193
Insurance Cost of Birth

Dear Senator Kelly & Members of the Labor & Commerce Committee:

ASHNHA, representing community hospitals & nursing homes across Alaska asks your support of SB 193.

We consider it unfortunate that consumers and health providers must turn to the Legislature to mandate health insurance coverage. Ideally, this should be negotiated and agreed upon between the buyers and sellers of health insurance. Unfortunately, the cost of health care, and everyone, including insurers, attempting to find ways to control or reduce costs has triggered this appeal to the Legislature.

A debate is currently underway nationally on the issue of appropriate length of hospital stay for a mother and her newborn following delivery. Statistics nationally show the average length of stay for all hospital deliveries in 1970 was 4.1 days. By 1992, the average had decreased to 2.6 days. In Alaska, hospital administrators feel this is needed legislation even though the trend has been to release obstetrical patients and their newborns within 24 hours.

The cost of an additional day of obstetrical care can run from $600 to a $1,000.00. This can be a major cost impact to a young family and should be covered, when medically necessary, by health insurance.

Sincerely,

Harlan R. Knudson
President/CEO

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

ALASKA WOMEN'S LOBBY

416 Harris Street, Suite 208, Juneau, Alaska 99801
(907) 463-6744 phone / (907) 586-2680 fax

11 February 1996

The Alaska Women's Lobby supports the passage of SB193 which would require insurance coverage for follow-up hospitalized medical care up to 48 hours after vaginal birth; and up to 96 hours after cesarean birth.

We agree with the sponsors' concern that there are legitimate reasons for some new mothers to require additional recovery time and information that can only be provided for in the hospital following birth.

Forced premature discharge can put an exhausted parent in jeopardy and the care of the new infant at risk. Training, such as how to breast feed is just one of many essential tasks that a new mother must be taught.

We urge the passage of this legislation.

Sincerely,

Leah L. Burton
for the Alaska Women's Lobby

Legislative Research Services

Alaska State Legislature
Legislative Affairs Agency
Division of Legal & Research Services

130 Seward Street Suite 218
Juneau, Alaska 99801-2196
Phone (907) 465-3991
Fax (907) 465-3351

January 22, 1996

MEMORANDUM

TO Senator Judith Salo

FROM Maureen Weeks MW
Legislative Analyst

RE **Childbirth: States Restricting 24-Hour Hospital Discharge**
Research Request 96 029

You asked how many states have passed laws curtailing so-called "drive-through deliveries," the practice among health insurers of paying for no more than 24 hours of hospital care after a vaginal delivery and no more than 48 hours after a cesarean section. You also asked how many states are contemplating such legislation.

States Which Restrict 24-Hour Discharge Policies

As of the first week in January 1996, the following five states had passed laws designed to force insurers to pay for at least 48 hours of hospital care after a vaginal delivery and 96 hours of care after a cesarean section.

- **Maryland** in May 1995 passed the Mothers' and Infants' Health Security Act requiring insurance plans to follow criteria for maternity and newborn care published in *Guidelines for Perinatal Care* by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (the guidelines recommend a 48-hour stay for uncomplicated deliveries) (Annotated Code of Maryland 19-1305.4)

- **New Jersey** on June 29, 1995, enacted legislation requiring insurers to cover "a minimum of 48 hours of in-patient 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" (New Jersey Session Law Service Ch. 138, 1995)

- **North Carolina** on July 28, 1995, passed a law requiring a health plan that covers childbirth "provide coverage for inpatient care for a mother and her newly born child for

[redacted]

a minimum of forty-eight hours after a vaginal delivery and a minimum of ninety-six hours after delivery by cesarean section" (General Statutes of North Carolina 58-3-170).

- **Massachusetts** on November 21, 1995, enacted a law requiring a minimum of 48 hours for inpatient care following a vaginal delivery and a minimum of 96 hours following a cesarean section (Massachusetts Session Laws for November 1995 not available in Alaska Legislative Reference Library).

- **New Mexico** on November 30, 1995, adopted a rule guaranteeing a minimum of 48 hours of inpatient coverage after vaginal deliveries and 96 hours of coverage following a cesarean section if the mother or the doctor felt it was necessary. The state used regulation rather than the legislative process because it wanted to "get the rule on the books" quickly, according to Bureau of National Affairs *Health Care Policy Report* (December 11, 1995). The proposal met opposition (see the above report and a synopsis in the November 13, 1995 issue of *Family Relations*, a State Capitals newsletter.

States Considering Laws to End 24-Hour-Discharge Policies

Medical ethicist George Annas, J.D., M.P.H., writing in the mid-December issue of the *New England Journal of Medicine*, lists 11 states considering laws which would require insurers to stop 24-hour-discharge policies (**California, Connecticut, Delaware, Illinois, Kentucky, Michigan, New York, Ohio, Pennsylvania, Rhode Island, and Wisconsin**). The number of states considering such laws is likely to increase with the passing days, for this type of legislation appears to be gaining momentum in state legislatures. In August, the Bureau of National Affairs' *Health Care Policy Report* listed five states considering legislation to stop "drive-through deliveries" (**California, Delaware, Illinois, New York, and Pennsylvania**), five months later, in January of this year, a *Business Week* article stated that 25 states "are expected" to introduce legislation to end such practices (the article named only California). **Alaska's** proposed legislation, introduced in January, is included on none of the above lists. Likewise, none of the lists mentions a **Georgia** bill featured in a December issue of *Family Relations*, a round-up of references in the media featuring family issues. That bill would make it illegal for insurance companies to move mothers and newborns out of the hospital within 24 hours of delivery unless the company paid for follow-up home visits. Finally, the lists do not mention a similar measure expected in **Tennessee** (reported by the Center for Health Policy Research at George Washington University in the Fall 1995 newsletter), nor do they mention a **Colorado** bill (House Bill 1015), introduced January 10, 1996, that would force insurers to pay for 48-hour and 96-hour hospital stays after childbirth (see *Managed Care Reporter*, Bureau of National Affairs, January 17, 1996).

Attached are copies of the articles mentioned in this memorandum, as well as pertinent laws from Maryland, New Jersey, and North Carolina.

URANCE COVERAGE FOR POST-DELIVERY CARE — 9/26/95

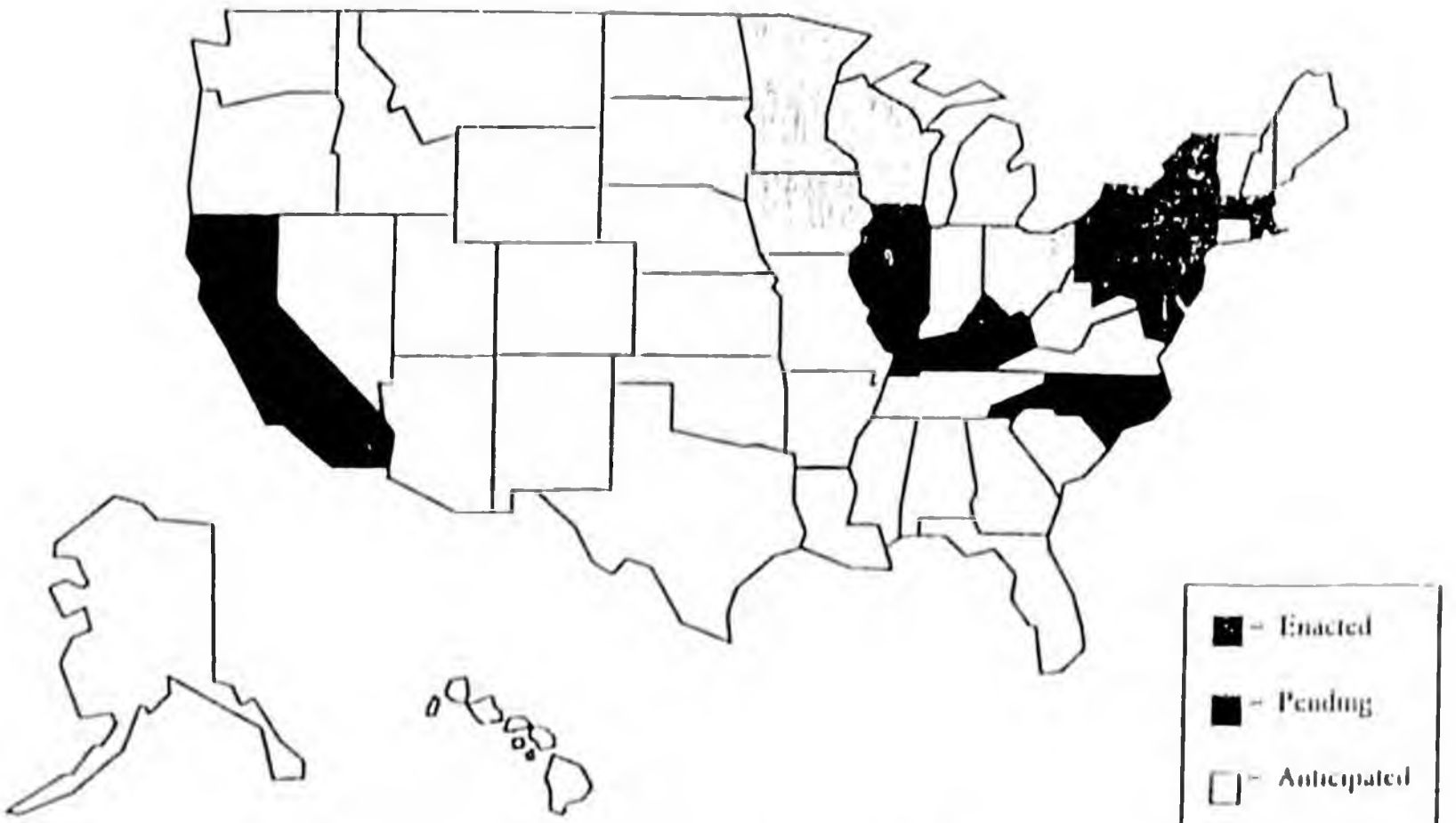
STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
ALABAMA					
ALASKA					
ARIZONA					
ARKANSAS					
CALIFORNIA	AB 1841	Carry Over	Requires min. of 48 hrs. inpatient	Requires coverage of 1 in-	
	AB 1978	Carry Over	care; permits earlier discharge if	home visit if mother and	
			infant meets AAP/ACOG Guide-	child discharged in less	
			lines for Perinatal Care medical	than 48 hrs.	
			stability criteria.		
COLORADO					
CONNECTICUT					Chapter working with
					Attorney General &
					other organizations.
DELAWARE	HCR 30	Carry Over			Creates task force
					to study issue.
	HB 357	Carry Over	Requires coverage of at least 48	Not addressed.	
			hrs. inpatient care if health care		
			provider prescribes it.		
FLORIDA					
GEORGIA					
HAWAII					
IDAHO					

Division of State Government Affairs
800/433-9016 Extension 7901

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
MINNESOTA					
MISSISSIPPI					
MISSOURI					
MONTANA					
NEBRASKA					
NEVADA					
NEW HAMPSHIRE					
NEW JERSEY	AB 2224	Enacted 1995	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Excludes policies covering home visits unless hospital stay determined to be medically necessary by attending physician or is requested by mother.	Min. 3 home visits by RN within 24 hrs., 25 to 48 hrs & 96 to 120 hrs. after discharge. Must include parent educ., assistance with breast/bottle feeding, & necessary tests.	"Attending physician" defined as obstetrician, pediatrician, or other physician.
NEW MEXICO	Regulation	In Hearings	Requires coverage of length of stay in accordance with Guidelines for Perinatal Care (48/96 hrs.) Excludes policies covering home visits unless hospital stay determined to be medically necessary by attending physician or is requested by mother.	Min. 3 home visits by RN within 24 hrs., 25-48hrs., & 96-120 hrs. after discharge, including parent educ., breast/bottle feeding assistance and necessary tests.	"Attending physician" defined as obstetrician, pediatrician or other physician.
NEW YORK	AB 8125	3rd Reading Carry Over	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Not addressed.	
	SB 5322	Carry Over	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Not addressed.	
NORTH CAROLINA	SB 345	Enacted 1995	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Not addressed.	

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
SOUTH CAROLINA					
SOUTH DAKOTA					
TENNESSEE					
TEXAS					
UTAH					
VERMONT					
VIRGINIA					
WASHINGTON					
WEST VIRGINIA					
WISCONSIN	AB 573	In Comm			
WYOMING					

1995-1996 State Legislation
Insurance Coverage for Postpartum Care



American College of Obstetrics and Gynecologists

The American College of Obstetricians and Gynecologists

May 23, 1995

STATEMENT ON DECREASING LENGTH OF HOSPITAL STAY
FOLLOWING DELIVERY

The American College of Obstetricians and Gynecologists (ACOG) is concerned about the decreasing length of time following delivery when mothers and newborns are discharged from the hospital. Although the trend to short hospital stays has been jokingly referred to as "drive through delivery," it is not a laughing matter.

As an organization dedicated to the primary health care of women and to insuring the optimal outcome of pregnancies, ACOG believes that changes in practice such as early discharge following obstetrical delivery should be based on sound scientific data that demonstrate good outcomes for mother and infant, as well as being cost effective. As yet, these data do not exist. Until they do, the burden of proof of safety of early discharge rests with those who are driving the change.

A recent analysis by the Centers for Disease Control and Prevention (CDC) found that between 1970 and 1992 the median length of stay for women who gave birth vaginally decreased by 46 percent (from 3.9 to 2.1 days), and for those who had a cesarean delivery by 49 percent (from 7.8 to 4 days).[1] Because the data included complicated deliveries, the median length of stay for uncomplicated vaginal deliveries or cesareans was probably considerably shorter.

Guidelines for Perinatal Care, a collaborative document between ACOG and the American Academy of Pediatrics (AAP), indicates that in otherwise uncomplicated deliveries the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean delivery, <u>exclusive of the day of delivery</u>.[2] Yet it has become common for insurers to limit length of stay to up to only 24 hours following vaginal delivery and up to 72 hours following cesarean delivery. ACOG's concern is heightened by reports of insurers proposing 12 hour stays following uncomplicated vaginal delivery and 48 hour stays following uncomplicated cesarean delivery, and by indications that some insurers are considering 6 hour stays for routine deliveries.

Although the move toward earlier discharge began in response to consumer demand during the 1970s -- to decrease medical interventions surrounding childbirth and provide a more family-centered birth experience -- the recent trend to even shorter length of stay following delivery appears to be driven primarily by financial motivations. At a time when obstetrical delivery is the most frequent cause of hospitalization in the United States, the shortening of a woman's hospital stay holds obvious appeal to insurers.

409 12th Street, SW Washington, DC 20024-2188 (202)638-5577

With critical legislative elections taking place later this year, he said, it was unlikely any issues deemed too controversial would be acted upon by the General Assembly.

The law required that rules had to be drawn by the Supreme Court regarding waiver provisions, including an expedited appeals process, Curry said. In the letter to Ryan, the court didn't give reasons for not writing the rules, nor did it have to in accordance to state law, Curry said.

A federal judge had ruled in June 1995 that the parental notice law could not be considered constitutional unless the state Supreme Court issued rules giving young women an opportunity to bypass the notification requirement by going to court. The Illinois Constitution gives only the Supreme Court the power to establish rules governing legal challenges.

While ACLU public information officer Valerie Phillips said her group was pleased with the decision, calling it "a victory for teenagers in Illinois who want the right to choose to have an abortion," legislators who labored for months to craft the law admit to being outright confused by the court's conduct.

"I'm really not sure if there are legal issues here that are causing this or if politics by the court are coming into play," state Rep. Ann Hughes (R-McHenry), co-sponsor of the bill that Gov. Jim Edgar (R) signed into law June 1, 1995, told BNA Jan. 25.

Second Failure For Notification Law

The court's inaction marks the second time Illinois has failed to approve a parental notification law. A similar 1983 law was deemed unenforceable because it did not offer the constitutionally guaranteed right to go to court to challenge the law.

Although the state Supreme Court eventually wrote rules to make the 1983 law enforceable, a federal judge later found those rules to be unconstitutional. Several other states, including Pennsylvania and Minnesota, have created bypass laws that have been declared constitutional.

The legislature passed two versions of a parental notice law following heated debate in its spring 1995 session, of which Gov. Edgar chose HB 955 to sign into law as the Parental Notice of Abortion Act of 1995.

The law required a minor to notify a parent, guardian or other family member before getting an abortion. Edgar had said when he signed it that he thought the law would withstand legal challenges. The law was challenged immediately, however, and a federal judge allowed an injunction request by the ACLU to put it on hold June 6, 1995.

New Notification Bills Proposed

Some lawmakers have submitted new notification bills; two are pending currently in the state Legislature. State Reps. Thomas Lachner (R-Lake Bluff) and Peter Roskam (R-Wheaton) have proposed bills for consideration.

One bill would require minors to notify a parent or legal guardian before having an abortion, and would impose civil court penalties on physicians who violate the rule. The other would require [redacted] to notify a family member, which could mean a sibling at least 21 years old.□

New Jersey

POST-NATAL HOSPITAL STAYS LONGER IN WAKE OF NEW LAW, STATE REPORTS

PHILADELPHIA—Women giving birth in New Jersey hospitals who have uncomplicated vaginal deliveries are staying in the hospital an average of almost two days, a marked increase from the average inpatient stay prior to the state's enactment last year of a mandatory 48-hour-stay law, the New Jersey Health Department said Jan. 22.

The Health Department said data from New Jersey's newly-developed electronic system of recording births shows an average inpatient stay of 1.3 to 1.4 days for women who gave birth prior to the June 28, 1995, enactment of A 2224. The law requires health insurers in the state to pay for at least 48 hours of inpatient care for a mother and her newborn after an uncomplicated vaginal birth (3 HCPR 1091, 7/10/95).

The average maternity stay climbed to 1.7 days in July 1995 and reached 1.9 days during the last three months of the year.

"This law has made an immediate and dramatic difference for women giving birth and for newborns," state Health Commissioner Len Fishman said in a statement. "Mothers who need the extra recovery time are exercising their choice to stay in the hospital. Health care providers also now have more time to test newborns for disorders that can cause mental retardation or death if not diagnosed early and treated promptly."

The percentage of blood samples taken from newborns less than 24 hours old dropped to just over 2.0 percent at the end of 1995, from 7.0 percent a year earlier, the Health Department said. Tests on blood drawn prior to 24 hours after a newborn's first protein meal cannot properly detect PKU, a disorder that can cause mental retardation if not treated promptly, the Health Department noted. Early discharge also makes it difficult to screen newborns in a timely fashion for hypothyroidism.

