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8576 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

ARTICLE 5.
REINSTATEMENT OF PROFESSIONAL PRIVILEGES AFTER DISCIPLINE.

Section

230. Appearance required for reinstatement of professional privileges
240. Documentation of rehabilitation

12 AAC 60.230. APPEARANCE REQUIRED FOR REINSTATEMENT OF PROFESSIONAL PRIVILEGES. A person seeking reinstatement of professional privileges whose license has been revoked or suspended or whose authority to practice has been limited or conditioned shall appear in person before the board at a time and place designated by the board to determine the individual's present fitness.

12 AAC 60.240. DOCUMENTATION OF REHABILITATION. An applicant for reinstatement of professional privileges has the burden of satisfying the board that he or she is rehabilitated.

ARTICLE 6.
CONTINUING EDUCATION.

Section

250. Purpose of continuing education
260. Hours of continuing education required
270. Computation of continuing education hours
280. Computation of academic continuing education hours
290. Accepted subjects
300. Approved nonacademic continuing education programs
310. Individual study
320. Instructor or discussion leader
330. Publications and presentations
340. Reinstatement
350. Report of continuing education

12 AAC 60.250. PURPOSE OF CONTINUING EDUCATION. The purpose of continuing psychology education is to insure that the renewal of licenses is contingent upon proof of continued competency and assure the consumer of an optimum quality of psychological health care by requiring licensed psychologists and psychological associates to pursue education designed to enhance and advance their professional skills and knowledge.

12 AAC 60.260. HOURS OF CONTINUING EDUCATION REQUIRED. (a) An applicant for renewal of a license as a psychologist, or a psychological associate, originally issued before July 1, 1981, shall obtain 40 credit hours of documented continuing education before the June 30, 1985 application for renewal.

(b) Each psychologist or psychological associate seeking renewal of his or her license on or after July 1, 1985, must obtain an average of 20 credit hours per year of documented continuing education during the previous licensing period.

12 AAC 60.270. COMPUTATION OF CONTINUING EDUCATION HOURS. (a) For the purpose of computing continuing education credit, 50 minutes of instruction constitutes one hour.

(b) Credit is given only for full hours of instruction received and not for a fraction of an hour.

(c) Credit is given only for class attendance hours and not for hours devoted to class preparation.

(d) Continuing education credit is given for auditing an academic course.

12 AAC 60.280. COMPUTATION OF ACADEMIC CONTINUING EDUCATION HOURS. (a) One quarter hour academic credit from a college or university constitutes 10 hours of continuing education.

(b) One semester hour academic credit from a college or university constitutes 15 hours of continuing education.

(c) Auditing one quarter hour of academic credit constitutes eight hours of continuing education.

(d) Auditing one semester credit hour of academic credit constitutes 12 hours of continuing education.

12 AAC 60.290. ACCEPTED SUBJECTS. To be accepted by the board, the subject of a continuing education program must contribute directly to the professional competency of a person licensed to practice as a psychologist or a psychological associate and must be directly related to the concepts of psychological principles, ethics, or practices as defined in AS 08.86.230(6).

12 AAC 60.300. APPROVED NONACADEMIC CONTINUING EDUCATION PROGRAMS. The following programs are accepted by the board if they meet the requirements of 12 AAC 60.290:

(1) professional development programs of the American Psychological Association and its state societies including workshops, seminars, symposia, or a presentation of a technical paper;

(2) college or university short courses not carrying academic credit; and

(3) other professional continuing education programs if the following

information is supplied to the board:

(A) name and address of person or organization sponsoring the course;
(B) instructor's name;
(C) title of course;
(D) the number of full 50-minute hours of actual instruction;
(E) the location and dates the course was conducted.

12 AAC 60.310. INDIVIDUAL STUDY. (a) The number of hours of continuing education credit awarded for completion of a formal correspondence program, videotape program, audio-cassette program, or other individual study program which requires registration and provides evidence of satisfactory completion will be determined by the board on an individual basis.

(b) Credit awarded under this section may not exceed one half of the total hours required in any licensing renewal period.

12 AAC 60.320. INSTRUCTOR OR DISCUSSION LEADER. (a) One hour of continuing education credit will be awarded for each hour completed as an instructor or discussion leader of educational programs meeting the requirements of 12 AAC 60.250—12 AAC 60.310. Credit will be awarded only for the initial course of instruction of the subject matter, unless there have been substantially new developments in the subject since the prior presentation.

(b) Credit awarded under this section may not exceed one-third of the total hours required in any licensing renewal period.

12 AAC 60.330. PUBLICATIONS AND PRESENTATIONS. Twenty credit hours of continuing education will be awarded for each

(1) authorship of a publication in a professional psychology journal, providing the publication relates directly to the concepts of psychological principles, ethics or practices, and is published or accepted for publication during the four year reporting period immediately preceding the license renewal;

(2) written or oral presentation at a meeting of the American Psychological Association, a technical meeting of a state psychology society, or meeting of a professional psychology-oriented organization, providing the presentation relates directly to the concepts of psychological principles, ethics or practices, and the presentation occurred during the four-year reporting period immediately preceding the license renewal; or

(3) authorship of a professional psychology book or monograph published or accepted for publication during the four year reporting period immediately preceding the license renewal.

12 AAC 60.340. REINSTATEMENT. (a) The license of any licensee which is not renewed by reason of failure to comply with the continuing education requirements of 12 AAC 60.250—12 AAC 60.350, may be reinstated after

submission to the board of proof of the completion of all continuing education credit hours required.

(b) A licensee unable to obtain the required continuing education hours for license renewal, due to reasonable cause or excusable neglect, must request exemption status in writing to the board with a statement explaining the reasonable cause or excusable neglect. The board will, in its discretion, prescribe an alternative method of compliance with the continuing education requirements as the board considers appropriate to the individual situation.