New Jersey's Electronic Birth Certificate System began in four hospitals in early 1995 and now operates in 41 hospitals and one birthing center. The state's two other birthing centers and 29 other hospitals with maternity units are expected to be on-line by mid-1996. The Health Department said the system will allow hospitals and health officials to collect and analyze information that ultimately can be used to improve the quality of health care.□

Massachusetts

MANAGED MENTAL HEALTH CARE FIRM CHOSEN TO ADMINISTER SERVICES UNDER PROGRAMS

BOSTON—Health officials in Massachusetts Jan. 19 announced they had chosen a managed care company to handle mental health services for Department of Mental Health consumers and the state's Medicaid population.

The combined plan, believed to be the first of its [redacted] the state an estimated $17

Post-Natal Care

LAWS TO CURB 'DRIVE-THROUGH DELIVERIES' GAINING MOMENTUM IN STATE LEGISLATURES

Efforts to impose conditions on post-delivery discharges of mothers and infants are gaining momentum in state legislatures just a few months after Maryland became the first state to enact restrictions.

New Jersey and North Carolina have joined Maryland in passing legislation in this area, while California, Delaware, Illinois, New York, and Pennsylvania are considering their own bills.

The Maryland law (SB 677), signed May 25 (3 HCPR 905, 6/5/95), generally requires insurers to provide a home visit for mother and child if they are discharged from a hospital prior to 48 hours after normal, vaginal deliveries.

The law—the "Mothers' and Infants' Health Security Act"—incorporates standards for obstetric and pediatric care jointly developed by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. It takes effect Oct. 1.

A stricter bill (A 2224) that requires insurers to pay for a 48-hour hospital stay after vaginal deliveries and 96 hours of inpatient care after a caesarean section was signed by New Jersey Gov. Christine Whitman (R) June 29 (3 HCPR 1091, 7/10/95). The requirement does not apply to insurers that provide benefits for post-delivery care for the mother and newborn at home, unless the attending physician determines the longer hospital stay is medically necessary or the mother requests it.

Lawmakers in neighboring Delaware and Pennsylvania introduced similar bills in June, shortly before the start of the summer recess.

Delaware

Delaware State Rep. Wayne Smith (R) told BNA he is optimistic about the prospects for passage of HB 357, which he co-sponsored with House Speaker Terry Spence (R) and Rep. Charles W. Welch (R), despite the likelihood of opposition from insurers.

"When you're talking about insurance guys against newborns and mothers, I'd bet on the newborns and mothers," Smith said. The bill was reported June 28 by the House Revenue and Finance Committee, which Smith chairs. It bars individual and group health plans from limiting post-delivery hospital stays for mothers or newborns to less than 48 hours. Although the measure does not address the length of stay following C-section births, "We're certainly open to amendments," Smith said.

He said Delaware insurers and hospitals "have a good track record" of deferring to physicians' recommendations on the length of a new mother's hospital stay, but "We want to make sure it's a right under our insurance code," he added.

Medical reports on potential health risks to newborns as a result of early discharge from the hospital and anecdotal reports from constituents about their experiences prompted the introduction of the bill, Smith said. By the time Delaware's legislative session resumes in January 1996, a number of other states will have enacted similar bills, Smith predicted, building momentum for Delaware to do likewise.

Pennsylvania

In Pennsylvania, a measure sponsored by state Rep. Lawrence H. Curry (D) was introduced June 15. The proposed Mothers' and Infants' Health Security Act (HB 1747) would mandate benefits for at least 48 hours of inpatient care for a mother and her newborn after a vaginal delivery and 96 hours of hospitalization after a C-section.

It also would require insurers to pay for at least three home visits by a registered nurse after the mother and child are discharged. During the home visits one day, two days, and four to five days after discharge, the nurse would provide services such as parent education, training in breast or bottle feeding, and appropriate clinical tests and medical evaluation of the mother and baby.

The measure was referred to the House Insurance Committee, where it faces an uncertain future now that several of the state's managed care organizations have taken steps to address their customers' concerns.

Meanwhile, Pennsylvania Blue Shield and Independence Blue Cross Aug. 2 announced a change in policy effective immediately for their managed care plans in southeastern Pennsylvania. Rather than limiting coverage for new mothers who have routine deliveries to a 24-hour hospital stay with three post-discharge home visits, the plans now give subscribers the option of a 48-hour hospital stay with no home visits, Independence Blue Cross spokesman Chris Rathke said. The policy of a three-day inpatient stay after a C-section delivery remains unchanged.

Bruce Hironimus, director of government affairs for Pennsylvania Blue Shield, said the insurer's health maintenance organizations elsewhere in the state already give new mothers the option of a 48-hour hospital stay following routine deliveries.

Other insurers have indicated they will take similar steps to address the issue, Pennsylvania House Insurance Committee Chairman Nicholas A. Micozzie (R) told BNA. Micozzie said a private-sector solution is preferable to government mandates, which boost health care costs. As a result, he said of Curry's bill, "It will not be presented to the committee until I'm fully knowledgeable it's needed."

New Jersey's new law dealing with insurers' limits on maternity hospital stays received extensive coverage in the Philadelphia-area media and probably had more to do with the policy change by the Blues than

the introduction of Curry's bill, Hironimus said. He [illegible] the change in policy a "progressive and proactive move to satisfy the Blues' southeastern Pennsylvania managed care customers, who include a number of New Jersey residents, and to "try to get as much consistency as possible" in response to the change in New Jersey law.

North Carolina

In July, the North Carolina legislature enacted as part of an insurance bill a requirement that insurance companies pay for a minimum 48-hour hospital stay for vaginal deliveries and a minimum 96-hour stay for C-sections (Chapter 517 of the 1005 session).

In North Carolina, legislation is enacted when it passes both house of the Legislature; bills are not sent to the governor.

The amendment covering maternity stays, offered by Rep. Arlene Pulley (R-Wake and Durham Counties), was added to the Senate bill during consideration by the House. The House passed the bill July 27 by a vote of 92-11. The amended version went back to the Senate, which passed it 43 to 0 on July 28.

In California, the Senate Insurance Committee July 20 approved related legislation 8-1 with little debate.

The measure (AB 1841) by Assemblywoman Liz Figueroa (D-Fremont) would apply to every health care service plan contract, non-profit hospital service plan contract, and certain disability insurance policies, and is intended to reduce the risk of readmissions for common neonatal problems such as jaundice or dehydration, according to the bill's author.

In applying utilization review standards, plans would be required to follow the most current version of the ACOG-AAP standards, according to the bill.

In New York state, two bills have been introduced that would establish minimum hospital stays for childbirth. The bills would require that all health insurance policies and managed care plans cover at least a two-day hospital stay for vaginal childbirths and a five-day minimum stay for all caesarean births. Both bills are in committees of each house (A 8125, S 5322).

In Illinois, Rep. Lauren Beth Gash (D-Highland Park) introduced a bill in June that would prohibit insurers and managed care companies from restricting a woman's hospital stay to less than 48 hours unless home care follow-up visits are provided. State Sens. James DeLeo, Arthur Berman, and John Cullerton, all Democrats from Chicago, announced in July that they will introduce a similar bill in the state Senate. Both bills are expected to be considered this fall.

Legislation also has been introduced in Congress. Sens. Bill Bradley (D-NJ) and Nancy Kassebaum (R-Kan) introduced a bill (S 969) June 27 that would require a minimum stay of 48 hours for vaginal deliveries and 96-hour stays after a caesarean section delivery. Hearings on S 969 will be held in early September, a committee source told BNA.

A companion bill (HR 948) was introduced in the House June 28 by Rep. George Miller (D-Calif).

Risks v. Costs

Supporters of the restrictions say the common practice of discharge within 24 hours or less—sometimes called "drive-through deliveries"—poses health risks, especially for infants. In particular, they say signs of jaundice usually do not show up in infants until 24 hours after birth or later and that adequate PKU screening—a test of a baby's ability to metabolize protein—is not possible until 23 hours after delivery. If not diagnosed within 21 days, PKU leads to mental retardation, according to the American Academy of Pediatrics.

From 1970 to 1992, the average length of stay for mothers after a vaginal delivery declined 46 percent from 3.9 days to 2.1 days, according to the U.S. Centers for Disease Control and Prevention (CDC). Discharge within 12 hours after vaginal deliveries is increasingly common.

The impetus for the change, even managed care companies concede, is cost. "I don't think anybody would say it is not," said Camille Dobson, deputy director of the Maryland Association of Health Maintenance Organizations, which "vigorously opposed" the new Maryland law.

Obstetric delivery is the most common reason for hospital admission in the United States, according to the CDC. As such, keeping down costs associated with delivery can translate into significant savings for a health plan.

Supporters of the discharge restrictions say health plans have gone too far. "There are only a few studies indicating that highly motivated women with high income and education levels have done well with discharge as soon as 24 hours. Of course they're going to do well," said Bobbi Seabolt, lobbyist for the Maryland chapter of the American Academy of Pediatrics.

"The insurance companies decided without data they were going to perpetrate this experiment on the public," she added.

Guidelines Allow Flexibility

HMOs and other managed care companies generally oppose the legislation and strongly dispute the implication that shorter hospital stays compromise medical care.

"We believe [discharge] is a medical decision that should be made by physicians on a case-by-case basis and not through a legislative mandate," said Laura Caliguiri, legislative programs coordinator for the American Managed Care and Review Association.

The joint ACOG-AAP "Guidelines for Perinatal Care" recommend post-delivery discharge after normal, vaginal births at 48 hours but "allow for a woman to go home at the 24-hour time frame when that woman has passed some checkpoints indicating that it is safe," noted Susan Pisano, spokeswoman for the HMO trade group Group Health Association of America.

"There is sort of this misperception that they're only covered for that" 24-hour stay, Pisano said. "HMO coverage is comprehensive coverage. If a mother or child is sick and needs more care, they'll get it."

Concern in Maryland

What prompted the concern about the length of postpartum hospital stays in Maryland was a spike in

1058-7713/93/$0+$1.00

the statewide rate of inadequate PKU testing due to "insufficient milk feeding." The rate went from 5 percent in 1989 to 30 percent in 1993, according to Susan Panny, a physician and director of the Office of Hereditary and Congenital Diseases in the Maryland Department of Health and Mental Hygiene. About 25 cent of infants with inadequate PKU tests in 1993 ...er underwent a follow-up screening, according to state data.

An adequate PKU test requires 24 hours of milk feeding and most newborns do not receive their first milk feeding until four hours after birth. Discharges within 24 hours or less of delivery were blamed for the testing deficiency. In Maryland, about five cases of PKU are diagnosed each year, Panny said.

The Maryland Association of HMOs vigorously objected to the view that early discharges were to blame for what Dobson called "the perceived problem with PKU testing."

"There was not enough data to verify that HMOs were not obtaining results in a timely manner," Dobson said. Moreover, "virtually 100 percent of HMOs schedule a follow-up visit within two weeks" ' delivery, Dobson said.

Some HMOs also objected to the requirement for a home visit on quality grounds, maintaining that an office visit ensured mother and child would be seen by properly trained staff and with appropriate lighting and other medical conditions, Dobson said.

Officials in North Carolina engaged in a similar debate. Charles Hammond, chairman of obstetrics at Duke University Medical Center, said he has concerns about mothers who have not had adequate prenatal care and education before their deliveries.

According to Hammond, in parts of the East Coast there are groups of women who are underinsured and who do not have ready access to good medical care. It is especially critical that these women stay in the hospital long enough after delivery to be properly educated about how to care for their babies.

"I'm not sure we would like to rule out any short stay, but the problem is obstetricians and gynecologists get frustrated when they must [approve a short stay] even when circumstances clearly indicate a longer stay is needed."

"Our feeling is that medical policy decisions need to be based on data rather than anecdotal information," says Jan Emerson, director of public relations for Blue Cross and Blue Shield of North Carolina. She said that Blue Cross and Blue Shield is in the midst of a study to determine if 24-hour stays, which are now standard for healthy deliveries, are adequate for new mothers.

"If you are a new mom and have had a healthy delivery, many people prefer to be at home. Hospitals are for very sick people," said Emerson.

Outrage In California

The precipitating event in California was the June 19 release of an internal memorandum for a downtown Los Angeles health facility owned by Kaiser Foundation Health Plan Inc./Southern California Region. The memo was obtained by Consumers for Quality Care, an advocacy group.

Dated March 31, the memo from the Southern California Permanente Medical Group says, "For the post partum patients who deliver vaginally and are otherwise normal, we will encourage the patient to complete their rest and bonding with the baby at home as early as 8 hours after delivery. Any assistance with care and breast feeding can be accomplished in the outpatient setting."

An attachment that lists benefits of the early-discharge policy for patients and staff notes that the policy will allow Permanente to "[r]educe our overhead costs to remain competitive in a fluid marketplace and thus retain our jobs and attract more patients."

In a statement issued by Consumers for Quality Care, Assemblywoman Figueroa said, "I am outraged that HMOs and hospitals in California have formal policies to encourage the release of mothers who have just had babies for the sole reason of cost cutting."

"When I saw that [memo], I was just appalled," Figueroa told BNA. "It tugged at all my strings: as a legislator, as a mom, and as an enrollee of a managed care system. I just felt offended in all my aspects."

The "flexible discharge policy" outlined in the memo remains in effect at Kaiser Los Angeles, said Ruth Petrucha, a physician and a maternal/fetal specialist at the facility. Since it went into effect in April, five mothers and newborns have been discharged at eight hours from among 500 births.

While several California groups have testified in favor of Figueroa's bill, none have gone on record opposing it.

The California Association of HMOs is not taking a position on the bill, but is working with the author on several issues, spokeswoman Tina Tingus told BNA.

The association supports the use of appropriate guidelines regarding inpatient care and is proposing more studies to determine if shortened hospital stays affect the health of mothers and newborns. Much of the debate on the length of stay has occurred without empirical evidence that supports or refutes existing practices, CAHMO said in a July 20 release.

CAHMO and its member plans encourage further study in this area to help determine what length of stay is appropriate for normal, healthy births, and how to avoid complications, Executive Director Myra Snyder said. CAHMO represents nearly all licensed HMOs in California, which provide coverage to 12 million people.

The California Medical Association supports the bill, spokeswoman Danielle Walters told BNA.

However, she noted that CMA is working with Figueroa on the bill's provisions for home nurse visits and flexibility for patients who could go home earlier than 48 hours after birth.

The bill is likely to be amended at least one more time to clarify many of the issues raised by CAHMO, CMA, and other groups, and to address provisions for midwife deliveries, according to several sources working on the bill. The Senate Appropriations Committee also will consider the bill.

Codifying Clinical Criteria

The managed care industry has been quick to object to the adoption of medical guidelines in state statutes

"Putting any kind of medical criteria in statute is foolish, because it changes," said Dobson. The ACOG-AAP perinatal guidelines are revised every three to five years.

The new Maryland law could create a situation in which "UR agents wouldn't know what version of the guidelines to rely on" when authorizing hospitalizations, Dobson suggested.

"It is an unusual situation to have clinical guidelines being made into statute. We do think it is important not to legislate a cookie-cutter approach," said CHAA's Pisano.

Managed care companies also are leery of the precedent. "It's the start of the slippery slope," Dobson said. "What's next? Are you going to start putting guidelines for coronary bypass surgery into statute? Do you want to do that?"

The impact of the new law in Maryland will be strongest on those plans that do not already offer post-delivery home visits as part of their package of benefits, Dobson said. They will be required to do so under the new law.

"Managed care companies should look upon this whole event that the 12-hour and 24-hour discharges have struck a raw nerve in many people," said Seabolt.□

—By Thomas W. Derry, Laura Mahoney, Lorraine McCarthy and Sheri Sellmeyer

Post-Natal Care

ABBREVIATED HOSPITAL STAYS SPUR INNOVATIONS IN AFTER-DELIVERY CARE

CHICAGO—The abbreviation of hospital stays for new mothers and their babies, created by insurance industry efforts to keep costs down, has spurred several innovative approaches to after-delivery care.

A suburban Chicago hospital has developed a program that provides free follow-up home assistance that many insurance companies will not pay for. The hospital started the program in January after noticing that many women were forced because of their insurance plans to leave the hospital before they said they were ready for the challenges of a new baby, Sue Brandt, unit manager of maternity services, told BNA.

"It started when we realized a lot of insurance companies weren't going to let patients stay in," Brandt said. "We just couldn't meet the patients' needs in the short period of time—particularly in teaching them how to take care of themselves and, more importantly, how to take care of the baby. We felt it was important to do the visits and we didn't feel that we should charge for it."

Currently, several Chicago area hospitals will send a nurse to examine the newborn and its mother but only if the insurance company pays for the visit, an informal survey of several hospitals revealed.

For the first four months of Lake Forest's program, only first-time mothers were visited, Brandt said. After that initial pilot program was successful, the program was extended to all moms who requested it, and most did, she said. The program has since become a hit not only with patients, but also pediatricians, and is set to become a long-time fixture at the hospital, Brandt said.

"With capitation coming, I would rather see lots of other things go before I would give up this," she said.

Birthcare Inn

In Boston, maternity nurse Evelyn Crotty has created Birthcare Inn, a program that places new mothers and their babies in a local hotel with a nurse on duty to handle a wide range of needs. The $185 a day charge includes room, nursing care, parenting classes, breakfast, and parking, Crotty told BNA. The average stay at Birthcare Inn, which will be housed at Boston's Doubletree Guest Suites Hotel, would be one to three days, Crotty said.

Interested new mothers would call Crotty, who would reserve a room at the hotel, she said. The family would be greeted at the hotel, settled in by a nurse, and then scheduled for instructions in breast-feeding and other aspects of parenting, Crotty said. Initially a nurse will not be on duty 24 hours a day, but would be able to respond within 15 minutes when summoned by phone, said Crotty, a maternity nurse for 13 years.

Crotty acknowledged that so far insurance companies have been skeptical, but she plans to pitch her idea to large corporations as a possible employer-covered job benefit.

"My goal here is not to attack insurance companies," Crotty said. "My goal is provide a necessary service to new mothers and their babies. This is for women who would need a little bit more than home care."□

—By Thom Wilder

Medicaid

TENN., ORE. MANAGED CARE EFFORTS SAID TO PRODUCE DIFFERENT RESULTS

Two states that began ambitious programs to move more Medicaid recipients into managed care plans in 1994 produced widely different results, largely because of their previous experience with managed care and the pace at which the changes were developed, according to case studies released by Mathematica Policy Research Inc.

The first year of Tennessee's TennCare program produced "mixed and controversial" results, while Phase 1 of the Medicaid component of the Oregon Health Plan received widespread support throughout that state, concluded the study prepared for The Henry J. Kaiser Family Foundation and The Commonwealth Fund.

Managed care, which already covers nearly one-fourth of Medicaid beneficiaries, "is rapidly becoming the primary way health services are delivered to low-income Americans," the two organizations said in a joint statement accompanying the report.

The TennCare program—"quickly developed" and implemented in January 1994 just two months after the state obtained the necessary Section 1115 waiver from the Health Care Financing Administration—perhaps moved too quickly in achieving its goal of enrolling Medicaid beneficiaries into managed care, the report suggested.

Some 400,000 previously uninsured persons were signed up and the number of managed care organizations enrolling them grew from from one covering 35,000 persons to more than 13 covering the majority of TennCare enrollees. But the rapid pace of change "created considerable confusion for patients, providers, and health plans," Mathematica said.

TennCare More About Saving Costs

"Starting from a base of limited managed care, TennCare predictably did not shift in year one to a system with fully functioning and well-developed MCOs," Mathematica said, adding that the program in the first year was "much more about managed costs than managed care, with limited change in the delivery system."

TennCare officials expect some sorting out among participating plans, perhaps including changes in market share, consolidations, or even failures," the report said of the plan's future. But as of the end of 1994, when data for the report was gathered, "it was still too early to tell how well MCOs manage financially within the capitation rates paid because of uncertainty about incurred but not reported obligations and year-end settlements." Start-up costs also cloud the financial analysis of the first year, the report said.

In contrast, the Medicaid component of the "multi-faceted and ambitious" Oregon Health Plan "is broadly viewed as successful and as a potential benchmark for what is possible with careful planning and realistic goal setting," the report said, pointing out that Oregon started "from a solid base of managed care experience."

More than one-third of Oregonians were enrolled in HMOs when the first phase of the OHP was begun in February 1994 and 31 percent of Medicaid recipients already were enrolled in at least partially capitated plans.

"All licensed health maintenance organizations in Oregon are participating, fully capitated plans are being relied on more than originally anticipated, and extremely high rates of voluntary plan selection have been achieved," Mathematica reported. More than 70 percent of OHP enrollees were in fully capitated plans by the end of the first year of operation, researchers found.

Even the state's "priority list" of what health care services would be covered—"controversial outside of Oregon because of its explicit rationing"—was widely accepted within the state because of the process used to develop it, the report said.

The case studies, directed by Marcia Gold of Mathematica, will be followed by additional reports on Medicaid managed care programs in New York, California, and Minnesota.

"Managed Care and Low Income Populations: A Case Study of Managed Care in Tennessee" (Document No. 1062) and "A Case Study of Managed Care in Oregon" (Document No. 1063) are available at no charge from the Henry J. Kaiser Family Foundation publications request line, (800) 656-4533.

Post-Natal Care

RAPID DISCHARGES AFTER C-SECTIONS LEAD TO MORE HOSPITAL READMISSIONS

Babies who are sent home from hospitals within 24 hours after being delivered by cesarean section are more than three times as likely to develop problems and return to the hospital as those who stay for two or more days after their birth, according to a study released Aug. 9 by HCIA Inc.

The study found that 4.3 percent of babies who were discharged within 24 hours after cesarean deliveries had to be readmitted for serious health problems—mostly perinatal infections or disorders caused by low birthweight—compared to 1.3 percent of cesarean-section babies who were allowed to stay for two to seven days after birth.

By contrast, infants who were delivered by regular birth had no statistically significant differences in readmission rates regardless of whether they were sent home within 24 hours or after longer stays, the study found.

Health plans increasingly have been paying only for 24-hour hospital stays after childbirth, prompting several states to pass or consider laws requiring insurers to pay for longer stays (3 HCPR 1275, 3/7/95).

HCIA found that mothers who belong to health maintenance organizations were far more likely to be discharged quickly than those with other private insurance or Medicaid coverage. Most of those with HMO coverage—57.7 percent— were sent home within 24 hours, compared to 35.9 percent of those with other commercial insurance coverage and 39.3 percent of Medicaid recipients.

The study also found wide regional disparities in the timing of hospital discharges. In the Western states, 73 percent of mothers and babies were sent home in 24 hours or less, compared to 37 percent of those in the Southern states and 30.1 percent of those in the Midwest. Only 10.2 percent of mothers and infants in the Northeast were sent home within 24 hours.

The study was based on information from HCIA's database of 10 million all-payer discharges and covered 274,731 mothers and 1.4 million infants.

Copies of the study, *Hospital Length of Stay and Re-admission Rates for Normal Deliveries and Newborns*, are available for $75 plus shipping and handling from HCIA Inc., (800) 568-3282.

Medical Savings Accounts

W[illegible] COULD REDUCE MEDICAL COSTS; [illegible]INGS MAY NOT FLOW TO MEDICARE

Medical savings accounts have the potential to reduce medical spending by Medicare enrollees, but savings would not necessarily flow to the Medicare program, according to a report released Aug. 7.

Any savings to the Medicare program depend on the level of government contributions to MSAs and the type of beneficiaries who enroll in such plans, said the report, prepared for The Henry J. Kaiser Family Foundation. The report, *Medical Savings Accounts for Medicare Beneficiaries*, was written by Jack Rodgers, Price Waterhouse LLP and James W. Mays, Actuarial Research Corp.

House Republicans have indicated that MSAs with high deductible catastrophic medical coverage would be one of several options for Medicare beneficiaries under a reform plan to be outlined in September.

Deductible levels below $4,000 would not be "economically sensible" for the Medicare population, the report stated. Further, the report said limiting enrollment to a one-time choice for beneficiaries would minimize risk selection problems but would not be feasible because of changes in beneficiaries' income and assets over time.

Reduction In Outlays?

Medicare outlays could be reduced if government payments for MSA plans were set lower than the actuarial value of the "traditional" Medicare program, but that outcome is unlikely, the report said.

"Enticing Medicare beneficiaries to enroll in MSA plans will be extremely difficult if premiums for those plans were set at lower rates than the actuarial value of traditional Medicare," the report said. "Medicare enrollees who joined MSA plans would, in effect, be accepting higher risks for lower returns."

Under an MSA as explained by the authors, private insurance carriers would sell catastrophic insurance plans combined with an MSA. The government would make a fixed contribution to the insurance company to cover the costs of the premium, and would make a cash contribution to the beneficiary's MSA.

"The logic for Medicare MSA plans is that beneficiaries would be given a government contribution to their MSAs which would more than offset the additional out-of-[illegible] spending associated with the catastrophic [illegible]eductibles," the report said.

'Death Spiral'

According to the authors, a "death spiral" for the traditional Medicare program could occur if MSAs are offered and Congress limits the growth of per capita costs to a maximum level.

If an MSA is offered and healthier beneficiaries chose that option, the cost of the traditional program—with sicker beneficiaries—would increase above the level allowed by Congress, prompting a reduction in benefits and disenrollment of beneficiaries.

If only sicker beneficiaries are left yet again, further benefit reductions again would be likely because of increased per capita costs, the report said.

"It is possible that adverse selection would not be strong enough to cause a death spiral, but it would still lead to a loss of benefits for those enrollees who chose traditional coverage," the report said.

Another effect of MSAs could be that managed care would decline if MSA plans become popular, the authors said, although they probably would not seriously erode the managed care market.

For additional information about the report, contact The Henry J. Kaiser Family Foundation, 2400 Sand Hill Road, Menlo Park, Calif. 94025, (415) 854-9400.

Pharmaceuticals

WYDEN WANTS SENIORS' DRUG CONCERNS ADDRESSED IN MEDICARE REFORM DEBATE

Congress must address the costs associated with hospitalizations of senior citizens resulting from the prescription of inappropriate drugs as part of the debate on reforming the Medicare program, Rep. Ron Wyden (D-Ore) told an Aug. 8 press briefing.

Better coordination and education among providers and patients can prevent the needless injuries, deaths, and costs associated with prescription drug overdoses, "lethal" combinations of medications, and the inappropriate prescription of drugs, Wyden said.

Hospitalizations caused by "prescription misadventures" cost $20 billion annually, according to a General Accounting Office report released at the briefing.

Wyden, a member of the House Commerce Subcommittee on Health and Environment, pledged to push for congressional action on improving geriatric training in medical schools and drug utilization reviews that can "bring Medicare into the 21st century" and improve the health of seniors when Congress begins consideration of Medicare reform in September.

Without those protections, she contended, the waiver plan will have a disparate impact on people with AIDS, HIV, or chronic disabilities.

As HCFA undertakes its civil rights and ADA analysis of the waiver application, the task force will put its concerns in writing during the week of Oct. 16 and expects a formal response, Dooha reported.□

Medicaid

ILLINOIS GOV. EDGAR SEEKS TO RESTORE HOSPICE CARE FUNDING

CHICAGO—Illinois Gov. Jim Edgar (R) announced Sept. 21 that his administration is acting to restore Medicaid funding for hospice care after it was eliminated during budget negotiations earlier this year.

The governor's office said Oct. 5 that Edgar is bringing the hospice care issue back for discussion in the fall veto session because of its importance to Illinois residents.

"Hospice care is a humane and cost-effective way of providing health care to poor people who are terminally ill," Edgar said in a statement. "Based on studies we have done, I am convinced that funding hospice care as an alternative to much more expensive hospital care will save taxpayers millions of dollars."

The outlay for the restored hospice care is expected to be approximately $6 million during the current fiscal year. The hospice program is expected to be more than offset by savings in hospital care, Edgar said.

Edgar had included hospice care in the budget he submitted in March, but it was eliminated during budget negotiations with the Legislature at the close of the spring session.□

Pharmaceuticals

ILLINOIS EXPANDS FREE DRUG PROGRAM FOR UNINSURED PERSONS WITH AIDS/HIV

CHICAGO—The Illinois Department of Public Health announced Sept. 19 an increase from 16 to 110 the number of life-prolonging drugs available at no charge to people with the human immunodeficiency virus or acquired immune deficiency syndrome who do not have adequate insurance coverage or are not eligible for Medicaid.

In addition, the program has been modified to allow participants in the department's AIDS Drug Reimbursement Program to obtain a two-week supply of emergency drugs from a local pharmacist rather than having to wait for the prescription to be filled through the usual mail order outlet.

"As more and more individuals in Illinois are confronted with this tragic epidemic, we must continue to find ways to expand and tailor the program so these critical drugs are getting to people who need them," John Lumpkin, state director of health, said in a statement.

The department anticipates the program will serve an average of 750 to 800 persons a month at a cost of $3.8 million in the coming year. The state contributes $2.2 million to the program and the remainder is from federal funds.

To be eligible, a person must be diagnosed with AIDS or HIV infection and have a monthly income at or below 400 percent of the federal poverty level. The maximum income is $29,380 for a single person and $40,120 for a household of two.

In addition, participants cannot receive full coverage for prescription drugs through insurance or other government subsidy programs or medical assistance through the Medicaid program.

Further information about the program can be obtained through the Illinois Department of Public Health's AIDS Activity Section at 525 W. Jefferson St., Springfield, Ill. 62761, (217) 524-5983.□

Post-Natal Care

MASS. SENATE APPROVES BILL TO REQUIRE MINIMUM HOSPITAL STAYS FOR CHILDBIRTH

BOSTON—The Massachusetts Senate Oct. 11 passed and sent to the House a measure (S 2000) requiring insurers to pay for a minimum of 48 hours of inpatient care following vaginal births and 96 hours following a cesarean section.

If the bill is enacted, Massachusetts would join Maryland and New Jersey with laws mandating minimum stays following childbirth, supporters said. Several other states are considering similar legislation.

The bill recognizes that "personal safety must take precedence over the needs of the bottom line of the insurance companies," said Sen. Mark C. Montigny (D), a sponsor and chairman of the legislature's Insurance Committee. The measure allows an early discharge only if agreed upon by the patient and doctor under regulations that would be drawn up by the Department of Public Health.

DPH regulations would be issued within 120 days of the law's implementation with the assistance of an advisory committee that would include consumers, legislative representatives, and officials from the Massachusetts Nurses Association, the Massachusetts Hospital Association, the Massachusetts Medical Society, the College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Massachusetts Association of Health Maintenance Organizations, and Blue Cross Blue Shield.

The bill applies to insurance companies and HMOs and prohibits hospitals from allowing early discharges except in accordance with state regulations. Insurers would be forbidden from terminating services, reducing capitation payments, or otherwise penalizing doctors or other providers who order care consistent with the new law.□

Post-Natal Care

NEW YORK HMOs SUPPORT BILL TO ESTABLISH MINIMUM HOSPITAL STAYS

ALBANY, N.Y.—The New York State Health Maintenance Organization Conference announced its support Oct. 10 for state legislation that would establish minimum hospital stays for women giving birth.

The conference, which represents the state's HMO industry, sent a letter to Gov. George E. Pataki (R)

asking him to propose legislation that would require a minimum stay of two days for an uncomplicated vaginal delivery and four days for a cesarean birth.

Under the proposed bill, a woman whose physician determined that she and her baby met accepted medical criteria and were guaranteed appropriate home care could be discharged earlier.

"With all the confusion and misinformation nationally about maternity lengths of stay, the intent of our bill is to clarify the level of care that women in New York are already receiving and, at the same time, guarantee that shorter lengths of stay are medically determined and accompanied by after-care services," Kathryn Allen, president of the conference, said in releasing the proposal.

Bills that would have established two-day minimum stays for vaginal deliveries and five-day minimum stays for cesarean births were introduced in the 1995 legislative session, but died on the floor of the state Assembly and the Rules Committee of the Senate (A 3125, S 3322). The Legislature is scheduled to return to Albany in January for its 1996 session.□

Financing

N.Y. PANEL CONSIDERING CONTRIBUTIONS FROM HMOs, INSURERS, OFFICIAL REPORTS

LAKE GEORGE, N.Y.—The task force appointed by Gov. George E. Pataki (R) to study New York's health care financing system is considering a variety of ways to provide care for the uninsured, including requiring a greater contribution from health maintenance organizations and insurers, state Health Commissioner Barbara A. DeBuono told a conference of the Healthcare Association of New York State Oct. 11.

DeBuono said, as the state crafts a new financing system, she is increasingly concerned about providing health care to some 2.4 million New Yorkers without coverage. Moreover, she said that number probably will increase under the Medicaid block grant proposal before Congress since the state will be forced to tighten its Medicaid eligibility requirements.

DeBuono said, under the current system, hospitals, outpatient clinics, and the public health system are treating some of the uninsured population.

"I'm very worried about the growth of this population and whether or not these entities that have been committed to serving this population will be able to do it in the future," DeBuono told the conference. "I also worry about the commitment that our insurance industry and our HMO industry is prepared to make for the social and the public good of covering and supporting the care for this growing uninsured population."

DeBuono said the state probably will move away from a system that provides direct subsidies to hospitals for providing care to the uninsured and more toward a system focused on providing care to individuals.

DeBuono, when asked by reporters after the conference, declined to cite specific proposals for covering the uninsured or for requiring that insurers and HMOs play a greater role. But she said the task force is looking at what other states have done, especially Minnesota, and is considering a variety of options. In addition, she said one proposal under consideration is a form of tax break for small businesses who provide coverage to their employees.

DeBuono said everyone "has to step up to the plate," including small businesses, large businesses, HMOs, insurers, hospitals, and the government.

Pataki appointed the task force last month to develop a plan for the state's hospital financing system, which is known as the New York Prospective Hospital Reimbursement Methodology (3 HCPR 1575, 10/2/95).

Politics And Waivers

The health commissioner also told the conference that the state's Medicaid waiver application before the Health Care Financing Administration is being held up on political grounds, not substantive ones. She said the state has answered all of HCFA's substantive questions on the waiver, which would allow the state to shift most of its Medicaid population into managed care.

DeBuono told reporters that the political problem is that the administration in Washington is Democratic and the one in Albany is Republican. "It now is a question of is there the political will on the part of the administration to help New York out and to support our desire to restructure our Medicaid program?"

DeBuono said, if the current block grant proposal for Medicaid is enacted, New York will have to "completely and totally restructure" its Medicaid program. The $4 billion to $5 billion savings expected from the waiver program over the next several years "is simply not going to cut it," she said.□

AIDS

NEW N.Y. POLICY PERMITS MOTHERS TO LEARN RESULTS OF TESTING ON NEWBORNS

ALBANY, N.Y.— New York Gov. George E. Pataki (R), reversing a longstanding state policy, announced Oct. 10 that the state has settled a lawsuit to permit mothers to find out the results of certain HIV tests performed on their newborns (*Baby Girl Doe v. Pataki*, NY SupCt, No. 10661-95, settled 10/10/95).

Pataki said, under the settlement, the state Health Department will draft regulations that will allow mothers to sign a consent form indicating whether or not she wants to be informed of her infant's human immunodeficiency virus test results.

In addition, the regulations will require that prenatal care providers counsel pregnant women about the risk of mother-to-child transmission of the HIV virus and encourage all pregnant women to be tested voluntarily.

All babies born in New York state since 1987 have been anonymously tested for the HIV virus under an ongoing epidemiological study. The New York State Senate passed legislation earlier this year to make the test results available to mothers, but the bill died in the state Assembly.

Elisabeth Cooper, co-chairwoman of a coalition called the New York Task Force on Women and AIDS, said the task force supports a policy of voluntary testing and mandatory counseling. She said the mandatory counseling provisions in the settlement are inadequate, however, because they do not cover physi-

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CENSUS BUREAU FINDS 39.7 MILLION LACK HEALTH INSURANCE COVERAGE IN 1994

In 1994, 39.7 million persons were without health insurance coverage, constituting 15.2 percent of the population, the Census Bureau reported Oct. 5.

In addition, the bureau's 1994 annual report on income and poverty indicated that 29 percent of the poor had no health insurance of any kind, about double the rate for all persons. Poor persons comprised 27.3 percent of uninsured persons.

Census officials pointed out that the 1994 survey questions on health insurance were changed from the prior years, suggesting that the results are not strictly comparable with 1993 and earlier periods.

Of the 139.1 million workers in 1994, 53.3 percent had employer-provided health insurance policies in their own names, Census found. There is no comparable figure for 1993 and earlier because there were no questions in the earlier surveys pertaining to types of insurance, a Census analyst said.

Some 70.3 percent of the population was covered by a private insurance plan for some or all of 1994. The remaining insured persons had government coverage, which included Medicaid (12.1 percent or 31.8 million), Medicare (12.9 percent or 33.9 million), and military health care coverage (4.3 percent or 11.3 million).

Part-time workers—those working 35 hours a week or less—had the lowest coverage. In 1994, 19.5 percent of these workers had no health insurance coverage.

State figures showed considerable variation in the proportion of populations that lacked health insurance coverage last year. The range was from 8.4 percent of persons in North Dakota lacking coverage to 24.2 percent in Texas.

Post-Natal Care

PEDIATRICIANS ISSUE POLICY ON CRITERIA FOR RELEASING NEWBORNS FROM HOSPITALS

Minimum criteria should be met and the decision should be made mutually between a new mother and her physician to release newborns from hospitals, the American Academy of Pediatrics said in a policy statement issued Oct. 10.

Insurance companies set arbitrary newborn discharge policies based on few scientific data, AAP charged. But certain criteria and conditions should be met before an infant is released, the group said. It is unlikely that the recommended standards could be accomplished in less than 48 hours, according to AAP, which represents 49,000 pediatricians.