12 AAC 60.350. REPORT OF CONTINUING EDUCATION. (a) An applicant for renewal of a license to practice psychology shall submit, on a form provided by the department, a sworn statement of the continuing education in which the applicant participated. The statement must indicate the following, if appropriate:

(1) the sponsoring organization;
(2) the location of the course or correspondent;
(3) the title or description of course or both;
(4) the principal instructor;
(5) the dates of attendance or period of correspondence;
(6) the titles, issues, and dates of publications or presentations; and
(7) the number of continuing education hours claimed.

(b) Falsification of any written evidence submitted to the board under this section is unprofessional conduct and constitutes grounds for censure, reprimand, or license revocation or suspension.

ARTICLE 7.
GENERAL PROVISIONS.

Section

900. Filing of addresses
910. Independent practice by psychological associate
990. Definitions

12 AAC 60.900. FILING OF ADDRESSES. Each person licensed under AS 08.86 shall file with the department his or her current mailing address and shall immediately report to the department at its Juneau office any change of address, giving both old and new address.

12 AAC 60.910. INDEPENDENT PRACTICE BY PSYCHOLOGICAL ASSOCIATE. (a) The board will certify a psychological associate licensed under this chapter to practice without supervision, under AS 08.86.164(c), if the psychological associate submits

(1) a written application on the form provided by the department;
(2) payment of the application fee required in 12 AAC 02.330;
(3) official college transcripts verifying at least 48 semester credit hours or 72 quarter credit hours of graduate study related to psychology which may include the hours earned during study for the master's degree required for licensure;
(4) documentation of the equivalent of five years of supervised psychological associate practice, as defined in 12 AAC 60.990(a), within the last 10 years, averaging at least 1,500 hours of supervised practice per year; and
(5) recommendations by the applicant's supervisor evaluating the clinical skills of the associate and recommending the associate for unsupervised practice;
(b) *Repealed 3/17/91.*
(c) Personal psychotherapy of the psychological associate may be included as supervised practice for 10 percent of the total supervised practice hours required.

12 AAC 60.990. DEFINITIONS. (a) In this chapter and AS 08.86:
(1) "accredited school" means a school which is accredited by any regional accrediting agency recognized by the American Association of Collegiate Registrars and Admissions Offices;
(2) "appropriate supervision" means supervision by a licensed psychologist who is responsible for insuring that the extent, kind, and quality of the psychological services performed are consistent with the training and experience of the supervised person and supervision that is consistent with
(A) the standards established in 12 AAC 60.185; or
(B) the alternate supervision plan accepted by the board under 12 AAC 60.080(c).
(3) "professional incompetence" means lacking sufficient knowledge, skills, or professional judgment in a field of practice in which a psychologist or psychological associate engages, to a degree likely to endanger the mental health or well-being of patients.
(4) "reasonable cause or excusable neglect" means:
(A) chronic illness;
(B) retirement;
(C) military service; and
(D) hardships as individually determined by the board.
(5) "technical meeting" means a professional meeting incorporating formal written or oral presentations of psychology related research, theory, or applied topics.

(6) "supervised practice" includes direct client contact and preparation for direct client contact, staff meetings, case conferences, report writing, co-therapy, in-service training, and psychodiagnostic assessment.

(b) As used in AS 08.86.204(8), "lewd conduct" includes any act of sexual abuse of or sexual relations with a patient, or sexual misconduct substantially related to the functions, duties, or qualifications of a psychologist or psychological associate.

CHAPTER 01. CENTRALIZED LICENSING.

Section

10. Applicability of chapter
20. Board organization
25. Public members
30. Quorum
35. Appointments and terms
40. Transportation and per diem
50. Administrative duties of department
60. Application for license
65. Establishment of fees
70. Administrative duties of boards
75. Disciplinary powers of boards
80. Department regulations
87. Investigative and enforcement powers of department
88. Conviction as grounds for disciplinary action
90. Applicability of the Administrative Procedure Act
100. License renewal, lapse and reinstatement
102. Citation for unlicensed practice or activity
103. Procedure and form of citation
104. Failure to obey citation
105. Penalty for improper payment
110. Definitions

Sec. 08.01.010. Applicability of chapter. This chapter applies to the

(1) Board of Public Accountancy (AS 08.04.010);

(2) State Board of Registration for Architects, Engineers and Land Surveyors (AS 08.48.011);

(3) Athletic Commission (AS 05.05 and AS 05.10);

(4) Board of Barbers and Hairdressers (AS 08.13.010);

(5) Big Game Commercial Services Board (AS 08.54.300);

(6) Board of Certified Direct-Entry Midwives (AS 08.65.010);

(7) Board of Certified Real Estate Appraisers (AS 08.87.010);

(8) Board of Chiropractic Examiners (AS 08.20.010);

(9) Board of Clinical Social Work Examiners (AS 08.95.010);

(10) Board of Dental Examiners (AS 08.36.010);

(11) Board of Dispensing Opticians (AS 08.71.010);

(12) Board of Electrical Examiners (AS 08.40.011);

(13) Board of Marine Pilots (AS 08.62.010);

(14) Board of Marital and Family Therapy (AS 08.63.010);

(15) Board of Mechanical Examiners (AS 08.40.220);

(16) State Medical Board (AS 08.64.010);

(17) Board of Nursing (AS 08.68.010);

(18) *[Repealed]*;

(19) Board of Examiners in Optometry (AS 08.72.010);
(20) Board of Pharmacy (AS 08.80.010);
(21) State Physical Therapy and Occupational Therapy Board (AS08.84.010);
(22) Board of Psychologist and Psychological Associate Examiners (AS 08.86.010);
(23) Real Estate Commission (AS 08.88.011);
(24) Board of Veterinary Examiners (AS 08.98.010);
(25) regulation of acupuncturists under AS 08.06;
(26) regulation of audiologists under AS 08.11;
(27) regulation of business licenses under AS 43.70;
(28) regulation of collection agencies under AS 08.24;
(29) regulation of concert promoters under AS 08.92;
(30) regulation of construction contractors under AS 08.18;
(31) regulation of electrical and mechanical administration under AS 08.40;
(32) regulation of professional geologists under AS 08.02.011;
(33) regulation of hearing aid dealers under AS 08.55;
(34) regulation of morticians under AS 08.42;
(35) regulation of the practice of naturopathy under AS 08.45;
(36) regulation of nursing home administrators under AS 08.70.