Among the minimum criteria are: pregnancy and labor are uncomplicated and delivery was vaginal; baby is urinated and passed one stool; no evidence of jaundice in first 24 hours of life; the baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding; the baby's vital signs are documented as being normal and stable for the 12 hours preceding discharge; and a physician-directed source of care for mother and baby has been identified.

AAP emphasized that each mother-infant pair should be evaluated individually to determine the optimal time of discharge. "The fact that a short hospital stay for healthy term infants can be accomplished does not mean that it is appropriate for every mother and infant," AAP said.

The policy, initiated by AAP's Committee on Fetus and Newborn, was published in the Oct. 4 issue of the AAP's journal *Pediatrics*.

Cost Containment

STUDY FINDS COMPETITION MORE EFFECTIVE THAN REGULATION IN CONTROLLING COSTS

Based on a comparison study of state health care expenditures under competition-based managed care and state government rate regulation, researchers concluded that a properly structured competitive approach could play a significant role in controlling health expenditures in the United States.

For the study, published in the October *American Journal of Public Health*, researchers Glenn A. Melnick and Jack Zwanziger looked at data on cumulative growth in real per capita health expenditures between 1980 and 1991 to compare California—a state with a pro-competitive policy—with the national average and with four states with established hospital regulatory programs—Maryland, New Jersey, New York, and Massachusetts.

Selected measures studied included expenditures for hospital services, physician services, retail drugs, and the total of all three measures.

"Aggregate data show that California not only did much better than the national average in controlling growth in hospital expenditures per capita but also did better than all of the states with hospital rate regulation programs," the researchers stated.

Furthermore, the data provide no evidence that health expenditures were shifted from the hospital sector to other sectors in California as a result of competition, the researchers observed. "Rather, it appears that states with hospital regulatory programs are the ones that show evidence of the so-called 'ballooning or unbundling' effect, in which expenditures in the unregulated sectors grew much more than the national average for many of the regulatory states," they added.

The researchers noted that their data covered only 70 percent of total health expenditures and that there could have been shifts to the other sectors, such as long-term care.

May 5, 1995

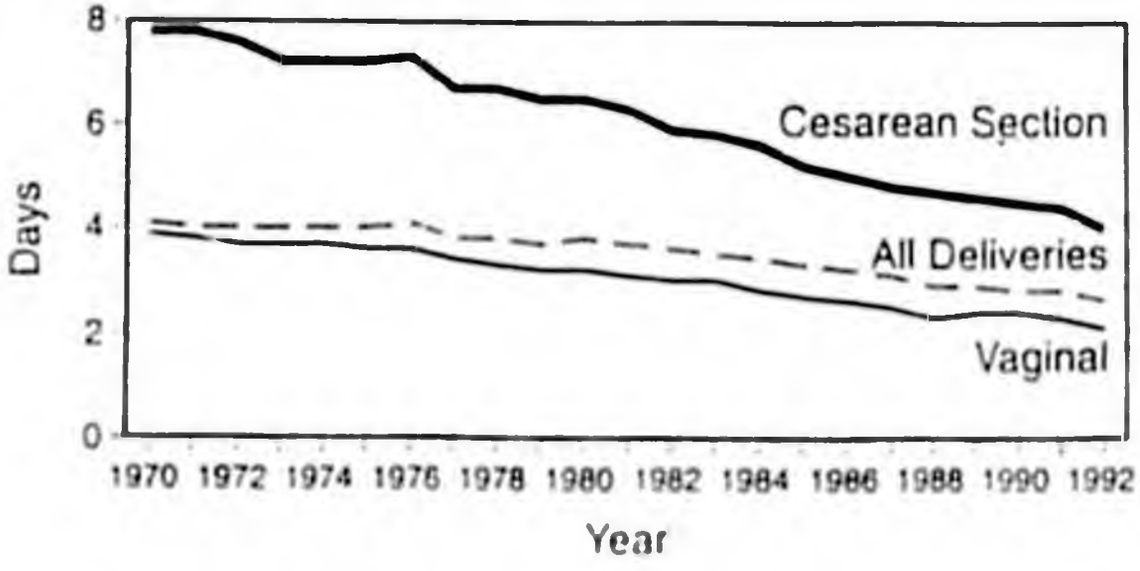
Trends in Length of Stay for Hospital Deliveries — United States, 1970–1992

Obstetric delivery is the most frequent cause of hospital admission in the United States, reflecting the approximately 4 million births in this country each year (*1*). Because of steadily increasing hospital costs, overall lengths of hospital stay have declined. To assess national trends in length of stay for hospital deliveries, data were analyzed from CDC's National Hospital Discharge Survey (NHDS) from 1970 through 1992, by method of delivery. This report summarizes the results of the analysis.

Since 1965, the NHDS has collected data from U.S. nonfederal, short-stay hospitals. Each year, approximately 200,000 inpatient records are selected from approximately 400 hospitals; data are weighted to represent all hospitalizations nationally (*2,3*). Selected patient information (e.g., medical diagnoses and surgical procedures) is abstracted from each record. For this analysis, the NHDS provided information about mother's age and race/ethnicity; method of payment; and the hospital's ownership, size, and location. Estimates for average length of stay were derived from the 20,000–33,000 deliveries each year among all records sampled. Hospital stays of <24 hours were recoded as 0 days; these hospitalizations accounted for <1% of all deliveries and were relatively constant by year (i.e., 0.3% in 1970 to 0.7% in 1992). The proportion of all deliveries that occurred outside of hospitals also was stable from 1975 (0.9%) to 1990 (1.1%) (*4*).

In 1970, the average length of stay for all hospital deliveries was 4.1 days (median: 4 days). By 1992, the average had decreased by 37% to 2.6 days (median: 2.0 days). The average length of stay for women who gave birth vaginally decreased by 46% (from 3.9 to 2.1 days) and for those who gave birth by cesarean section by 49% (from 7.8 to 4.0 days) (Figure 1). The decrease in the average length of stay for all deliveries was smaller than that for either method because the percentage of deliveries by cesarean section increased from 5.5% to 23.5% during this period (*5*).

FIGURE 1. Average length of stay for hospital deliveries, by delivery method — United States, 1970–1992



Status of State Action
As of November 29, 1995

Bills Enacted

Maryland (allows 24-hour discharge if mother and baby meet specified medical criteria and follow-up home care is provided)
Massachusetts
New Jersey
North Carolina

Bills Pending

California
Delaware
Illinois
Kentucky
New Jersey
New York
Ohio
Pennsylvania
Wisconsin

Intent to Introduce Bill

Maine
Rhode Island
Washington

Task Force Established to Study Issue

Rhode Island

Regulatory Action Pending

New Mexico

(Information from the American Academy of Pediatrics)

Utilization

Question Of Profit Motive Raised By Debate On Mandated Length-Of-Stay For Childbirth

The extent to which profits are behind the trend in early releases of women and newborns following childbirth was debated among physicians addressing a Senate panel Sept. 12.

Physicians representing the American Medical Association and the American College of Obstetricians and Gynecologists called the trend unsafe, while physicians representing prominent managed care providers, The Permanente Medical Group Inc., and Group Health Association of America, defended early releases as medically sound, and urged Congress not to mandate lengths of stay.

The Senate Labor and Human Resources Committee was considering legislation (S 969) that would require health insurers to allow new mothers and their infants to remain in the hospital for a minimum of 48 hours after a normal birth and 96 hours after a caesarean delivery. Maryland and New Jersey already have enacted similar legislation, and other states are considering such restrictions (1 MACR 24, 7/5/95).

Dartmouth Medical School neonatologist Judith Frank said the consequences of early discharges are largely unknown. Yet because obstetrical delivery is the most frequent cause of hospitalizations today, she charged, it has become a logical target for cost-limiting interventions.

Evaluating Discharge Policies

Sharon Levine, associate medical director of The Permanente Medical Group, said Kaiser was exploring processes for evaluating a new mother and her child for discharge at the eight-hour mark. About 60 percent of new mothers in the plan leave the hospital after 24 hours, she said.

Sen. Bill Bradley (D-NJ), whose state was the second to enact legislation similar to S 969, said "drive-through deliveries" potentially put millions of mothers and infants at risk. He questioned why Kaiser would be looking at starting such a process at the eight-hour time frame if it was not considering even earlier releases. Levine explained that for a 24-hour release, the process begins on average at the 20-hour mark.

Levine stated that Kaiser provides unlimited stays in the hospital when they are medically necessary. She said three recent studies did not find adverse outcomes associated with shorter lengths of stay.

"To freeze standards of care into statute through legislation will impede progress towards the dual goals of quality improvement and cost effectiveness," Levine testified.

Speaking for GHAA, Richard Marshall, chief of pediatrics for the Harvard Community Health Plan, said the organization was studying the effect of the trend on newborns and mothers. But the group finds it inappropriate to establish an "inflexible statutory standard for an exact number of hours for a hospital maternity stay." Instead, the industry should focus on quality, comprehensive prenatal and follow-up care.

"By means of enhanced pre- and post-natal education and support and a post-discharge home visit, we believe we can provide a quality of care for mother and baby equal to or better than that traditionally provided," Marshall asserted.

The bill does not mean lawmakers "should intervene in every case in all circumstances," Bradley said. □

Provider Regulation

Health Attorneys Supportive Of NAIC Bulletin On Risk-Bearing Entities

PHILADELPHIA—Health care attorneys have been "very supportive" of the bulletin on insurance licensure for risk-bearing entities released by the National Association of Insurance Commissioners, said Greg Stiles, NAIC senior counsel and health policy manager.

The bulletin recommends that states subject health provider networks that assume risk on a prepaid basis to regulation under state insurance laws (1 MACR 161, 9/16/95). It "substantiates what they've [attorneys] been saying all along"—that risk-bearing entities will be regulated, Stiles told BNA Sept. 8 at NAIC's quarterly meeting in Philadelphia.

NAIC is working to allay states' concern that risk should not be spread, for example, from a state-licensed health maintenance organization to an unlicensed physician-hospital organization which accepts a capitation contract from the HMO, he said. "States will hold the HMO liable. The question is how good is that guarantee."

Industry provider groups have told NAIC that even if a PHO is in the business of insurance it should be regulated differently from an HMO based on how much risk it assumes, Stiles said. "There's a question of whether a middle ground exists."

NAIC is probing the question in its ongoing debate over definitions of various risk-bearing entities, including closed and open networks, fee-for-service entities, and entities with and without gatekeepers, said Kenney Shipley, chairwoman of the NAIC Health Plan Accountability Working Group of the Regulatory Framework Task Force, Sept. 11.

The different entities may come through a single door. The NAIC is trying to design a single regulatory

Analysis

Utilization

Laws To Curb 'Drive-Through Deliveries' Gaining Momentum In State Legislatures

Efforts to impose conditions on post-delivery discharges of mothers and infants are gaining momentum in state legislatures, one month after Maryland became the first state to enact restrictions.

The Maryland law (SB 677), signed May 25, generally requires insurers to provide a home visit for mother and child if they are discharged from a hospital prior to 48 hours after normal, vaginal deliveries.

The law—the "Mothers' and Infants' Health Security Act"—incorporates standards for obstetric and pediatric care jointly developed by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). It takes effect Oct. 1.

A stricter bill (AB 2224) that mandates a 48-hour hospital stay after vaginal deliveries passed the New Jersey Legislature June 12. Gov. Christine Todd Whitman (D) signs the measure into law June 28.

In bellwether California, freshman Assemblywoman Liz Figueroa (D) introduced a bill modeled on the Maryland statute June 26 (AB 1978). The bill has the backing of Assembly Speaker Doris Allen (D), who also chairs the Assembly Health Committee. Hearings are being planned for later this summer. A bill also may be introduced in Massachusetts.

In New York state, two bills have been introduced which would establish minimum hospital stays for childbirth. The bills would require that all health insurance policies and managed care plans cover at least a two-day hospital stay for vaginal childbirths and a five-day minimum stay for all caesarean births. Both bills are in committees of each house (A 5125, S 5322).

Legislation also has been introduced in Congress. Sens. Bill Bradley (D-NJ) and Nancy Kassebaum (R-Kan) introduced a bill (S 969) June 27 that would require a minimum stay of 48 hours for vaginal deliveries and 96-hour stays after a caesarean section delivery. A companion bill (HR 948) was introduced in the House June 25 by Rep. George Miller (D-Calif).

Risks vs. Costs

Supporters of the restrictions say the common practice of discharge within 24 hours or less—sometimes called "drive-through deliveries"—poses health risks, especially for infants. In particular, they say signs of jaundice usually do not show up in infants until 24 hours after birth or later and that adequate PKU screening—a test of a baby's ability to metabolize protein—is not possible until 28 hours after delivery. If not diagnosed within 21 days, PKU leads to mental retardation, according to the American Academy of Pediatrics.

From 1970 to 1992, the average length of stay for mothers after a vaginal delivery declined 46 percent from 3.9 days to 2.1 days, according to the U.S. Centers for Disease Control and Prevention (CDC). Discharge within 12 hours after vaginal deliveries is increasingly common.

The impetus for the change, even managed-care companies concede, is cost. "I don't think anybody would say it is not," said Camille Dobson, deputy director of the Maryland Association of Health Maintenance Organizations, which "vigorously opposed" the new Maryland law.

Obstetric delivery is the most common reason for hospital admission in the United States, according to the CDC. As such, keeping down costs associated with delivery can translate into significant savings for a health plan.

Supporters of the discharge restrictions say health plans have gone too far. "There are only a few studies indicating that highly motivated women with high income and education levels have done well with discharge as soon as 24 hours. Of course they're going to do well," said Bobbi Seabolt, lobbyist for the Maryland chapter of the American Academy of Pediatrics.

"The insurance companies decided without data they were going to perpetrate this experiment on the public," she added.

Guidelines Allow

HMOs and other managed-care companies generally oppose the legislation and strongly dispute the implication that shorter hospital stays compromise medical care.

"We believe it [discharge] is a medical decision that should be made by physicians on a case-by-case basis and not through a legislative mandate," said Laura Caliguiri, legislative programs coordinator for the American Managed Care and Review Association.

The joint ACOG-AAP "Guidelines for Perinatal Care" recommend post-delivery discharge after normal, vaginal births at 48 hours but "allow for a woman to go home at the 24-hour time frame when that woman has passed ... e checkpoints indicating that it is safe," noted Susan ... ano, spokeswoman for the HMO trade group Group Health Association of America.

"There is sort of this misperception that they're only covered for that" 24-hour stay, Pisano said. "HMO coverage is comprehensive coverage. If a mother or child is sick and needs more care, they'll get it."

Concern in Maryland

What prompted the concern about the length of postpartum hospital stays in Maryland was a spike in the statewide rate of inadequate PKU testing due to "insufficient milk feeding." The rate went from 5 percent in 1989 to 30 percent in 1993, according to Susan Panny, M.D., director of the Office of Hereditary and Congenital Diseases in the Maryland Department of Health and Mental Hygiene. About 25 percent of infants with inadequate PKU tests in 1993 never underwent a followup screening, according to state data.

An adequate PKU test requires 24 hours of milk feeding, and most newborns do not receive their first milk feeding until four hours after birth. Discharges within 24 hours or less of delivery were blamed for the testing deficiency. In Maryland, about five cases of PKU are diagnosed each year, Panny said.

The Maryland Association of HMOs vigorously objected to the view that early discharges were to blame for what Dobson called "the perceived problem with PKU testing."

"There was not enough data to verify that HMOs were not obtaining results in a timely manner," Dobson said. Moreover, "virtually 100 percent of HMOs schedule a follow-up visit within two weeks" of delivery, Dobson said.

Some HMOs also objected to the requirement for a home visit on quality grounds, maintaining that an office visit ensured mother and child would be seen by properly trained staff and with appropriate lighting and other medical conditions, Dobson said.

Outrage in California

The precipitating event in California was the June 19 release of an internal memorandum for a downtown Los Angeles health facility owned by Kaiser Foundation Health Plan Inc.'s Southern California Region. The memo was obtained by Consumers for Quality Care, an advocacy group.

Dated March 31, the memo from the Southern California Permanente Medical Group says, "For the postpartum patients who deliver vaginally and are otherwise normal, we will encourage the patient to complete their rest and bonding with the baby at home as early as 8 hours after delivery. Any assistance with care and breast feeding can be accomplished in the outpatient setting."

An attachment that lists benefits of the early-discharge policy for patients and staff notes that the policy will allow Permanente to "[r]educe our overhead costs to remain competitive in a fluid marketplace and thus retain our jobs and attract more patients."

In a statement issued by Consumers for Quality Care, Assemblywoman Figueroa said, "I am outraged that HMOs and hospitals in California have formal policies to encourage the release of mothers who have just had babies for the sole reason of cost cutting."

"When I saw that [memo], I was just appalled," Figueroa told BNA. "It tugged at all my strings: as a legislator, as a mom, and as an enrollee of a managed-care system. I just felt offended in all my aspects."

The "flexible discharge policy" outlined in the memo remains in effect at Kaiser Los Angeles, said Ruth Petrucha, M.D., a maternal/fetal specialist at the facility. Since it went into effect in April, five mothers and newborns have been discharged at eight hours from among 600 births.

Codifying Clinical Criteria

The managed-care industry has been quick to object to the adoption of medical guidelines in state statutes.

"Putting any kind of medical criteria in statute is foolish, because it changes," said Dobson. The ACOG-AAP perinatal guidelines are revised every three to five years.

The new law could create a situation in which "UR agents wouldn't know what version of the guidelines to rely on" when authorizing hospitalizations, Dobson suggested.

"It is an unusual situation to have clinical guidelines being made into statute. We do think it is important not to legislate a cookie-cutter approach," said GHAA's Pisano.

Managed-care companies also are leery of the precedent. "It's the start of the slippery slope," Dobson said. "What's next? Are you going to start putting guidelines for coronary bypass surgery into statute? Do you want to do that?"

The impact of the new law in Maryland will be strongest on those plans that do not already offer post-delivery home visits as part of their package of benefits, Dobson said. They will be required to do so under the new law.

"Managed-care companies should look upon this whole event that the 12-hour and 24-hour discharges have struck a raw nerve in many people," said Seabolt. □

—by Thomas W. Derry

NEWS IN BRIEF:

-- Indiana parents could sue if children removed from home unjustly
Under proposed legislation, parents in Indiana could sue the state if they believed child welfare officials unjustly removed their children from the home. A House committee unanimously approved a bill that would let parents file lawsuits if the state interferes with a parent's right to raise his or her child with out showing a compelling government interest. The vote on HB 1346, authored by Rep. Jon Padfield, came after testimony from parents who say their children were removed from their homes after false reports of abuse had been made. Although several lawmakers expressed concerns about portions of the controversial legislation, all agreed that the Indiana Family and Social Services Agency Administration had overstepped its bounds in too many cases and needed to be restrained. The state agency is responsible for investigating reports of child abuse and neglect.

-- Kansas committee debates issue of 'drive-by deliveries'
Debate already has turned partisan on a Kansas proposal for dealing with so-called drive-by births. The Health and Human Services Committee is considering a resolution that would ask health insurance companies to pay for at least three days' worth of care for new mothers and their infants. It would also ask the Insurance Department to gather statistics and other information. The committee's chairman, Rep. Carlos Mayans, proposed the resolution. He and other Republicans would rather ask companies to voluntarily follow a standard than mandate one in state law. The committee's Democrats favor a mandate, as does Democratic Insurance Commissioner Kathleen Sebelius. The committee had a hearing on the resolution, but members debated the proposal vigorously even before the first witness finished testifying. The committee took no action.

-- Utah committee votes down bill to lower school dropout age to 14
The Utah Senate Education Committee voted 3-2 to reject a bill that would have lowered the school dropout age from 18 to 14. Utah Taxpayers Association head Howard Stephenson sponsored the bill as a way for schools to get rid of troublemakers. The state Office of Education, the Utah Education Association and the Utah PTA opposed the plan, saying that state discipline policies are in place that give schools the option of suspending unruly students. Chronic offenders can be kicked out altogether at age 16, said Doug Bates, legislative and legal specialist with the state office. Committee members commended Stephenson's theory that denying students access to education would make them want to return to school. However, the majority believed the idea was flawed. The kids this law would apply to are "without values," said Sen. Nathan Tanner. "They will see it as freedom to go on to more disruptive behavior."

-- Kentucky House passes bill to lengthen maternity hospital stays
The Kentucky House passed a bill to require insurers to cover longer hospital stays for women and their newborn babies. Rep. Steve Riggs said parents and babies would benefit from his bill, which seeks to reverse a trend toward shorter hospital stays for delivering babies. The bill passed 92-0 and now heads to the Senate. Under the bill, health insurance plans would have to provide inpatient hospital care lasting at least 48 hours for women who had vaginal deliveries and 96 hours for women who delivered by Cesarean section. Mothers and their babies now are often sent home in 24 hours, Riggs said. Some insurers have proposed that hospital stays be reduced to 12 hours, he said. The short stays are a cost-cutting effort by the insurers, he said.

-- Texas city council rejects larger property tax break for seniors
The Austin, Texas, city council has rejected a plan to offer a larger property tax break to senior citizens who own their homes. On a 3-2 vote, the council refused to expand the current tax

break, which exempts seniors from tax liabilities on home values up to $51,000. The failed proposal would have allowed seniors to skip property taxes on home values up to $100,000. The current tax break was not affected by the vote. "This is not a tax cut. It's a tax shift," Mayor Bruce Todd said before casting a vote against the measure. Todd said that the loss of $2.8 million in tax revenues would create a larger burden on young taxpayers and older residents who rent their homes. There are about 18,500 homes owned by senior citizens in Austin. Seniors are expected to pay $5.4 million in property taxes this year. That's about 4 percent of the $127 million in property taxes the city expects to collect.

... Indiana House panel approves bill requiring coverage of longer maternity stays

Insurers would have to cover 48-hour hospital stays for new mothers under a bill approved by an Indiana General Assembly panel. The bill sponsored by Rep. Mary Kay Budak would require insurers to follow guidelines adopted by the American College of Obstetricians and Gynecologists. The guidelines call for a 48-hour hospital stay after delivery, and a 96-hour stay after a Caesarean section. The House Insurance, Corporations and Small Business Committee approved the bill 10-2. One negative vote came from Rep. Tim Brown, the legislature's only physician member. He said that the bill is unnecessary and that the legislature should not set medical standards. Budak said that the bill does not mandate specific lengths of stays. It would allow a mother and baby to go home sooner if their physician approves and if they will receive a checkup at home or the hospital within 48 hours.

... Oklahoma Senate bill tackles runaway problem

Sen. Helen Cole said that a loophole in Oklahoma law makes it almost impossible for some parents to retrieve their runaway children. Therefore, she has introduced Senate Bill 74, which would make it a crime to encourage a child to be a runaway. "It would be illegal for an adult to hide a runaway, even if the child went there of his own free will," said Ms. Cole. A runaway would be defined as a minor who had been gone from the home for 48 hours. After 72 hours, the child would be classified as an endangered runaway, alerting authorities to the possibility of foul play. A person convicted of encouraging a child to remain a runaway could face a $1,000 fine and a year in prison. A second offense would be a felony, with a penalty of three years in prison and a $5,000 fine. The measure also would make it a felony for anyone to harbor an endangered runaway.

HOMEOWNERS:

Ohio Ordinance Would Make Homeowners Responsible For Drug Use

People in Cincinnati, Ohio, who allow their houses to be used for dealing drugs could end up in jail along with the dealers. The City Council plans to follow Cleveland's lead in shutting down crack houses by making homeowners responsible for property where drugs are sold. "It's a very aggressive tool," Brad Barbat, criminal justice director for Attorney General Betty Montgomery, said. "It has been effective in Cleveland and could be in Cincinnati, too."

The council members unanimously have endorsed the proposal and asked the city solicitor to prepare a draft for adoption. "The persistence of crack and drug houses in our neighborhoods is an unacceptable blight on our community," Mayor Roxanne Qualls said. "It is intolerable that a person can knowingly allow drug activity to continue on property they legally own. Property owners must assume responsibility."

The Cleveland Crack House SWAT Team, using a similar ordinance, has closed more than 850 crack houses since its inception in 1991. Qualls said that the Cleveland example shows that

When a patient does not notify the company, a computer automatically denies the claim. Then customer service personnel research why the claim was denied, Nelson said. Customers can challenge a claims denial through a three-tiered appeals process, where circumstances surrounding the failure to notify are taken into consideration. The decision whether to extend coverage is based on the patient's circumstances, such as emergency situations, she said. Neither woman from University Hospital appealed the denial, she said, adding: "Most people understand this when they buy a policy and to most people, it's not a big deal." "If you're going to buy a managed care plan, you better be prepared to have your care managed."

Georgia Senate Passes Bill Giving New Mothers Longer Hospital Stays

A bill that would require insurers to cover new mothers for a minimum hospital stay of two days won overwhelming approval 54-1 in the Georgia Senate. The measure puts the decision of when to send mothers home back in the hands of doctors rather than managed health care providers, said Sen. Nadine Thomas, the bill's sponsor. "One of the problems providers are having around Georgia is they cannot practice safe medicine because they have (insurers) saying, 'You've got to get this person out, you've got to get this mother out, you've got to get this baby out,'" said Thomas.

The bill, which must now be approved by the House, would require hospital stays of at least 48 hours for normal births and 96 hours for Caesarean births unless the patient and her doctor agree she should leave earlier. Insurers would also be required to pay for a follow-up medical visit within 48 hours if the woman leaves the hospital early.

Charges that insurance companies were forcing women out of hospitals before they could safely go home prompted the measure, which even drew votes from lawmakers who questioned that reasoning. "You make it sound like people are being forced out of the hospital after 24 hours. Isn't the question really who pays for a stay in the hospital after the first 24 hours?" said Sen. Mike Egan, who voted for the bill. The only vote against the bill came from Sen. Bob Guhl, who said that the legislation would drive up the cost of health insurance. "Don't tell me that, if we save one child, it's worth a million dollars. We've heard enough of that," Guhl said. "Private enterprise knows how to deal with the situation better than a legislator."

Compromise On Maternity Stays Advances In Virginia Legislature

Virginia legislators advanced a compromise bill that would stop insurers from pushing mothers and newborns out of the hospital 24 hours after childbirth if doctors don't think they are ready to go home. Critics of "drive-through childbirth" say that in the past few years more and more insurers have limited post-childbirth hospital stays to as little as a day. The bill endorsed by House of Delegates and Senate committees would force insurers to base discharge decisions on set medical guidelines. "This establishes that the doctor will determine the length of stay," said Del. Clifton A. Woodrum, a sponsor of the bill. Gov. George Allen has not yet decided if he will support the bill, a spokeswoman said.

Woodrum's original measure would have required insurers to allow new mothers and their babies to stay in the hospital no less than 48 hours after a regular delivery or 96 hours after a Caesarean delivery unless a mother wants to go home earlier. Insurance representatives vigorously opposed that, saying that doctors, not lawmakers, should determine the lengths of stays. The compromise bill would require insurers to pay for additional hospital time if doctors find that the mother or child does not meet criteria set forth in discharge guidelines prepared by the American Academy of Pediatrics and the American College of Obstetricians

and Gynecologists. Insurers also would have to pay for post-childbirth home visits if a doctor thinks they are necessary based on the guidelines.

Doctors and an association of health maintenance organizations support the compromise. "I think it's great," said Dr. William Moskowitz, associate professor of pediatrics at the Medical College of Virginia Hospitals. "I think the HMOs clearly have always tried to take care of their patients as best as possible but a lot of times they lose sight of what the primary goal is." Many doctors and nurses say that longer stays often are needed because some medical problems don't show up in the first day and new mothers often haven't learned to care for their babies yet.

The Virginia Association of HMOs supported the compromise but said many HMOs already use the guidelines. May Fox, the association's executive director, said that the bill will only apply to maternity patients with a demonstrated need to stay in the hospital. Women who feel fatigued but are otherwise healthy will not be able to stay longer, she said. Ms. Fox said that she had no idea how much the bill could cost HMOs that will have to adopt the guidelines. The association represents about 23 HMOs. The bill also applies to Medicaid recipients but will cost nothing extra because Medicaid programs already adhere to the guidelines, said Tom McGraw, director of the program delivery division of the Virginia Department of Medical Assistance Services.

ABORTION:

Iowa City Council Approves Parental Notification Ordinance

Quad Cities-area teenagers wanting to have an abortion would have to get permission from a parent first under an ordinance approved by the Davenport, Iowa, City Council. The move comes as two abortion providers look to open the only clinics in the Quad Cities. The ordinance, approved on a 7-3 vote, requires the parent or guardian of a girl younger than 18 to be notified at least 48 hours before the abortion is performed. Exceptions would be a medical emergency, a written notice of notification from the parent or guardian or reported cases of sexual abuse, neglect or physical abuse.

Planned Parenthood of Greater Iowa and the Iowa City-based Emma Goldman Clinic for Women both announced plans in 1995 to open health clinics here that would provide abortions. Planned Parenthood's Judy Rutledge said her group is investigating whether the city can legally regulate abortions. "I think there's a question as to whether the city has the authority to pass these type of ordinances," she said. Right now, the closest access to abortion from the Quad Cities--Davenport, Bettendorf, Rock Island, Ill., and Moline, Ill.--is the Emma Goldman Clinic. The parental notification ordinance will not take effect until May 15, in hopes that the Iowa legislature will have acted on a parental notification bill it has been studying. "We hope it sends a message to our legislature--we need action on this," Council member Joe Seng said.

DOMESTIC VIOLENCE:

Most New York Domestic Violence Victims Get Unemployment Insurance

State officials say most people who lose their jobs due to domestic violence are able to collect unemployment insurance in New York and that no specific changes are needed in the benefit program to accommodate them. The state Labor Department was ordered by the state legislature last year to examine the problems of employees who are forced to leave or miss work due to violence in the home, and devise an unemployment benefits policy for them. The

(89)

Don't send babies home so soon

By Betsy McCaughey

If you're expecting a child or a grandchild, beware of the danger ahead.

In 1970, the average hospital stay for mother and newborn, after a normal delivery, was four days. By 1992, it had been cut to two days. Now one day is the rule, as insurers intercede aggressively to slash hospital time and costs, and some health maintenance organizations (HMOs) are ordering mother and baby out after eight hours. Women in labor are being told to wait in the hospital parking lot, as long as they can bear it, so that the clock doesn't start ticking on the hospital stay their HMOs allow.

The danger is to your baby. Early discharge means infants are sent out of the hospital nursery before the doctor can be sure they are healthy. Doctors used to spot congenital heart defects, jaundice, dehydration and streptococcal infections during a newborn's second or third day in the nursery. Detection on the first day often isn't possible. Now, by day two, babies and mothers are out of the hospital and on their own when the symptoms finally appear.

"You don't catch the babies who need help," worries Dr. Rita Harper, chief of neonatology at Northshore University Hospital in Manhasset, N.Y. Dr. Harper knows that before the days of early discharge, almost 9 percent of the newborns moved into intensive care from the well baby nursery were transferred during their second day of life. Their need was not apparent until the second day. Now, babies are out of the hospital by the second day.

Dr. Augusto Sola, professor of pediatrics at the University of California, San Francisco, is heartsick over the consequences. Since early discharge took hold in California in 1992, he has seen six otherwise healthy, full-term newborns rushed to his neonatal intensive care unit with permanent brain damage due to severe jaundice (bilirubin encephalopathy).

Medical science had virtually eliminated this tragedy two decades ago, because doctors were able to diagnose jaundice, usually in the second or third day of life, and treat it with special lights to stop the damage. Surveying data from all the hospitals in California, he found that in 1992 alone, nine full-term newborns discharged early as healthy suffered irreversible brain damage because of severe jaundice.

Mental retardation is also a small, but serious risk. For decades states have required that all newborns be given a simple test for PKU, a metabolic disorder that can cause lifelong mental retardation if it is not treated soon after birth. In the 1940s, 1 percent of all people in institutions for the retarded in the

U.S. had PKU. "Preventing the mental retardation that goes along with PKU has been a major success story," says Dr. Harry Ostrer, Director of Human Genetics at NYU Medical Center. "Now kids are falling through the cracks," for the first time in decades, and the culprit is early discharge.

For screening to be reliable, babies must be older than one day and younger than 21 days. In Maryland last year, one third of babies were taken from the hospital too young for an accurate screening. 18 percent of these babies were never brought back for retesting, and many others were brought back too late for a reliable test. Dr. Ostrer calls the lapse in newborn screening "a major source of alarm."

The American College of Obstetricians and Gynecologists recently cautioned that early discharge is "a large, uncontrolled, uninformed experiment." Imposing an experimental practice, such as early discharge, on new parents without their informed consent is "highly unethical," Dr. Sola explained at a recent Senate hearing. There have been no clinical trials to evaluate the risk of early discharge.

Last spring the American Medical Association called for a moratorium until the risks are known. Insurers balked, but hospitals from St. Louis to New Rochelle, New York and Greenwich, Conn., acted to put patients ahead of profits, announcing that women and newborns can spend the second day free, if insurers won't pay. The irony is that highly profitable HMOs are reaping millions, while publicly supported hospitals are picking up the tab.

People around the world are striving to curb health care costs, but in the United States newborns are bearing the brunt. Not so in Canada, Japan, Great Britain or Germany where hospital stays after birth average from 2.5 to 7 days. These countries control health consumption far more aggressively than the United States, but even they draw the line at discharging newborns too early.

New Jersey, Rhode Island, North Carolina and Maryland have changed their insurance laws to require 48-hour coverage for normal births and extended coverage for difficult and Caesarean births. Recently, New York's Gov. George Pataki announced support for similar legislation, and other states are following. If babies in these states deserve a safe start for the first 48 hours of life, how can it be that babies in all 50 states don't deserve it?

Insurers across the nation should support the federal Newborns and Mothers Health Protection Act of 1995. This bill, introduced by Sens. Nancy Kassebaum and Bill Bradley requires insurers to provide coverage for a 48-hour hospital stay for normal births. The goal is to ensure that doctors and their patients, not the insurance company, decide when it is safe to leave the hospital. Democrats and Republicans in the House of Representatives have introduced several similar bills. Partisanship is taking a back seat to the safety of our youngest children. Federal action is also needed to safeguard families whose health coverage would not be affected by state legislation due to the Employee Retirement Income Security Act (ERISA).

The Newborns and Mothers Health Protection Act will help make sure that your next child or grandchild has a safe start for the first two days of life. Only insurance companies are against it.

Betsy McCaughey is lieutenant governor of New York State.

Longer Hospital Stays for Childbirth Are Needed, Pediatricians Say

CHICAGO, Oct. 10 (AP) — Most mothers and babies need to stay in the hospital at least 48 hours after childbirth, the nation's largest group of pediatricians said today, bucking a trend toward shorter stays that save money.

"The fact that a short hospital stay can be accomplished does not mean it is appropriate for every mother and infant," the American Academy of Pediatrics said in a policy statement.

Increasingly, insurers are refusing payment for hospital stays beyond 24 hours after an uncomplicated delivery, said the 49,000 member academy, based in Elk Grove Village, a suburb of Chicago.

Three states — Maryland, New Jersey and North Carolina — have enacted laws to insure that mothers and newborns have at least 48 hours in the hospital under most circumstances, according to the American College of Obstetricians and Gynecologists.

Similar bills are pending in Congress and in California, Delaware, Illinois, Kentucky, Massachusetts, Minnesota, New York, Ohio, Pennsylvania and Rhode Island, the organization said.

The obstetricians' group and the pediatricians have recommended in the past that hospital stays after childbirth range from at least 48 hours for vaginal deliveries to 96 hours for Caesarean sections.

The new guidelines refine the old ones, said Dr. William Oh, chairman of the pediatricians' Committee on Fetus and Newborn. The guidelines are published in the October issue of the Journal Pediatrics.

"Mothers are very upset because some of the hospitals are discharging mothers within 6, 12 and, at most, 24 hours," Dr. Oh said by telephone. "Many of the mothers are still recovering from labor."

Pediatricians are very concerned for medical reasons, said Dr. Oh, chairman of pediatrics at Brown University School of Medicine in Providence, R.I.

Discharging babies only hours after they are born does not allow time to spot developments.

The timing of the discharge should be decided by the doctor and not by "arbitrary policy" established by a third party, the guidelines say.

Mothers and infants should be hospitalized together until 16 conditions are met, which generally takes more than 48 hours, the academy said.

The conditions include: an absence of medical complications, completion of at least two successful feedings, the baby has urinated and passed a stool, a documented ability of the mother to care for the baby, including receiving training in feeding, newborn care and infant safety; performance of certain laboratory tests, and identification of a continuing source of medical care.

The conditions also include assessing whether the mother abuses alcohol or drugs, has a history of child abuse or mental illness, is homeless, has been a victim of domestic violence or lacks social support.

Lynne Fritter, a spokeswoman for the Health Insurance Association of America, agreed that decisions about when to discharge mothers and newborns should be made case by case.

"I'm not aware that there is a policy out there where they refuse to pay after 24 hours," Ms. Fritter said from the Washington headquarters of the association, which represents more than 200 insurers. "It has always been up to physicians whether to keep the mother and child in the hospital after 24 hours."

New York Times
p. A17
October 11, 1995

Check in, deliver, go home

Hospitals are hustling new mothers out in a day—or less. Is it risky?