Sec. 08.01.020. Board organization. Board members are appointed by the governor and serve at the pleasure of the governor. Unless otherwise provided, the governor may designate the chair of a board, and all other officers shall be elected by the board members. Unless otherwise provided, officers of a board are the chair and the secretary. A board may provide by regulation that three or more unexcused absences from meetings are cause for removal.

Sec. 08.01.025. Public members. A public member of a board may not:
(1) be engaged in the occupation that the board regulates;
(2) be associated by legal contract with a member of the occupation that the board regulates except as a consumer of the services provided by a practitioner of the occupation; or
(3) have a direct financial interest in the occupation that the board regulates.

Sec. 08.01.030. Quorum. A majority of the membership of a board constitutes a quorum unless otherwise provided.

Sec. 08.01.035. Appointments and terms. Members of boards subject to this chapter are appointed for staggered terms of four years. A member of a board serves until a successor is appointed. An appointment to fill a vacancy on a board is for the remainder of the unexpired term. A member who has served all or part of two successive terms on a board may not be reappointed to that board unless four years have elapsed since the person has last served on the board.

Sec. 08.01.040. Transportation and per diem. A board member is entitled to transportation expenses and per diem as set out in AS 39.20.180.

Sec. 08.01.050. Administrative duties of department. (a) The department shall perform the following administrative and budgetary services when appropriate:

(1) collect and record fees;

(2) maintain records and files;

(3) issue and receive application forms;

(4) notify applicants of acceptance or rejection as determined by the board or as determined by the department under AS 08.06 for acupuncturists, under AS 08.11 for audiologists, under AS 08.18 for contractors, under AS 08.40 for electrical and mechanical administrators, under AS 08.45 for naturopaths, under AS 08.55 for hearing aid dealers, or under AS 08.70 for nursing home administrators;

(5) designate dates examinations are to be held and notify applicants;

(6) publish notice of examinations and proceedings;

(7) arrange space for holding examinations and proceedings;

(8) notify applicants of results of examinations;

(9) issue licenses or temporary licenses as authorized by the board or as authorized by the department under AS 08.06 for acupuncturists, under AS 08.11 for audiologists, under AS 08.18 for contractors, under AS 08.40 for electrical and mechanical administrators, under AS 08.45 for naturopaths, under AS 08.55 for hearing aid dealers, or under AS 08.70 for nursing home administrators;

(10) issue duplicate licenses upon submission of a written request by the licensee attesting to loss of or the failure to receive the original and payment by the licensee of a fee established by regulation adopted by the department;

(11) notify licensees of renewal dates at least 30 days before the expiration date of their licenses;

(12) compile and maintain a current register of licensees;

(13) answer routine inquiries;

(14) maintain files relating to individual licensees;

(15) arrange for printing and advertising;

(16) purchase supplies;

(17) employ additional help when needed;

(18) perform other services that may be requested by the board;

(19) provide inspection, enforcement, and investigative services to the boards and for the occupations listed in AS 08.01.010, regarding all licenses issued by or through the department;

(20) retain and safeguard the official seal of a board and prepare, sign, and affix a board seal, as appropriate, for licenses approved by a board;

(21) issue business licenses under AS 43.70.

(b) The form and content of a license, authorized by a board listed in AS 08.01.010, including any document evidencing renewal of a license, shall be determined by the department after consultation with and consideration of the views of the board concerned.

(c) *[Repealed 1987]*

(d) At the request of one of the following boards, the department may contract with public agencies and private professional organizations to provide assistance and treatment to persons licensed by the board who abuse alcohol, other drugs, or other substances:

(1) Board of Clinical Social Work Examiners;
(2) Board of Dental Examiners;
(3) Board of Dispensing Opticians;
(4) State Medical Board;
(5) Board of Nursing;
(6) Board of Examiners in Optometry;
(7) Board of Pharmacy;
(8) State Physical Therapy and Occupational Therapy Board;
(9) Board of Psychologist and Psychological Associate Examiners; and
(10) Board of Veterinary Examiners.

Sec. 08.01.060. Application for license. All applications for examination or licensing to engage in the business or profession covered by this chapter shall be made in writing to the department.

Sec. 08.01.065. Establishment of fees. (a) Except for business licenses, the department shall adopt regulations that establish the amount and manner of payment of application fees, examination fees, license fees, registration fees, permit fees, investigation fees, and all other fees as appropriate for the occupations covered by this chapter.

(b) *[Repealed 1992]*

(c) The department shall establish fee levels under (a) of this section so that the total amount of fees collected for an occupation approximately equals the actual regulatory costs for the occupation. The department shall annually review each fee level to determine whether the regulatory costs of each occupation are approximately equal to fee collections related to that occupation. If the review indicates that an occupation's fee collections and regulatory costs are not approximately equal, the department shall calculate fee adjustments and adopt regulations under (a) of this section to implement the adjustments. In January of each year, the department shall report on all fee levels and revisions for the previous year under this subsection to the office of management and budget. If a board regulates an occupation covered by this chapter, the department shall consider the board's recommendations concerning the occupation's fee levels and regulatory costs before revising fee schedules to comply with this subsection. In this subsection, "regulatory costs" means costs of the department that are attributable to regulation of an occupation plus

(1) all expenses of the board that regulates the occupation if the board regulates only one occupation;

(2) the expenses of a board that are attributable to the occupation if the board regulates more than one occupation.