Nicole Jundanian, 28, an annuities company co-owner and manager from Chevy Chase, Md., did everything by the book to prepare for the arrival of her first child in October. She joined up for Lamaze classes and read how-to manuals even as she toiled through labor. Still, she was in such a stupor after delivering at 3:25 a.m. and being discharged the next day that she failed to recognize how poorly Jack Joseph was nursing. "He was jaundiced and dehydrated, and I didn't even know it," she says. Nor did the hospital staff picked up the baby's problems.

Luckily, Jundanian had hired a caregiver trained in assisting new mothers, who spotted the condition in time. But the baby and his mother—still sore and bleeding heavily from the delivery—spent much of their first week together commuting back and forth to the doctor's office. "I was a basket case," recalls Jundanian. "If I'd only been in the hospital longer, I would have had an easier time."

In and out. In today's cost-conscious climate of managed care, however, that has become a luxury for most new moms. Maternity stays have shrunk dramatically from the weeklong sojourn common in the 1950s and still common in Europe (box) to a national average of just 2½ days in 1992, the latest available figure. That's roughly five hours shorter than the 1991 average but still sufficient compared with the 24 to 36 hours most health care plans now stipulate for routine vaginal deliveries—which can mean a late-night discharge. Four days is standard for Caesarean births. Some providers, primarily on the East Coast, are working toward turnarounds as short as six hours—a practice obstetrical hands jokingly refer to as "drive-through OB."

Many health professionals contend that abbreviated stays afford little opportunity for mothers to rest, let alone learn such basics as umbilical-cord care or breast-feeding; indeed, lactation may not occur for four days. Moreover, while most newborn problems surface during the first six hours, jaundice, heart murmurs and some other potential ills tend to develop later. Some screening tests, such as the one for the metabolic disorder phenylketonuria, or PKU, which is treatable if caught early, may even prove unreliable if performed too soon. Other tests might simply go undone in the brief time available.

House call. *A specialist in home maternal care spotted trouble in Jack Joseph Jundanian.*

Motherhood abroad

Typical hospital stay for new mothers:

Australia: 4 to 6 days

Canada: 2½ days

France: up to 2 weeks, 5-day minimum

Germany: 7 days

Great Britain: 3 days

Ireland: 5 to 6 days

Japan: 5 to 7 days

Netherlands: Mostly home births with [illegible] nurse for a week

Sweden: 1 to 3 days, with midwife [illegible]

United States: 24 to 36 hours

[illegible]

"The issue is safety, and it's a big one," says Rachel Schwartz, associate director of the National Perinatal Information Center in Providence, R.I., who has surveyed the research on early discharge for a conference this week sponsored by the Department of Health and Human Services' Maternal and Child Health Bureau. "We don't have enough experience with one-day stays to know if we can prevent the train wrecks."

Maternity wards are hardly alone in feeling managed care's tightening grip, of course. Some medical centers now perform outpatient mastectomies. Others no longer routinely keep chest-pain sufferers for overnight observation. Even cardiac cases are getting the boot earlier. Reconfigured staffing and medical advances have allowed Fairfax Hospital in Northern Virginia, for example,

to pare the average length of stay for bypass patients to just under a week from 12.2 days in 1989.

Cardiac cases, however, are not expected to go home, attack the laundry and wake up for midnight feedings. Moreover, unlike previous generations of mothers, today's mom can't count on having an experienced relative there to coach her on nursing or spot a fever. That kind of child-care education has been a hallmark of the maternity-ward stay—only now there is insufficient time, and fewer nurses, to dispense it. "Our problem is trying to get everything done for a woman and then trying to get her out because she is on a time clock," grumbles Doris Johnston, associate administrator for patient care services at Columbia Hospital for Women in Washington, D.C. "It's very frustrating."

Insistent mom. *Sheryl Mulhall argued for a second night's stay—and Tyler, unlike a previous baby, lived.*

But is it actually dangerous? Medical studies, though scant, show no adverse health impact for mothers or infants discharged early. And a computer analysis of 140,000 deliveries nationwide between 1990 and 1993, done for *U.S. News* by HCIA Inc., a health care information company in Baltimore, found no significant association between length of stay and readmission rate. If anything, the 2.4 percent of women requiring rehospitalization within a year had enjoyed extended first stays. "The one-day discharge is so common that if people were having complications, they'd show up statistically by now," says Richard Dovle, a San Diego-based internist with Milliman & Robertson, an actuarial consulting group that creates guidelines for health insurers.

Home sweet home. Moreover, early-discharge programs appear to be popular with patients. Some 85 percent of Kaiser Permanente maternity patients polled recently, for example, expressed satisfaction with their hospital stay. Breast-feeding tends to go more smoothly at home than on a busy maternity ward. And the faster mother and child check out, the less likely they are to pick up hospital germs.

Still, anecdotal evidence suggests that some problem cases slip through the system. Three years ago, exhausted new mom Sheryl Mulhall emerged from a long morning shower to find her 3-day-old son blue and lifeless in his bassinet. So in February 1993, when the hospital tried to discharge her a day after giving birth to strapping baby Tyler, the Rochester, Ill., mother of two dug in her heels. Because Mulhall had the flu, her doctor finagled another night. That evening, Tyler didn't eat; next morning in the nursery, he turned pale and struggled to breathe. "Had we been home, we would have lost him," shudders Mulhall. She later learned her son—revived with sugar water and now a peppy toddler—has a genetic enzyme deficiency thought to cause 5 percent of some 7,000 crib deaths annually. "I'm thankful I stood my ground," says Mulhall.

Not all mothers are so insistent, ... their babies so fortunate. ...n the two years since 24-hour turnarounds became common in Cincinnati Children's Hospital has readmitted five infants suffering from severe dehydration caused by difficulties related to breast-feeding, including one who lost a leg as a result and another who ended up brain damaged. Less severe conditions may simply go uncounted: in an ongoing survey of early dischargees by Holy Cross Hospital in Silver Spring, Md., visiting nurses are discovering problems—many of them stemming from a lack of knowledge about lactation and feeding—in a quarter of the mothers or infants checked a day or two later.

The villain, experts contend, is not short stays per se, but lack of follow-up

Home improvement. *Cleveland nurse Beverly Wenh educates new moms like Brenda Gomes in baby care and breast-feeding.*

or support. "It's unbelievable what we find on home visits," underscores obstetrics nurse Lenore Williams, president of Professional Nurse Associates Inc., a private nursing practice in Cleveland that specializes in maternal health care. "I came across one mom who said, 'All my babies had jaundice,' and when I flipped back the covers, there was this baby as yellow as a banana from a liver infection." Visiting nurses and other maternity experts report seeing everything from blood clots and depression in mothers to infants with infected umbilical cords, collar bones broken from delivery and heart murmurs. One Baltimore nurse recently peered the door to find a newborn vomiting meconium—its own fecal matter, swallowed in utero.

Home follow-ups included in some health plans can prevent such complications from becoming emergencies. In a recent survey of 1,616 Kaiser Permanente families under her firm's care, Williams found infections in 7 percent of the mothers and 3 percent of the infants, yet the rate of hospital readmission was less than 1 percent.

With a day in the hospital now billing at an average of about $1,500, the savings can be substantial. The total topped $500,000 for 925 Ohio Kaiser Permanente patients in a 1990 study by Professional Nurse Associates. Moreover, follow-up care can stave off emergency-room visits by reassuring a mother that her infant's rolling eyes are a sign of sleepiness, not of seizures, or by spotting formula left sitting too long. "It's win-win for everyone," says nurse Williams.

Videotape support. Except, perhaps, for hospitals. To compensate for shorter stays, many are expanding prenatal education beyond the pant-pant-blow of traditional labor classes, to include breast-feeding and choosing a pediatrician. At Columbia Hospital for Women, new parents soon will be sent home with a videotape that addresses such issues as circumcision care. While Alta Bates Medical Center in Berkeley, Calif., gets newborns back for checkups at 72 hours, even on weekends. Next year, Alta Bates plans to factor a home visit into its per capita maternity costs.

Many managed-care plans, including Kaiser Permanente and Humana, and some insurers also provide home visits. But hurdles—like having to get approval before discharge—can prove deterring. And no guidelines or federal rules mandate such services. That leaves it up to new mothers like Nicole Jundanian to search out their own experts—and foot bills of up to $300 a week. "It's another situation where women and children are being shortchanged," concludes Edward Bailey, chief of general pediatric services at Bay State Medical Center Children's Hospital in Springfield, Mass., who instituted home follow-ups four years ago to support early discharges and has seen no adverse health impact in 13,000 births.

Neither Bailey nor his peers expect maternity stays to lengthen. But if the bean counters have avoided a train wreck so far, it may only be because "most babies are healthy and very resilient," notes Marcia Charles-Mo, chair of the pediatrics department at Alta Bates. Unless they provide a dose of follow-up support, however, insurers and managed-care plans could find their robust bottom lines bouncing rapidly into the red. ■

BY MARY LORD

#MeToo

Soon

Across the country, babies just hours old are being discharged from hospitals—simply to satisfy insurance companies. Tiny lives are at risk. Here's how you can help stop this shocking practice.

Pat Steenland, 40, a professor of English literature in Moraga, CA, gave birth to her first child, Miya, March 15 at 12:05 A.M. A mere fourteen hours later, at 2:00 P.M. on Thursday, the hospital discharged her. "I wasn't at all ready to go home," says Steenland. "I had been up two nights straight because I kept going into labor and then stopping. I was exhausted. I had also started hemorrhaging and was hooked up to an IV with Pitocin to stop the bleeding." The hospital really wanted to send her home at noon but, says Steenland, "a very nice nurse gave us two extra hours. I was hooked up to the IV until literally ten minutes before I walked out the door."

But that wasn't the worst of it. Once home, on Friday night, Miya started to wail. Her temperature was 102.7. Steenland and her husband, Glen Morwald, an artist, called their pediatrician, who told them to unswaddle her. That brought her temperature down. On Saturday morning they took her to the doctor's office where a blood test was taken. On Monday morning they got a call that Steenland remembers as "just chilling." The blood test showed signs of a massive infection that could be streptococcus. The doctor told Steenland to take Miya immediately to Children's Hospital Oakland. "We were terrified," she says.

Miya was rushed to intensive care and started on intravenous antibiotics. When the culture from the blood test finally came back, it confirmed that she had alpha streptococcus, a rare but fortunately mild form.

When the hospital was ready to release her, Health Net, the family's HMO, wanted to have a home nurse come to their home once to teach Pat and Glen how to administer antibiotics to their infant daughter with an intravenous needle in her scalp. "I told them 'No,'" Pat says. "Fortunately someone at the hospital was doing the negotiating for me so it was easier. I said either they pay for five days of home nurse visits or five more days of intensive care. Finally they agreed.

"But they didn't let up the pressure," Steenland says. "The home nurse tried to get us to learn to flush the IV line so she could come only two times a day instead of four. One night the line was jammed and the nurse had to replace it and draw blood from my daughter's scalp, and I said, 'You expected *me* to deal with this? It was hard enough to *watch*.'

"It really was a terrible ordeal, a trauma," Steenland remembers. "Fortunately, Miya's perfectly fine now—for her, it's as though nothing happened. For us, it's going to be with us for the rest of our lives. I think the twenty-four hour release is a terrible policy. I keep saying, 'How many babies are going to die before they change it?'"

A potent coalition of doctors, mothers, and some of the nation's leading politicians are wondering the same thing, and have joined forces to lead an outcry against what have become known as "drive-through deliveries." This refers to a policy of releasing mothers and their newborns from the hospital too soon—anywhere from eight to 24 hours after birth. The result has been a growing number of infants who've developed life-threatening complications—and even died.

In May, the American College of Obstetricians and Gynecologists (ACOG) issued a statement calling for a moratorium on the practice and called upon insurance companies to prove that early discharge is safe. For many years, ACOG and the American Academy of Pediatrics have recommended that mothers and newborns spend 48 hours in the hospital unless, in select cases, doctors deem earlier release safe, according to strict criteria. (According to the National Center for Health Statis-

BY JEANIE RUSSELL KASINDORF

ts. the average length of stay for mothers and babies ecreased from 4.1 days in 1970 to 2.4 days by 1993.) In its tatement, ACOG cited reports of two serious problems hat doctors were suddenly seeing: babies suffering brain amage from untreated jaundice that parents weren't rained to recognize, and breast-fed babies suffering from ehydration because mothers didn't realize they weren't etting enough milk. Soon after, the American Medical ssociation passed a resolution saying that discharges hould be "determined by the clinical judgment of attend- g physicians and not by economic considerations."

Obstetricians also complained loudly about how diffi- lt early discharge was on women. "The risks are greater the newborn than the mother," says Anthony Caggiano, D., past president of the New Jersey Obstetrics and ynecology Society and president-elect of the Medical ociety of New Jersey. "But our concern is the abuse of others. They are exhausted, they're sore, yet they're also ed because of the new baby and all the people calling visiting. They don't have time in twenty-four hours to e a deep breath and get a good night's sleep and learn w to take care of their newborn and themselves before ey leave the hospital."

In May, Maryland passed a law requiring that infants ho are discharged in 24 hours meet certain medical crite- a and receive a home visit. In June, New Jersey legisla- rs passed a stricter law mandating insurance companies d HMOs to cover a 48-hour stay in the hospital if the other requests it. Alan Langsner, M.D., senior consul- nt of pediatric cardiology at St. Barnabas Medical enter in Livingston, NJ, told legislators that "it is only a atter of time before an infant with a correctable cardiac ion dies in the name of early newborn discharge." rents, doctors say, have no way of recognizing the subtle gns—bluish red or purplish blood or small changes in skin luring—of that heart condition.

By summer, bills were introduced in New York, Califor- a, Pennsylvania, and Massachusetts. In June, Senator ill Bradley (D-NJ) filed a bill to require health insurers allow new mothers to remain in the hospital for a mini- um of 48 hours (96 hours for a cesarean). Senator Nancy assebaum (R-KS) signed on as a cosponsor. In the ouse, Congressman George Miller (D-CA) proposed a milar bill. Even the leading ladies in both political par- s—First Lady Hillary Rodham Clinton and New Jersey's epublican Governor Christine Todd Whitman—have voiced support. Governor Whitman signed her state's bill at a New Jersey hospital and then, for the photo opportunity, stood bedside with a new, smiling mother. And Hillary Clinton said on *The Oprah Winfrey Show*, "I personally am appalled that we are now discharging mothers with babies as soon as we possibly can get them out the door."

Throughout the emotional debate, the insurance companies and HMOs have stood firmly opposed. Why? It costs from $700 to $1,110 for an additional day in the hospital for each of the four million babies born each year. In defense of the early-release policy, Susan Pisano, spokesperson for the Group Health Association of America, says, "These decisions need to be made on a patient by patient basis by the attending physician, not by legislators in some cookie cutter approach."

It was in 1993 that insurance companies—especially HMOs—began asking their doctors to make sure mothers and newborns were discharged in 24 hours (two to three days for cesarean sections). State Senator John J. Matheussen (R-NJ), who sponsored his state's 48-hour bill, says that HMOs force their doctors to comply. Holly H. Roberts, D.O., an obstetrician-gynecologist in Red Bank, NJ, says that an HMO she works with, which she declines to name, "came into my office and showed me a chart of how soon their doctors got their patients out and threatened to drop me from their system if I didn't get my patients out sooner. They also told me there would be a financial incentive if I decreased my patients' length of stay."

In some states it has dropped even lower. In 1994, 16.6 percent of the babies discharged from California hospitals—90,000 babies—went home in under 12 hours. And in March 1995, the Southern California Permanente Medical Group, a division of Kaiser Permanente, the nation's largest HMO, issued a memo to its doctors asking them to "encourage" mothers to leave the hospital "as early as eight hours after delivery." They were also warned that, even with such breathtakingly speedy discharges, home health visits were "not to be used routinely." The memo—which was made public by a Los Angeles-based watchdog group called Consumers for Quality Care (CQC)—gave the doctors a checklist of things to tell new mothers about why they should go home early, including the fact that "hospital food is not tasty." Elaine Bum-Pyrez, spokesperson for CQC, says, "It's outrageous because it's totally profit driven. It's clearly not giving any concern to the mother or the newborn."

Indeed, some feel conditions have deteriorated to sheer recklessness once hospitals got into the early discharge habit. "Initially HMOs intended only full-term, healthy babies to be released within twenty-four hours," says Susan Panny, M.D., a pediatrician in the Maryland Department of Health and Mental Hygiene. However, when her department did a study of Maryland births they found that in 1992, 22.2 percent of all newborns who were not considered healthy were discharged before 24 hours. "It's very scary," Dr. Panny says.

One of those scary things that pediatricians are seeing—which they almost never saw before—is permanent brain damage caused by untreated jaundice. Jaundice is very common among newborns and causes no problems when babies are treated soon after detection. When left untreated, however, jaundice can lead

to mental retardation or impairment, motor problems, and hearing loss.

"When I went to medical school," says Augusto Sola, M.D., the director of neonatal clinical services at the University of California San Francisco Medical Center, "I remember a professor showing me pictures of babies with untreated jaundice. He said, 'Your generation is very lucky. You will never see this problem again.'" So when Dr. Sola began seeing babies with untreated jaundice, he looked at his hospital's records. He discovered that from June 1992 to October 1994, five babies had been admitted for the late stages of the condition. All five had been discharged from other area hospitals between eight and 28 hours after birth, and four of the five had no home nurse visit within two days of release. In the 20 years prior, there hadn't been a single admission for the condition at UCSF Medical Center. "A mother cannot be expected to diagnose jaundice that needs to be treated," Dr. Sola says. "Even doctors cannot always agree on it."

Yvette Joseph, 29, a New Jersey mother who is a mathematics editor at a school publishing company, sadly learned that all too well. She gave birth to a son, Nigel, at 7:32 P.M. on September 12, 1994. Since her insurance company would not pay for a second day, mother and son were released from the hospital the next evening around 10:20. "Before we were released, the baby was shivering very badly," Joseph says. "The nurses didn't know what was wrong. They said, 'Maybe he just hasn't adjusted well.' They released us anyway. The next day, a Wednesday, a visiting home nurse came and told us he was jaundiced, but we should expect that and to just expose him to sunlight. He was still shivering and she said his immune system just hadn't adjusted as well as other children's."

Nigel's yellow color continued to worsen. On Friday they talked to Seymour Charles, M.D., their pediatrician, and made an appointment to see him first thing Monday morning. As soon as he examined the baby, he rushed him to the nearest hospital. "It was a shattering experience," Dr. Charles says. "I'll never forget it. That baby was as yellow as can be and very lethargic. His temperature was down to ninety-three, his heart beat was down to eighty-three. I was afraid the baby was going to die."

Nigel spent two weeks in the hospital. When he was five months old, he started having six or seven seizures a day. "His eyes would roll back in his head," Joseph says, "and he would go limp." Now he has a seizure only about every fourth day, but no one is sure whether he will ever completely recover. "This baby is not out of the woods," Dr. Charles says. "This baby could grow up to have a seizure disorder."

"What's so sick about this," says Dr. Charles, the chairman of the Insurance Committee of the New Jersey Pediatric Society, "is that we have systems in place in every major medical center to monitor and screen newborn infants. HMOs are saying all this is superfluous. They are taking all the technology that we built up for newborns in the hospital and casting it aside. We have one baby dead from streptococcus because the poor, unsuspecting mother can't possibly recognize it. And yet there is no way it would go unrecognized in a newborn nursery."

The case Dr. Charles is talking about is the one that prompted ACOG to issue its call for a moratorium on early discharges. Michelina Alanna Bauman was born at 12:13 A.M. on May 16, an apparently healthy full-term baby. "She came out pink as a flower," her mother, Michelle Bauman, says. "She was beautiful." The next afternoon Michelle, 28, a housekeeper, and her husband, Steve, 30, a cement truck driver, took Michelina home to their house in Williamstown, NJ. The family's HMO, U.S. Health Care, paid for mothers and full-term newborns to spend only 24 hours in the hospital.

Around 10:30 that night, Michelina started moaning and refused to eat. Her parents stayed up all night trying to comfort her. Although they had no way of knowing it, their 2-day-old baby was dying of a massive beta streptococcus infection that her tiny body was unable to fight.

At 6:00 A.M. the next morning, they called the pediatrician. During the following day, the Baumans made four calls to their pediatrician, who told them the baby probably just had gas. As the day went on, Michelle remembers, Michelina's moans got "louder and louder." Michelle tried to comfort her by putting her in her baby swing for short periods of time. At three that afternoon, purple spots began to appear on her skin, a sign a neonatal nurse or doctor would have recognized as a "terminal event." The pediatrician's office said it was probably "just newborn rash."

At six that night Michelina died in her baby swing. Michael Grossman, D.O., the vice-president of medical affairs at Kennedy Memorial Hospitals-University Medical Center of New Jersey, where she was born, says that had Michelina "spent one more day in the hospital, the infection would have been detected and treated and she would have had a fifty-fifty chance of recovery."

"The system didn't even give our baby a chance," says a distraught Michelle Bauman. "Even if they had tried all they could and she hadn't made it, it would be easier to accept. My husband and I don't even know what to say to each other. He carries the little hat she wore home from the hospital with him all the time. We have pictures of her all over the house. I walk around and talk to the pictures and tell her I'm sorry. Some days I feel like grabbing her through the picture and just holding her, but I can't do that." ★

JOIN THE GOOD HOUSEKEEPING LOBBY!

If you want to help prevent the deaths and illnesses of any more newborns due to drive-through deliveries, fill in this petition and mail it to:

Senator Bill Bradley, Washington, DC 20510.

_____, 1995

Dear Senator Bradley:

Please add my name to the list of supporters of the Newborns' and Mothers' Health Protection Act of 1995, cosponsored by Senator Bill Bradley (D-NJ) and Senator Nancy Kassebaum (R-KS), which will require insurance companies to allow mothers and their infants to spend a minimum of 48 hours in the hospital after a baby's birth.

Sincerely,

name _____

address _____

Senate Finance Committee

To: Larry Stevens

From: Kathy

Date: 2-20-96

Subject: Bill Number: SB193 Version: _____

Fiscal Note WITHOUT a Senate Finance Committee Referral

Title: Ins. coverag for certain costs of birth

Referrals: S (L+C)

Sponsor(s): Solo

Department: DOA

BRU: All state agencies.

Component: _____

Comments: _____

Attachments:

Fiscal Note(s)
Bill History from BASIS

SB

197

HOUSE COMMITTEE REPORT

(11)

Date Referred to Committee: April 12, 1996 FURTHER REFERRALS:

Date of Committee Action: 4/26/96

The FINANCE Committee considered: CSSB 197(L&C)

CS FOR SENATE BILL NO. 197(L&C) INS:DOMESTIC VIOL. VICTIMS & DISCLOSURES

"An Act relating to insurance covering an insured who is a victim of domestic violence and requiring certain disclosures by an insurer."

recommends it be replaced with the following committee substitute H/S CSSB 197(FIN) [ ] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

[X] zero fiscal note(s) DPS [X] zero fiscal note(s) CED 2/23/96

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Foster	X			
Mulder	X			
Martin	X			
Kohring	X			
Therriault	X			
Navarre				X
Kelly	X			
Parnell			X	
Grussendorf	X			
Brown				X

CHAIR'S SIGNATURE _____ Richard Foster

No. 1

FISCAL NOTE

Bill Version: CS SB 197(L&C)

(S) Publish Date: 2-23-96

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Revision Date: February 20, 1996
Department: Commerce and Economic Development
Title: Prohibit Increase in Ins. for Domestic Violence
BRU: Insurance
Component: Operations
Sponsor: Senators Donley, Ellis, Salo
Requestor: Senate L&C Committee
COMPONENT SERIAL NO. #364

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	00	00	00	00	00	00
CAPITAL EXPENDITURES						
CHANGE IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1008 GF/MHTAA						
Other						
TOTAL	00	00	00	00	00	00

Estimate of any current year (FY 96) cost: $ 00

POSITIONS

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)
No fiscal impact.

Prepared by: Joan Brown, Administrative Officer
Phone: 465-2587
Division: Insurance
Date: 2/20/96
Approved by Commissioner: William L. Hensley
Date: 2-20-96
Agency: Commerce and Economic Development

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FISCAL NOTE

STATE OF ALASKA **BILL NO: SB 197**

1996 LEGISLATIVE SESSION

Revision Date

Title: Ins Domestic Viol Victims & Disclosures

Dept. Affected: Public Safety

BRU: CDVSA

Component: CDVSA

Sponsor: Senator Donley

Requestor: H Finance

COMPONENT SERIAL NO. 0521

EXPENDITURES/REVENUES: (Thousands of Dollars) (inflation not included)

OPERATING	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL EXPENDITURES	-0-	-0-	-0-	-0-	-0-	-0-
CHANGE IN REVENUES ( ) Revenue Code	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

Estimate of current year (FY 96) impact: $

POSITIONS

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact is anticipated to the Council at this time

Prepared By: Jayne E Andreen Phone: 907-465-4356

Division: Council on Domestic Violence and Sexual Assault Date: 4/19/96

Approved by Commissioner: [signature] Date: 4/19/96

Agency: Ronald L Otte, Dept of Public Safety

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adopted

AMENDMENT 1 by Mulder

OFFERED IN THE HOUSE FINANCE COMMITTEE
TO: HOUSE CS FOR CSSB 197(L&C)

Page 1, Line 6:
After "An insurer" insert the following language

"offering life, disability or health insurance in Alaska"

9-LS1218\W.1
Ford
4/10/96

AMENDMENT 2 failed

OFFERED IN THE HOUSE

TO: HCS CSSB 197(L&C)

Page 1, following line 14:

Insert a new subsection to read:

"(c) Records maintained by an insurer that identify as [redacted] the insured [redacted] a victim of domestic violence are confidential and may not be disclosed by an insurer except with the permission of the applicant or the insured or as authorized by a court of competent jurisdiction." or The Div of Insurance.

9-LS1218\W.2
Ford
4/10/96

AMENDMENT 3 Withdrawn

OFFERED IN THE HOUSE

TO: HCS CSSB 197(L&C)

Page 2, lines 1 - 7:

Delete all material and insert:

"Sec. 21.36.440. REQUIRED DISCLOSURE. An insurer who refuses to provide insurance coverage to an applicant or insured, or who cancels existing coverage shall provide a written explanation of the refusal or cancellation to the applicant or insured."

Adopted

9-LS1218\W.5
Ford
4/25/96

AMENDMENT 4

OFFERED IN THE HOUSE

TO: HCS CSSB 197(L&C)

Page 1, line 9:

Delete "applicant or insured"

Insert "person"

Page 1, line 13:

Delete "an insured or applicant"

Insert "a person"

9-LS1218\W.3
Ford
4/9/96

AMENDMENT Withdrawn

OFFERED IN THE HOUSE BY REPRESENTATIVE BROWN

TO: HCS CSSB 197(L&C)

Page 1, line 6:

Delete "(a)"

Page 1, lines 11 - 14:

Delete all material.

9-LS1218\W.4
Ford
4/9/96

W. McKinnon

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE BROWN

TO: HCS CSSB 197(L&C)

Page 1, following line 14:

Insert a new subsection to read:

"(c) An insurer may not underwrite or rate a medical condition as allowed under (b) of this section if the underwriting or rating adversely affects an applicant or insured who is a victim of domestic violence unless

(1) the insurer explains the reason for the underwriting or rating to the applicant or insured in writing; and

(2) the underwriting or rating

(A) does not have the purpose or effect of treating the existence of domestic violence as a medical condition or underwriting criterion;

(B) is not based on an actual or perceived correlation between a medical condition and domestic violence;

(C) is otherwise permitted by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition without regard to whether the condition or claim is related to domestic violence; and

(D) is based on a determination, made in conformance with sound actuarial principles and support by reasonable statistical evidence, that there is a correlation between the medical condition and a material increase in insurance risk."

SENATOR DAVE DONLEY

ALASKA STATE LEGISLATURE

Sponsor Statement

HCSSB 197(L&C)

Prohibiting Insurance Companies from Discriminating Against Victims of Domestic Violence

4/10/96

SB 197 unanimously passed the Senate on February 28th. SB 197 protects victims of domestic violence from insurance company discrimination such as refusing to provide coverage, from canceling a policy, and from increasing premiums only on the basis of domestic violence. SB 197 also requires upon written request of the applicant an insurer must disclose the reason insurance coverage was denied or cancelled.

SB197 was amended by the House Labor & Commerce Committee deleting a sub-section requiring confidentiality of records identifying an individual as a victim of domestic violence. The House Labor & Commerce Committee also added a sub-section further defining that this shall not prevent insurers from rating for medical conditions in the same manner as before.

SB 197 was drafted with the advise and support of the Division of Insurance.

The statutory provisions contained in SB 197 are necessary to protect victims of domestic violence. An informal survey by the Sub-Committee on Crime and Criminal Justice of the United States Judiciary Committee shows that eight out of sixteen of the largest insurance companies use domestic violence as a factor while rating insurance.

Eight states have passed legislation similar to SB 197 including Florida, Connecticut, Iowa, Delaware, California, New Jersey, Pennsylvania, and Massachusetts. Legislation similar to SB 197 passed California's legislature with only one opposing vote. There is legislation similar to SB 197 pending in six states and in Congress. Alaska's proactive measures follow the nation-wide trend by adopting legislation that protects innocent victims of domestic violence from insurance discrimination.

Currently, there is no protection in Alaska for victims of domestic violence against insurance premium increases, cancellation, or denial. SB 197 protects innocent victims of domestic violence from being unfairly discriminated against by insurance companies. Insurers discriminating against domestic violence victims has been a serious problem in the lower 48 and SB 197 will prevent similar occurrences in Alaska.

SB 197 is supported by Alaska's State Division of Insurance, Network on Domestic Violence and Sexual Assault, Council on Domestic Violence and Sexual Assault, Alaska Women's Resource Center, STAR Rape Crisis Center, WICCA, Alaska Women's Lobby, Abused Women's Aid in Crisis, Sitkans Against Family Violence, Alaska Council on Prevention of Alcohol and Drug Abuse, Inc., and Alaska Women's Political Caucus.

If you have any question regarding SB 197, please contact myself or Amber Ala of my staff at 465-3892.

January-May: STATE CAPITOL • JUNEAU, AK • 99801-1182 • (907) 465-3892 • FAX: (907) 465-6595
June-December: 716 W. 4TH AVE. • STE. 430 • ANCHORAGE, AK • 99501 • (907) 258-8181 • FAX: (907) 258-1648

MEMBER: Senate Finance Committee • Senate State Affairs Committee

4/25/96 pm Lorie Hagan SB 14

Advocates working to end violence against women encourage battered women to document their injuries by seeking medical care and by requesting that violent incidents be noted in their medical records

Health care providers, usually the first service professional and non-family member to have contact with women who have been abused, are in a unique position to identify victims of domestic violence.

Identification of abused women through routine screening and accurate diagnosis can break the cycle of violence. Early intervention can prevent or ameliorate many of the long-term health and social consequences associated with victimization.

1994, ANDVSA Medical Providers Booklet - currently revising to include Dental documentation + identification

1995, the Alaska Division of Public Health Section of Maternal, Child and Family Health received a three year grant to train medical professionals and develop sustainable training teams for continued training--only state project to be funded.

Nationally, the AMA, American College of Obstetrics and Gynecology, Am College of Physicians, Am Trauma Society, Am Assoc of Emergency Physicians, Am Academy of Family Physicians, the Nursing Network on Violence Against Women and others are also working to reduce injuries, prevent domestic violence and save lives by the development of professional medical educational materials addressing the care (including documentation) of battered women.

National Health Initiative-requires medical institutions to develop domestic violence protocols, plans for training and improving their facilities response to dv.

Battered women are finding the courage to reach out for medical care and documentation. Medical care-givers have become committed to the prevention of this lethal crime through identification, and documentation.

In the lower 48, they now know that doing the right and responsible thing may result not only in the loss of health insurance coverage but, other important protections such as life, disability and homeowners insurance.

The reality is that every woman is at risk of becoming a victim of domestic violence. Just as their is no excuse for domestic violence there is no excuse, legal or otherwise, for the insurance industry to justify and continue this discriminatory practice.

Separating from an abuser is a difficult and often dangerous process. Not being able to obtain health, homeowners, or automobile insurance means you can't afford to take your children to a doctor, you can't own or perhaps even rent a home, and you can't own a car--all are significant factors in being able to establish a life free from the violence. Insurance discrimination exacerbates the problem of obtaining freedom--adding one more hurdle which may be impossible to clear.

Surveys indicate that insurance discrimination against victims of domestic violence is widespread. An informal survey by the staff of the Subcommittee on Crime and Criminal Justice of the United States House Judiciary Committee in 1994, found eight out of the sixteen largest insurers in the country were using domestic violence as a factor when deciding whether to issue and how much to charge for an insurance policy.

In 1995, the Pennsylvania Insurance commissioner surveyed company 24% practices on a statewide basis. ~~Those~~ survey results showed that ~~20~~% of those insurers responding to the survey used domestic violence as an underwriting criterion for both new and renewal business.

Even more disturbing was the fact that despite the amount of public attention this problem has received, only 6 of the 437 responding companies had stopped using domestic violence as an underwriting criterion.

You may hear from insurers that this legislation inappropriately intrudes into the underwriting process and unfairly favors victims of domestic violence. We disagree. Insurance is a highly regulated business subject to prohibitions against discrimination based on classifications society deplores. Because we as a community have made a commitment to end domestic violence, it is appropriate and necessary to stop practices such as insurance discrimination, which undermine that commitment.

The Network is concerned with the HL&C version of this bill. A provision to hold confidential the records insurers may have documenting a consumer's domestic violence situation has been removed. The provision to allow consumers to know the reason for a denial of insurance has been changed to shift the onus from the insurers providing that information to the consumer who now must request the information in writing. And a provision was added to the bill to allow insurers to rate or underwrite based on a victim's medical condition.

Confidentiality of records is important to encourage victims to avail themselves of as many remedies including medical care and documentation as

possible. Knowing that revealing their status as a victim may jeopardize their ability to access services will prevent them for coming forward.

Disclosure should be a routine part of an insurers work with consumers. We do not accept the industry's claims that it would be cost prohibitive.

The medical conditions clause allows companies the latitude to continue their discrimination. Had insurers not created a special class called "victims of domestic violence" for underwriting and rating purposes, there would be no need for this legislation. To reiterate a point made earlier, *of the over 400 companies in Pennsylvania who were made aware of this discrimination only 6 chose to change their practices. Of the 8 out of 16 major national companies that practice this discrimination only 1 changed.* It seems the industry as a whole is not interested or willing to look at medical conditions without regard to cause.

The reality is that every woman is at risk of becoming a victim of domestic violence. Just as their is no excuse for domestic violence there is not excuse, legal or otherwise, for the insurance industry to justify and continue this discriminatory practice.

TESTIMONY OF TERRY FROMSON - Attorney, Women's Law Project (Philadelphia) Jcommy — 4/25/96

My name is Terry Fromson. I'm an attorney with the Women's Law Project in Philadelphia, a non-profit law office dedicated to improving the legal and economic status of women. I am here today as a NAIC consumer representative, and I'm grateful for the opportunity to have input on this important issue during this year.

I represent a woman in Pennsylvania who was denied insurance from two different insurance companies because of a 'so-called' history of domestic violence. She was denied life insurance, health insurance and mortgage disability insurance. She's not available today to tell you her story in her own words. Since she was denied insurance almost 2 years ago, she has lent herself to this effort, on behalf of herself and all battered individuals, to stop this practice. To tell you the truth, she's worn out from it. She simply cannot tell her story in public again, unfortunately, and I hope you will accept my words in her place.

She's a 25-year old woman who holds down two jobs and has a 5-year old daughter. Approximately two years ago following the family's departure from the family home, the death of the husband's father, the husband began drinking heavily. Arguments followed, and a physical incident occurred. Her husband pushed her--pushed her into a piece of furniture with a pointed object. She ended up having a gash that went through her clothing, through her hip, bruises on her body. She did what advocates for battered women advise you to do. She went to her doctor and she sought treatment. She asked her doctor very specifically to please record this information, both the nature of her injuries and the cause of her injuries, so that should she need help in the future, either for herself or for her daughter, she would have evidence to bring forward.

Unfortunately, she then proceeded to try and get a better deal on her life insurance. She felt she was being charged too much. She went to an insurance agent, and applications were filed for life insurance as well as health and mortgage disability. She received letters from both of those companies informing her that, based on medical records, which revealed a history of domestic violence, she was unable to be insured. To say the least, this shocked her, and only contributed to the upset she had been experiencing over her own personal situation.

She came to the Pennsylvania Coalition Against Domestic Violence, and the Coalition came to the Women's Law Project. We have been working together in an effort to overcome this problem. On her behalf, and on behalf of the class of similarly situated people, we filed a complaint with our state insurance department. In conjunction with the state insurance department, we have been working on legislation in our state. A bill was recently introduced, that we hope will pass, to amend the Unfair Insurance Practices Act--to specifically rule out this kind of behavior from insurance companies. Recently, I was pleased to receive a letter from the Insurance Department. They are undertaking a survey of insurance companies in our state to find out what their practices are.

I would, also, like to read from the Congressional Record of the Senate on March 9, 1995 when Senator Wellstone introduced a bill entitled, *Victims of Abuse Access to Health Insurance Act* because Mr. Wellstone describes three additional instances of discrimination that occurred in the state of Minnesota. So, if I could just read briefly from his statement. Senator Wellstone says: "In Minnesota, three insurance companies denied health insurance to an entire women's shelter because as a battered women's program, we were high risk." The women's shelter in Rochester was told that it was considered uninsureable because its employees are almost all battered women. A woman sought the services of Women House in St. Cloud because the abuse during her 12-year marriage had escalated to such an extent that she was hospitalized for a broken jaw and spent 2 weeks in a mental health unit of a hospital. She was, subsequently, denied coverage by two insurance companies. One said they would not cover any medical or psychiatric problems that could be related to past abuse.