(d) The license fee for a business license is set by AS 43.70.030(a). The department shall adopt regulations that establish the manner of payment of the license fee.

Sec. 08.01.070. Administrative duties of boards. Each board shall perform the following duties in addition to those provided in its respective law:

(1) take minutes and records of all proceedings;

(2) hold a minimum of one meeting each year;

(3) hold at least one examination each year;

(4) request, through the department, investigation of violations of its laws and regulations;

(5) prepare and grade board examinations;

(6) set minimum qualifications for applicants for examination and license;

(7) forward a draft of the minutes of proceedings to the department within 20 days after the proceedings;

(8) forward results of board examinations to the department within 20 days after the examination is given;

(9) notify the department of meeting dates and agenda items at least 15 days before meetings and other proceedings are held;

(10) submit before the end of the fiscal year an annual performance report to the department stating the board's accomplishments, activities, and needs.

Sec. 08.01.075. Disciplinary powers of boards. (a) A board may take the following disciplinary actions, singly or in combination:

(1) permanently revoke a license;

(2) suspend a license for a specified period;

(3) censure or reprimand a licensee;

(4) impose limitations or conditions on the professional practice of a licensee;

(5) require a licensee to submit to peer review;

(6) impose requirements for remedial professional education to correct deficiencies in the education, training, and skill of the licensee;

(7) impose probation requiring a licensee to report regularly to the board on matters related to the grounds for probation;

(8) impose a civil fine not to exceed $5,000.

(b) A board may withdraw probationary status if the deficiencies that required the sanction are remedied.

(c) A board may summarily suspend a licensee from the practice of the profession before a final hearing is held or during an appeal if the board finds that the licensee poses a clear and immediate danger to the public health and safety.

A person is entitled to a hearing before the board to appeal the summary suspension within seven days after the order of suspension is issued. A person may appeal an adverse decision of the board on an appeal of a summary suspension to a court of competent jurisdiction.

(d) A board may reinstate a suspended or revoked license if, after a hearing, the board finds that the applicant is able to practice the profession with skill and safety.

(e) A board may accept the voluntary surrender of a license. A license may not be returned unless the board determines that the licensee is competent to resume practice and the licensee pays the appropriate renewal fee.

(f) A board shall seek consistency in the application of disciplinary sanctions. A board shall explain a significant departure from prior decisions involving similar facts in the order imposing the sanction.

Sec. 08.01.080. Department regulations. The department shall adopt regulations to carry out the purposes of this chapter including but not limited to describing

(1) how an examination is to be conducted;

(2) what is contained in application forms;

(3) how a person applies for an examination or license.

Sec. 08.01.087. Investigative and enforcement powers of department. (a) The department may, upon its own motion, conduct investigations

(1) to determine whether a person has violated a provision of this chapter or a regulation adopted under it, or a provision of AS 43.70, or a provision of this title or regulation adopted under this title dealing with an occupation or board listed in AS 08.01.010; or

(2) to secure information useful in the administration of this chapter.

(b) If it appears to the commissioner that a person has engaged in or is about to engage in an act or practice in violation of a provision of this chapter or a regulation adopted under it, or a provision of AS 43.70, or a provision of this title or regulation adopted under this title dealing with an occupation or board listed in AS 08.01.010, the commissioner may, if the commissioner considers it in the public interest, and after notification of a proposed order or action by telephone, telegraph, or facsimile to all board members, if a board regulates the act or practice involved, unless a majority of the members of the board object within 10 days,

(1) issue an order directing the person to stop the act or practice; however, reasonable notice of and an opportunity for a hearing must first be given to the person, except that the commissioner may issue a temporary order before a hearing is held; a temporary order remains in effect until a final order affirming, modifying, or reversing the temporary order is issued or until 15 days after the person receives the notice and has not requested a hearing by that time; a temporary order becomes final if the person to whom the notice is

addressed does not request a hearing within 15 days after receiving the notice; the commissioner or the commissioner's designee shall be the hearing officer at the hearing and shall issue a final order within 10 days after the hearing;

(2) bring an action in the superior court to enjoin the acts or practices and to enforce compliance with this chapter, a regulation adopted under it, an order issued under it, or with a provision of this title or regulation adopted under this title dealing with business licenses or an occupation or board listed in AS 08.01.010;

(3) examine or have examined the books and records of a person whose business activities require a business license or licensure by a board listed in AS 08.01.010, or whose occupation is listed in AS 08.01.010; the commissioner may require the person to pay the reasonable costs of the examination; and

(4) issue subpoenas for the attendance of witnesses, and the production of books, records, and other documents.

Sec. 08.01.088. Conviction as grounds for disciplinary action. Notwithstanding any other provision of this title, the conviction under AS 47.24.010 or 47.24.110 of a person licensed, certified, or regulated by the department or a board under this title may be considered by the department or board as grounds for disciplinary proceedings or sanctions.

Sec. 08.01.090. Applicability of the Administrative Procedure Act. The Administrative Procedure Act (AS 44.62) applies to regulations adopted and proceedings held under this chapter, except those under AS 08.01.087(b).

Sec. 08.01.100. License renewal, lapse and reinstatement. (a) Licenses shall be renewed biennially on the dates set by the department with the approval of the respective board.

(b) A license subject to renewal shall be renewed on or before the date set by the department. If the license is not renewed by the date set by the department, the license lapses. In addition to renewal fees required for reinstatement of the lapsed license, the department may impose a delayed renewal penalty, established by regulation, that shall be paid before a license that has been lapsed for more than 60 days may be renewed. The department may adopt a delayed renewal penalty only with the concurrence of the appropriate board.

(c) When continuing education or other requirements are made a condition of license renewal, the requirements shall be satisfied before a license is renewed.

(d) Except as otherwise provided, a license may not be renewed if it has been lapsed for five years or more.

Sec. 08.01.102. Citation for unlicensed practice or activity. The department may issue a citation for a violation of a license requirement under this

chapter or AS 43.70 if there is probable cause to believe a person has practiced a profession or engaged in business for which a license is required without holding the license. Each day a violation continues after a citation for the violation has been issued constitutes a separate violation.

Sec. 08.01.103. Procedure and form of citation. (a) A citation issued under AS 08.01.102 must be in writing. A person receiving the citation is not required to sign a notice to appear in court.

(b) The time specified in the notice to appear on a citation issued under AS 08.01.102 shall be at least five days, not including weekends and holidays, after the issuance of the citation, unless the person cited requests an earlier hearing.

(c) The department is responsible for the issuance of books containing appropriate citations, and shall maintain a record of each book issued and each citation contained in it. The department shall require and retain a receipt for every book issued to an employee of the department.

(d) The department shall deposit the original or a copy of the citation with a court having jurisdiction over the alleged offense. Upon its deposit with the court, the citation may be disposed of only by trial in the court or other official action taken by the magistrate, judge, or prosecutor. The department may not dispose of a citation, copies of it, or of the record of its issuance except as required under this subsection and (e) of this section.

(e) The department shall require the return of a copy of every citation issued by the department and all copies of a citation that has been spoiled or upon which an entry has been made and not issued to an alleged violator. The department shall also maintain, in connection with each citation, a record of the disposition of the charge by the court where the original or copy of the citation was deposited.

(f) If the form of citation includes the essential facts constituting the offense charged, and if the citation is sworn to as required under the laws of this state for a complaint charging commission of the offense alleged in the citation, then the citation when filed with a court having jurisdiction is considered to be a lawful complaint for the purpose of prosecution.

Sec. 08.01.104. Failure to obey citation. Unless the citation has been voided or otherwise dismissed by the magistrate, judge, or prosecutor, a person who without lawful justification or excuse fails to appear in court to answer a citation issued under AS 08.01.102, regardless of the disposition of the charge for which the citation was issued, is guilty of a class B misdemeanor.

Sec. 08.01.105. Penalty for improper payment. An applicant shall pay a penalty of $10 each time a negotiable instrument is presented to the department in payment of an amount due and payment is subsequently refused by the named payor.

Sec. 08.01.110. Definitions. In this chapter

(1) "board" includes the boards and commissions listed in AS 08.01.010;

(2) "commissioner" means the commissioner of commerce and economic development;

(3) "department" means the Department of Commerce and Economic Development;

(4) "license" means a business license or a license, certificate, permit, or registration or similar evidence of authority issued for an occupation by the department or by one of the boards listed in AS 08.01.010;

(5) "licensee" means a person who holds a license;

(6) "occupation" means a trade or profession listed in AS 08.01.010.

CHAPTER 02.
MISCELLANEOUS PROVISIONS.

Section

10. Professional designation requirements
11. Professional geologist
20. Limitation of liability
25. Compliance with student loan requirements
30. Courtesy licenses

Sec. 08.02.010. Professional designation requirements. (a) An acupuncturist licensed under AS 08.06, an audiologist licensed under AS 08.11, a person licensed in the state as a chiropractor under AS 08.20, a dentist under AS 08.36, a marital and family therapist licensed under AS 08.63, a medical practitioner or osteopath under AS 08.64, a direct-entry midwife certified under AS 08.65, a registered nurse under AS 08.68, an optometrist under AS 08.72, a registered pharmacist under AS 08.80, a physical therapist or occupational therapist licensed under AS 08.84, a psychologist under AS 08.86, or a clinical social worker licensed under AS 08.95, shall use as professional identification appropriate letters or a title after that person's name which represents that person's specific field of practice. The letters or title shall appear on all signs, stationery, or other advertising in which the person offers or displays personal professional services to the public. In addition, a person engaged in the practice of medicine or osteopathy as defined in AS 08.64.380, or a person engaged in any manner in the healing arts who diagnoses, treats, tests, or counsels other persons in relation to human health or disease and uses the letters "M.D." or the title "doctor" or "physician" or another title that tends to show that the person is willing or qualified to diagnose, treat, test, or counsel another person, shall clarify the letters or title by adding the appropriate specialist designation, if any, such as "dermatologist", "radiologist", "audiologist", "naturopath", or the like.

(b) A person subject to (a) of this section who fails to comply with the requirements of (a) of this section shall be given notice of noncompliance by

that person's appropriate licensing board. If, after a reasonable time, with opportunity for a hearing, the person's noncompliance continues, the board may suspend or revoke the person's license or registration, or administer other disciplinary action which in its determination is appropriate.

Sec. 08.02.011. Professional geologist. The commissioner of commerce and economic development shall certify an applicant as a professional geologist if the applicant is certified as a professional geologist by the American Institute of Professional Geologists.

Sec. 08.02.020. Limitation of liability. An action may not be brought against a person for damages resulting from

(1) the person's good faith performance of a duty, function, or activity required as

(A) a member of, or witness before, a licensing board or peer review committee established to review a licensing matter;

(B) a member of a committee appointed under AS 08.64.336(c);

(C) a contractor or agent of a contractor under AS 08.01.050(d) or AS 08.64.101(6);

(2) a recommendation or action in accordance with the prescribed duties of a licensing board, peer review committee established to review a licensing matter, committee appointed under AS 08.64.336(c), or contractor or agent of a contractor under AS 08.01.050(d) or AS 08.64.101(6) when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person, board, peer review committee, committee appointed under AS 08.64.336(c), or contractor or agent of the contractor under AS 08.01.050(d) or AS 08.64.101(6) after reasonable efforts to ascertain the facts upon which the action or recommendation is made; or

(3) a report made in good faith to a public agency by the person, or participation by the person in an investigation by a public agency or a judicial or administrative proceeding relating to the report, if the report relates to the abuse of alcohol, other drugs, or other substances by a person licensed by a board listed in AS 08.01.050(d).