I think these stories that you have heard this morning, both in my recounting and on the telephone, respond to the charge of the committee to assess the extent to which this problem exists. Unfortunately, we can't provide numbers to you; and there are good reasons for that. Domestic violence is a problem that has been shrouded in secrecy, not only because of the shame and emotional problems associated with it, but because of the fear of retaliation of coming forward. And, secondly, we simply have no access to the underwriting standards used by the insurance companies. But, we do have some information to go on.

In addition to the stories you have heard this morning, we know that there are a lot of victims of domestic violence. There are all kinds of statistics out there that have been collected since domestic violence became a public issue. In a recent 1994 survey, the Commonwealth Fund reported 4 million battered women in 1993. We know as a result of Congressman Shumer's efforts to survey the problem after my client came forward, the calls to 16 major companies in the United States revealed that 8 considered domestic violence an underwriting standard in both issuance and reading of policies. Now, while some of those insurance companies have modified their policy after Congressman Shumer's efforts, they still consider domestic violence a factor to be considered in what they are describing as the most serious and life threatening circumstances. Since I have no idea how they are determining which cases come under that category, and since it still leaves women at risk, I still think this is a problem. In addition, recently, I received a copy of a report from the Texas Office of Public Insurance Counsel, which, through state legislation, received the authority to request underwriting practices and survey them in their state. And they report that 12% of the companies surveyed decline coverage to low-income women because they understood that that group of women would have a higher risk of filing health claims.

What this shows is that companies are behaving on misperceptions about what domestic violence is. The companies that responded to Congressman Shumer that they were considering domestic violence a factor did so on two grounds. One, that this was a voluntary risk-taking activity on the part of women. This simply is not true, and it's something that domestic violence advocates have been trying to work on for a long time. Women are confined in these circumstances for all sorts of reasons, including economics, housing, children, and fear of retaliation. We know that the violence doesn't leave when you leave the household. We also know that domestic violence covers all kinds of people as an earlier witness testified. This is not a problem that is confined to any socio-economic class or race.

I am satisfied that this is a problem that needs to be addressed, and I hope that this committee can come forward and address it because I believe if it is allowed to persist, it will have an incredibly adverse effect both on the victims and the advocacy that we have been pursuing for the last 20 years.

Twenty years ago, this was not an issue anyone knew anything about. It is no longer shrouded in silence. States, the federal government, and non-profit organizations have worked hard to end domestic violence. They have created new legal protections, counseling services, treatment services--all kinds of help for victims of domestic violence. Advocates have worked with victims to come forward and take advantage of those services. If a victim now has to come forward to get help at the risk of losing insurance, which is devastating to someone who is in danger of physical injury--whose children are in danger of physical injury or in danger of losing their housing--they won't come forward, and we will be set back 20 years.

My client reported her injury just as she was supposed to, and it came back and hit her in the face. I don't know what she will do the next time she has to think about pursuing anything with her insurance company.

Domestic violence advocates have worked hard to educate people to the fact that domestic violence is a crime. Law enforcement personnel have treated it as a private matter. It is a crime; and, under the law, it should be treated that way. With respect to insurance companies, we would like them to understand that it is crime, also. It is not a medical condition. It is a crime, and it should not be used as a basis for denying or treating victims differently.

I would like to ask this committee to take a position opposing these practices--to encourage states to take action voluntarily, if they are able to under their existing legal framework, or to pursue a change in their law so that this practice is not allowed in their state. I would like to see you move forward wit the model legislation that was drafted. I've reviewed that legislation, and commented on it. It nee some fine tuning, in my opinion; but, I think it's a wonderful thing for the NAIC to do. I would like t see you support the federal legislation. There are know two bills pending. Senator Wellstone an Representative Wyden have raised this issue recently in Congress. I ask you to do everything that within your authority to do.

Thank you for the opportunity to testify today.

ALASKA NETWORK ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT

130 Seward Street, No. 501 • Juneau, Alaska 99801 • (907) 586-3650

Representative Mark Hanley
State Capitol (MS 3100)
Juneau, Alaska 99801-1182

April 18, 1996

Dear Representative Hanley:

The Network respectfully requests the scheduling of SB197 for the House Finance Committee's consideration. SB197 will prohibit insurers from discriminating against victims of domestic violence in rating and underwriting criteria decisions for issuing policies, canceling policies, denying benefits, or raising rates.

SB197's protections have been limited by amendments adopted by the House Labor and Commerce Committee. The Network supports the Senate version of the bill, and would appreciate the opportunity of providing testimony to the Finance Committee regarding our concerns.

Please find attached to this request a short list of reasons for supporting the provisions of the Senate version that were removed as well as a reason for opposing the medical conditions amendment that was added by HL&C; and, a small question and answer booklet about insurance discrimination toward victims of domestic violence.

The Network appreciates your support for the work of creating peace and ending domestic violence. We ask that support be extended to hearing SB197 as soon as possible and to consideration of restoring it to the Senate version. I am available to answer any questions you may have.

Sincerely,

Lauree Hugonin

Lauree Hugonin
Executive Director

ALASKA NETWORK ON
DOMESTIC VIOLENCE AND SEXUAL ASSAULT

We support the Senate version of SB197

The confidentiality clause is important in protecting the safety of victims and in ensuring they can seek assistance without the fear of losing their insurance.

Disclosure of reasons for denying insurance is important to assist the industry in choosing to not discriminate against victims of domestic violence. Informing consumers of the reasons for denial could be an automatic and routine matter for insurers. Consumers do not need to take an extra step of writing to ask for an explanation.

The medical conditions clause needs to be removed from the bill. It allows companies the latitude to continue their discrimination. Had insurers not created a special class called "victims of domestic violence" for underwriting and rating purposes, there would be no need for legislation. *Of the over 400 companies in Pennsylvania who were made aware of this discrimination only 6 chose to change their practices. Of the 8 out of 16 major national companies that practice this discrimination only 1 changed.* It seems the industry as a whole is not interested or willing to look at medical conditions without regard to cause.

Alaska needs to afford victims of domestic violence the fullest protections possible. Keeping insurers from discriminating against them is a significant step in ensuring victims are able to get and remain free from abuse.

JUNEAU EMPIRE

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Restore SB 197 protections

An important piece of legislation is moving through the Legislature. Senate Bill 197 would protect women who have been victims of domestic violence from being discriminated against by insurance companies. The bill would prohibit insurance companies from increasing insurance premiums, canceling or denying insurance on the basis of domestic violence.

We're not sure that this sort of insurance discrimination against women is a real problem in Alaska. The evidence may be somewhat anecdotal; insurance representatives argue that the problem is theoretical at best.

But we are sure that domestic violence itself is a problem: In 1994, approximately 4,884 Alaskan women were victims of domestic violence.

We're also sure that the failure of such legislation would send the wrong message to these women and others across the state.

Here is the current status of Senate Bill 197: It has passed out of the House Labor and Commerce Committee and is waiting to be discussed in House Finance. While it was in Labor and Commerce, some fundamental changes took place, which undermine the effectiveness of the bill as originally written.

The Labor and Commerce language allows insurance companies to share domestic violence information with nationally used data bases. This information sharing would mean a woman could escape an abusive relationship, but she could never truly leave her past behind in the eyes of insurance companies across the nation.

The original language also prevents insurance companies from disclosing information to alleged abusers. This becomes a matter of safety when a woman is filing a claim for either medical or property reasons. The bill as originally written prevents companies from approaching or confronting the alleged perpetrator with the confidential information. The reasoning behind this language is simple: Such disclosure could further endanger the woman.

We support the Senate version of the bill and encourage members of the House Finance Committee to carefully weigh merits of the requests of women's groups with those of the insurance industry.

Kenai-Soldotna Women's Resource & Crisis Center

March 20, 1996

Members of the House Labor & Commerce Committee:

Rep. Kott, Chair
Rep. Rokeberg, V. Chair
Rep. Porter
Rep. Sanders
Rep. Masek
Rep. Elton
Rep. Kubina

Dear Committee Members:

We support SB197. It is a proactive step in ensuring the insurance needs of Alaskan victims of domestic violence continue to be met.

Insurance discrimination against victims of abuse occurs on a widespread basis in the lower 48 and must not be allowed in Alaska.

Insurance discrimination puts victims at risk both by denying them the benefits that insurance provides and by discouraging them from seeking help that may cause them to lose their insurance.

No one asks to be beaten or abused. Domestic violence is a crime which permeates all races, religions, and economic classes. A person's "likelihood" of being a victim of a crime should not be used as a basis for underwriting insurance -- this mentality clearly places responsibility for criminal behavior on the victim, not the perpetrator. *To deny insurance to a victim of crime is unconscionable!*

<u>Please support SB197 as written, with no amendments!</u>

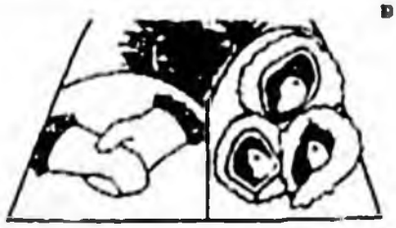
Thank you!

Sincerely,

Brenda G. Wiefferling
Executive Director

325 South Spruce Street
Kenai, Alaska 99611

Business Line . . . 283-9479
Crisis Line . . . 283-7257



Bering Sea Women's Group
A Safe Shelter for Women and Children
P.O. Box 1596 / Nome, Alaska 99762 / (907) 443-5444 or 1-800-570-5444 / (907) 443-5491

TRANSMITTAL COVER SHEET

Date: 3-20-96

To: Rep. Kott **Fax #:** 465 28 17

From: Bering Bouvia **Fax #:** 907-443-3748

Total page including the cover: 1

Comments:

I support SB 197. Please pass it out of the Committee in its current form.

Signature: Bering Bouvia

facsimile
TRANSMITTAL

[redacted]

to: Rep. Kott, Chair for (H)L&C
fax #: (907)465-2819
re: SB197
date: March 20, 1996
pages: 1 page(s) total, including this cover sheet

Please support SB197, as written, with no amendments. I am so pleased to see legislators writing proactive legislation!!! Protecting victims from insurance discrimination should definately be a priority to lawmakers and I'm happy to see you working towards that goal.

As I'm sure you are aware, insurance discrimation against victims of abuse occurs on a widespread basis in the lower 48 and must not be allowed in Alaska. SB197 would afford Alaska the opportunity to stop insurance discrimination before it starts.

Please share this message with the other members of your committee. I'll be looking forward to seeing this bill move forward for the protection of victims.

M.

From the desk of...

Michelle A. Callahan
Executive Director
USAFV
P.O. Box 36
Unalaska, AK 99685

tel: 907-581-1500
fax: 907-581-4000

NATIONAL UNDERWRITER: THE NATIONAL NEWSPAPER OF PROPERTY & CASUALTY INSURANCE AND RISK & BENEFITS MANAGEMENT - Published by the National Underwriter Co., Cincinnati, Ohio. MARCH 11, 1996

EDITORIAL COMMENT

Insurers Could Use Sensitivity Training

Insurance companies spend considerable sums of money attempting to convince the public of their sensitivity to the personal upheaval which can accompany a claim.

You are a victim of a crime or an accident. Your insurer is by your side in a flash with comforting words as well as the claim check, according to the cherished industry image of itself repeated in countless ad campaigns.

For at least one company in at least one instance, this is apparently not the case if the crime of which you are a victim is domestic abuse and your abuser figures in the claim you have filed.

According to a woman *National Underwriter* readers know only as "Vicki," claims adjusters at Farmers Ins. Co. of Washington not only treated her worse than shabbily after she filed a theft claim on her homeowners policy. They nearly got her killed by telling her abusive former boyfriend he was a suspect in the theft and that she had named him, according to Vicki, whose story was related in our Feb. 12 edition.

Vicki was lucky. Her abuser tried to kill her, but he only managed to put her in the hospital with serious injuries, she said. Vicki's allegations, if proven, mean those Farmers adjusters have blood on their hands.

At best, this is gross insensitivity by insurance company employees to the dangers with which victims of abuse live. We can only hope such instances are isolated. But whether widespread or isolated the stakes are high and demand *immediate action*.

Insurers need to move, and move quickly, to develop standards of conduct for employees who may come across professional situations involving victims of abuse. Particularly important is the need to take steps so company disclosures do not place an abuse victim in further physical jeopardy.

We agree with Washington Insurance Commissioner Deborah Senn and Terry Fromson, a staff attorney with the Women's Law Project, that enforceable insurance industry protocols need to be in place for dealing with professional situations involving victims of abuse.

But Ms. Senn and Ms. Fromson rightly acknowledge that legislative and regulatory measures are only part of the solution. They note that the industry itself has to assume some of the responsibility for educating and sensitizing its employees to the appropriate way of handling abuse victims professionally.

We agree. The industry has a moral and professional duty to ensure its employees are fully briefed in the appropriate way to conduct themselves so that, at the very least, their professional presence does not exacerbate situations where abuse is involved.

Insurer training documents and seminars for adjusters and underwriters should incorporate sections on the subject. And professional organizations of insurers and adjusters should put the subject on their meeting and continuing education agendas.

Aetna Life & Casualty's strategy of instructing employees to refer cases involving abuse victims "to a high level of authority in the department" where knowledge of an experience with such situations reside, as described by Steve Moskey, Aetna's director of consumer issues, is one solution with some merit.

But attitudes like those of the American Insurance Association that regulations or guide-lines for conduct should not apply to property casualty insurance because "it is just too problematic" are way off target.

Vicki's story proves that.

Domestic abuse is a barbarism which has survived in our modern society. It has rightly been universally condemned with no exceptions. It is unconscionable that any industry would try to justify any business practice which would economically penalize abuse victims simply because they are abuse victims, or would place them in further physical danger - in effect aiding and abetting the abuser.

Yet some in the insurance industry seek to do just this and others tacitly accept underwriting and other practices which further victimize abuse victims.

We urge insurers to take to heart their own ad copy and regard policyholders who are abuse victims as people who need their help rather than merely "claimants."

SB 197: "An Act prohibiting increases in health insurance premiums if the insured is a victim of domestic violence."

Some insurers have made a practice of increasing health insurance premiums based solely on the fact that the person was the victim of domestic violence directed against a spouse. This discriminatory practice has been widespread. A number of states have taken legislative action to prohibit such actions. The intent of this legislation is to prevent an insurer from increasing health insurance premiums solely because a person is a victim of spousal domestic abuse. The bill adds a section to AS 21.36 in the unfair trade practices statutes prohibiting this activity.

The department supports this legislation.

William L. Hensley, Commissioner

Date 1/24/96

WLH/JB/dgl/479pp.jb
012296a

WOMEN IN CRISIS

Counseling and Assistance

717 Ninth Avenue • Fairbanks, Alaska 99701

(907) 452-2293 • Fax: 452-2613 • 1-800-478-7273

April 17, 1996

The Honorable Mark Hanley, Co-Chair
House Finance Committee
State Capitol - Room 507
Juneau, AK 99801-1182

Dear Representative Hanley:

I am requesting that SB 197, "An Act prohibiting increases in health insurance if the insured is a victim of domestic violence" be heard by the House Finance Committee. This bill was intended to protect victims of domestic violence from being penalized with higher insurance premiums for being victims. This outrageous practice has occurred in other states and I hope we can prevent it here.

I am also requesting that the House Finance Committee approve the bill as it was passed out by the Senate. The amendments made by the House Labor & Commere Committee severely weaken the bill.

Thank you for your consideration.

Respectfully,

Sandy Samaniego
Executive Director

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF COMMERCE AND
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

P.O. BOX 110805
JUNEAU, ALASKA 99811-0805
PHONE: (907) 465-2515
FAX: (907) 465-3422
TDD: (907) 465-5437

February 16, 1996

The Honorable Tim Kelly
Chairman
Senate Labor & Commerce Committee
State Capitol, Room 101
Juneau, AK 99801-1182

Dear Senator Kelly:

Re: CS for SB 197 (9-LS1218\C Ford 2/15/96)

Thank you for the opportunity to testify last Thursday on SB 197, relating to insurance coverage for victims of domestic violence. I am aware of the kinds of responses that are occurring in other states to this issue. Typically, these responses tend to create a special class of persons as a means of addressing egregious action by a few insurers. The proposed committee substitute bill submitted by Senator Donley avoids this mistake while directly addressing the issue in a reasonable and workable manner.

This legislation makes the use of the fact that a person is a victim of domestic abuse, an unfair trade practice, while preserving the right to insurers to underwrite based on existing medical conditions. It avoids a mandate of coverage yet deals with the use of inappropriate information. The Division of Insurance supports this bill.

Sincerely,

Marianne K. Burke
Director

MKB/cw2378.ins
021696a
cc: Senator Donley

SB 197: "An Act prohibiting increases in health insurance premiums if the insured is a victim of domestic violence."

Some insurers have made a practice of increasing health insurance premiums based solely on the fact that the person was the victim of domestic violence directed against a spouse. This discriminatory practice has been widespread. A number of states have taken legislative action to prohibit such actions. The intent of this legislation is to prevent an insurer from increasing health insurance premiums solely because a person is a victim of spousal domestic abuse. The bill adds a section to AS 21.36 in the unfair trade practices statutes prohibiting this activity.

The department supports this legislation.

William L. Hensley, Commissioner

Date: 1/24/96

WLH/JB/dgV479pp jb
013295a

ALASKA WOMEN'S LOBBY
416 Harris Street, Suite 208, Juneau, Alaska 99801
(907) 463-6744 phone / (907) 586-2680 fax

14 February 1996

The Alaska Women's Lobby supports the passage of CSSB197 which relates to insurance coverage for a victim of domestic violence; and requires insurers who refuse coverage to an applicant or insured to provide a written explanation for that coverage.

The number of domestic violence victims who have been refused insurance coverage is a growing national problem.

We urge the passage of this bill which will remove one more traumatic barrier for victims of domestic violence.

Sincerely,

Leah L. Burton
for the Alaska Women's Lobby

Women In Safe Homes

P.O. Box 6552
Ketchikan, Alaska 99901
ADMINISTRATION: 907-225-0202
CRISIS LINE: 907-225-9474
FAX LINE: 907-225-2472

TELEFAX TRANSMITTAL SHEET

DATE: 3/20/96

FROM: Gigi Pilcher, Executive Director

TO: members of the House Labor and Commerce Committee

FAX NUMBER: _____

TOTAL # OF PAGES (including cover): 1.

MESSAGE: I urge your support of SB197 with no amendments.

HARD COPY TO FOLLOW: YES or NO