Sec. 08.02.025. Compliance with student loan requirements. (a) A person licensed under this title shall comply with the student loan repayment provisions under AS 14.43 that are applicable to the person. Notwithstanding another provision of law, a license issued to a person under this title may not be renewed if the borrower and the Department of Commerce and Economic Development have received notice from the Alaska Commission on Postsecondary Education that the licensee is in default on a student loan provided to the

licensee. This action may be taken no sooner than 60 days after the Alaska Commission on Postsecondary Education has notified the borrower of the default status of the loan as provided under AS 14.43.120(i). If an appeal of a determination of default status is pending on behalf of the licensee, the Alaska Commission on Postsecondary Education shall notify the department and renewal may not be denied under this section until and unless the appeal has been concluded and the default status affirmed. Denial of renewal of a license shall continue until the Department of Commerce and Economic Development receives notice from the Alaska Commission on Postsecondary Education that the licensee is no longer in default on the student loan.

(b) The Department of Commerce and Economic Development shall provide the applicable licensing board, if any, a copy of a notice received under (a) of this section.

Sec. 08.02.030. Courtesy licenses. (a) A board established under this title and the Department of Commerce and Economic Development, with respect to an occupation that it regulates under this title, may by regulation establish criteria for issuing a temporary courtesy license to nonresidents who enter the state so that, on a temporary basis, they may practice the occupation regulated by the board or the department.

(b) The regulations adopted under (a) of this section may include limitations relating to the

(1) duration of the license's validity;

(2) scope of practice allowed under the license; and

(3) other matters considered important by the board or the department.

CHAPTER 03.
TERMINATION, CONTINUATION AND REESTABLISHMENT OF REGULATORY BOARDS.

Section

10. Termination dates for regulatory boards
20. Procedures governing termination, transition and continuation

Sec. 08.03.010. Termination dates for regulatory boards.

(a) *[Repealed]*

(b) *[Repealed]*

(c) The following boards have the termination date provided by this subsection:

(1) Board of Public Accountancy (AS 08.04.010)—June 30, 1997;

(2) Board of Governors of the Alaska Bar Association (AS 08.08.040)—June 30, 1993;

(3) State Board of Registration for Architects, Engineers and Land Surveyors (AS 08.48.011)—June 30, 1997;

(4) Board of Barbers and Hairdressers (AS 08.13.010)—June 30, 1997;
(5) Big Game Commercial Services Board (AS 08.54.300)—June 30, 1994;
(6) Board of Certified Direct-Entry Midwives (AS 08.65.010)—June 30, 1998;
(7) Board of Certified Real Estate Appraisers (AS 08.87.010)—June 30, 1998;
(8) Board of Chiropractic Examiners (AS 08.20.010)—June 30, 1996;
(9) Board of Clinical Social Work Examiners (AS 08.95.010)—June 30, 2005;
(10) Board of Dental Examiners (AS 08.36.010)—June 30, 1997;
(11) Board of Dispensing Opticians (AS 08.71.010)—June 30, 1996;
(12) *[Repealed]*
(13) Board of Marine Pilots (AS 08.62.010)—June 30, 1999;
(14) Board of Marital and Family Therapy (AS 08.63.010)—June 30, 2005;
(15) *[Repealed]*
(16) State Medical Board (AS 08.64.010)—June 30, 2003;
(17) Board of Nursing (AS 08.68.010)—June 30, 2003;
(18) *[Repealed]*
(19) Board of Examiners in Optometry (AS 08.72.010)—June 30, 1996;
(20) Board of Pharmacy (AS 08.80.010)—June 30, 1999;
(21) State Physical Therapy and Occupational Therapy Board (AS 08.84.010)—June 30, 1997;
(22) Board of Psychologist and Psychological Associate Examiners (AS 08.86.010)—June 30, 2005;
(23) Real Estate Commission (AS 08.88.011)—June 30, 2004;
(24) Board of Veterinary Examiners (AS 08.98.010)—June 30, 1997.

Sec. 08.03.020. Procedures governing termination, transition and continuation. (a) Upon termination, each board listed in AS 08.03.010 shall continue in existence until June 30 of the next succeeding year for the purpose of concluding its affairs. During this period, termination does not reduce or otherwise limit the powers or authority of each board. One year after the date of termination, a board not continued shall cease all activities.

(b) The termination, dissolution, continuation or reestablishment of a regulatory board shall be governed by the legislative oversight procedures of AS 44.66.050.

(c) A board scheduled for termination under this chapter may be continued or reestablished by the legislature for a period not to exceed four years unless the board is continued or reestablished for a longer period under AS 08.03.010.

CHAPTER 02.
DIVISION OF OCCUPATIONAL LICENSING

Article

1. **Collection of Fees (12 AAC 02.010 — 12 AAC 02.030)**
2. **Occupational Licensing Fees (12 AAC 02.100 — 12 AAC 02.360)**
3. **Examination Review Procedures (12 AAC 02.400)**
4. **General Provisions (12 AAC 02.900 — 12 AAC 02.990)**

ARTICLE 1.
COLLECTION OF FEES

Section

10. Licensing and renewal fees
20. Prorating renewal fees
30. Prorating initial renewal fees

12 AAC 02.010. LICENSING AND RENEWAL FEES. (a) The department will collect fees and issue receipts for licensing and for license renewal for the boards listed in AS 08.01.010.

(b) The department will not issue a license or renew a license unless the applicable fees established in AS 08 or in this chapter have been collected, and a receipt has been prepared.

(c) Except as otherwise provided in this title, an application for initial licensure or renewal of license will be considered filed as of the filing date of the document, as determined by 12 AAC 02.920.

(d) *Repealed 5/4/90.*

(e) An application fee is not refundable.

12 AAC 02.020. PRORATING RENEWAL FEES. The department will prorate the first license renewal fees following initial licensure, in accordance with 12 AAC 02.030. All renewal fees, including penalty and delinquent fees must be paid by the licensee applying for renewal of a license, except as provided in 12 AAC 02.030(a)(1) and (b)(1).

12 AAC 02.030. PRORATING INITIAL RENEWAL FEES. (a) When the department issues an initial biennial license

(1) within the 90 days before the date by which it must be renewed, the applicant shall pay the entire license fee but is not required

to pay the prescribed renewal fee until the second renewal date;

(2) within the 12 months before the date by which the license must be renewed, the applicant shall pay the entire license fee, and shall pay one-half of the prescribed renewal fee at the time of renewal; or

(3) more than 12 months before the date by which the license must be renewed, the applicant shall pay the entire license fee, and shall pay the entire prescribed renewal fee at the time of renewal.

(b) When the department issues an initial annual license

(1) within the 90 days before the date by which it must be renewed, the applicant shall pay the entire license fee but is not required to pay the prescribed renewal fee until the second renewal date;

(2) within the six months before the date by which the license must be renewed, the applicant shall pay the entire license fee, and shall pay one-half of the prescribed renewal fee at the time of renewal; or

(3) more than six months before the date by which the license must be renewed, the applicant shall pay the entire license fee, and shall pay the entire prescribed renewal fee at the time of renewal.

(c) A quadrennial license issued before July 1, 1987 shall be renewed by the department as a biennial license upon payment of the entire prescribed biennial license renewal fee.

(d) The department will not prorate renewal fees if the initial licensing fee was $150 or less.

(e) The department will not prorate fees for applications, examinations, reexaminations, credential review or investigation, temporary or emergency permits, locum tenens permits, certificates, or other such fees established in AS 08 or in this chapter.

ARTICLE 2.
OCCUPATIONAL LICENSING FEES

Section

100. Fees established by department
105. Administrative fees
330. Board of psychologist and psychological associate examiners

12 AAC 02.100. FEES ESTABLISHED BY DEPARTMENT. The fees established in this chapter have been adopted by the department after considering any recommendations of the applicable board or commission listed in AS 08.01.010.

12 AAC 02.105. ADMINISTRATIVE FEES. Except as otherwise provided in this chapter for a particular board or occupation, the following fees apply to all boards and professions listed in AS 08.01.010:

(1) duplicate license fee, $5;

(2) fee for verification or certification of an Alaska license, registration, or examination, $20;

(3) name change, except for construction contractors, $5;

(4) photocopy fee, $.25 per page, which may be waived by the department if the total fee is less than $5;

(5) facsimile fee, $1 per page, which may be waived by the department if the total fee is less than $5;

(6) returned check fee, $20;

(7) penalty for reinstatement of a registration, license, permit or certificate which remains lapsed for more than 60 days, $50;

(8) exam postponement fee, $25;

(9) wall certificate fee, $20;

(10) fee for proctoring an examination for another state's applicant, $50;

(11) fee for specialized report of licensing data, $100 plus the cost of supplies;

(12) express delivery handling fee, $20; and

(13) fee for providing a roster of

(A) 1,500 or less licensees, $5;

(B) more than 1,500 licensees, $10;

(C) current business licenses. $100.

12 AAC 02.330. BOARD OF PSYCHOLOGIST AND PSYCHOLOGICAL ASSOCIATE EXAMINERS. The following fees are established for psychologists and psychological associates:

(1) nonrefundable application fee for initial license, $50;

(2) national examination fee, $275;

(3) credential review fee, $50;

(4) psychologist license for all or part of the initial biennial licensing period, $700;

(5) psychologist biennial license renewal fee, $700;

(6) temporary license fee, $150;

(7) psychological associate license fee for all or part of the initial biennial licensing period, $550;

(8) psychological associate biennial license renewal fee, $550;

(9) state examination fee, $50.

ARTICLE 3.
EXAMINATION REVIEW PROCEDURES

Section
400. Examination review

12 AAC 02.400. EXAMINATION REVIEW. (a) For nationally prepared and administered examinations, the examination review procedures established by the national examination organization will be used in conjunction with the procedures established in this section. National examinations which have no provision for examination review are not available for review under this section.

(b) An applicant who wishes to review a failed examination shall submit a written request to the division within 30 days after the notice of examination results was mailed to the applicant.

(c) All examination reviews will be conducted in the presence of division staff at the time and location determined by the division. An examination review will not be conducted within 30 days of the next examination the applicant is scheduled to take.

(d) Only an applicant who has failed an examination may participate in the examination review and the applicant may review only his or her own examination.

(e) An applicant may use the same reference materials during an examination review that were allowed during the examination itself, but applicants may not use other materials or take notes or make copies of any kind. All materials brought to an examination review are subject to inspection by the division staff.

ARTICLE 4.
GENERAL PROVISIONS

Section
900. Current address
910. Abandoned applications
920. Filing date
940. Effective date of renewed licenses
990. Definitions

12 AAC 02.900. CURRENT ADDRESS. A person licensed, registered, or certified by a board or commission listed in AS 08.01.010, or in an occupation listed in AS 08.01.010, shall maintain a current, valid, mailing address on file with the division at all times. The latest mailing address on file with the division is the address that will be used for

official communications, notifications, and service of legal process.

12 AAC 02.910. ABANDONED APPLICATIONS. (a) An application is considered abandoned when

(1) 12 months have elapsed since correspondence was last received from or on behalf of the applicant; or

(2) the applicant has failed to appear for two successive examinations.

(b) An abandoned application is denied without prejudice and the application fee forfeited.

(c) At the time an application is considered abandoned, the division will send notification of abandonment to the last known address of the applicant. An applicant may request a refund of all unused examination and licensing fees credited to the application by submitting a written request for refund within 30 days from the date notification of abandonment was mailed by the division. If no request for refund is received, all fees are forfeited.

12 AAC 02.920. FILING DATE. (a) Except as otherwise provided in this title, a document submitted to the division will be considered filed as of the postmark date of the document. If the document is submitted by a method that does not provide a postmark date, the document will be considered filed as of the date stamped on the document, when it is received in the division office.

(b) For the purposes of this section, "postmark date" means the date a document with prepaid postage and correctly addressed to the division is sent by the United States Postal Service or other established, domestic courier service.

12 AAC 02.940. EFFECTIVE DATE OF RENEWED LICENSES. (a) Except as provided in (b) of this section, the effective date of a renewed license will be the date a complete renewal application is filed with the division as determined by 12 AAC 02.920. A complete application includes

(1) a completed renewal form;

(2) any applicable renewal fees required by this chapter; and

(3) documentation of fulfillment of all applicable prerequisites to license renewal, such as continuing competency, recent experience, insurance coverage, or other requirements.

(b) The division will, in its discretion, show a retroactive effective date on a licensee's renewed license if the licensee

(1) holds a license that has been lapsed less than 60 days;

(2) requests in writing that the division issue a renewed license

showing an effective date that is earlier than the date the renewed license was issued;

(3) documents that the licensee was in substantial compliance with the renewal requirements in (a) of this section as of the requested effective date; and

(4) establishes to the satisfaction of the division that the licensee made a good faith effort to strictly comply with the renewal requirements.

(c) The division will not issue a renewed license with an effective date that is earlier than the postmark date of the licensee's first written attempt to renew the licensee's license. "Written attempt to renew" means an effort by the licensee to submit the proper documentation to comply with the license renewal requirements. A request for a renewal application form alone does not constitute a "written attempt to renew."

12 AAC 02.990. DEFINITIONS. As used in this chapter

(1) "department" means the Department of Commerce and Economic Development;

(2) "division" means the division of occupational licensing, Department of Commerce and Economic Development;

(3) "license" means a license, certificate, permit, registration, or similar evidence of authority issued by the division or by one of the boards listed in AS 08.01.010;

(4) "licensee" means a person who holds a license issued by the division or by one of the boards listed in AS 08.01.010.

AMENDMENT # 1

OFFERED IN THE HOUSE

BY REPRESENTATIVE ROKEBERG

TO: CS SB 165 (L&C) version G

Page 3, line ~~9~~ 10, after "experience":

Insert "as defined in regulation."

Page 3, line 13, after "(1)":

Delete "and (2)."

Insert ",(2) and (4)."

SB

193

FISCAL NOTE

No. 3

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; 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)

FUND SOURCE	FY97	FY98	FY99	FY00	FY01	FY02
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:	FY97	FY98	FY99	FY00	FY01	FY02
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

PREPARER TO PROVI[DE ... GOVERNO]R'S LEGISLATIVE OFFICE
For further [... Le]gislative Office

HEALTH & SOCIAL SERVICES
MED. ASSIST / MEDICAID SERVICES

101

(Rev 12/95)96fisno.xls/DAS DHSS

No. 2

FISCAL NOTE

Bill Version: CS SB195(L&C)

(S) Publish 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 — Phone: 465-2597

Division: Insurance — Date: 1/11/96

Approved by Commissioner: William L. Hensley — Date: 1-11-96

Agency: Commerce and Economic Development

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ZERO FISCAL NOTE - CED -
INSURANCE/OPERATIONS

FISCAL NOTE 1

STATE OF ALASKA
996 LEGISLATIVE SESSION

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

ı Date:
-n Act requiring insurance coverage for certain costs of birth
ıd providing for an effective date.
ponsor: Salo
equestor:

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

COMPONENT SERIAL NO. 64

xpenditures/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)

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
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:

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
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. Stalnaker [signature]
Division: Retirement & Benefits
Phone: 465-4470
Date:

Approved by Commissioner: Mark Boyer [signature]
Agency: Department of Administration
Date: 3/1/96

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Rev. 11/95

ZERO FISCAL NOTE - ALL STATE AGENCIES

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: March 27, 1996 FURTHER REFERRALS: Labor and Commerce

Date of Committee Action: 4/11/96

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: CSSB 193(L&C)

CS FOR SENATE BILL NO. 193(L&C) MANDATORY INSURANCE FOR COSTS OF BIRTH

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

recommends it be replaced with the following committee substitute HCS CS SB 193(HES) [ ] the same title [X] 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) ____

[ ] zero fiscal note(s) ____ [X] zero fiscal note(s) H+SS/2-21-96 (3)
CED/2-21-96 All agencies 2-21-96

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
[signature]	✓			✓
[signature]			✓	
[signature]	✓			
[signature]			✓	
[signature]	✓			
[signature]	✓			
[signature]	✓			

CHAIR'S SIGNATURE [signature]

HOUSE CS FOR CS FOR SENATE BILL NO. 193(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS SALO, Donley, Ellis, Duncan, Kelly, Pearce, Zharoff

REPRESENTATIVES Robinson, B.Davis, Finkelstein, G.Davis, Navarre

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to insurance coverage for certain costs of birth; and providing**
2 **for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 21.42 is amended by adding a new section to read:
5 Sec. 21.42.347. COVERAGE FOR COSTS OF BIRTH. (a) An insurer who
6 provides coverage for the costs of childbirth shall also offer coverage for the costs of
7 hospitalization or medical care following childbirth for a period of not less than
8 (1) 48 hours after a vaginal birth; and
9 (2) 96 hours after a caesarean birth.
10 (b) Except as otherwise required to offer coverage specified under (a) of this
11 section, this section does not affect a payment arrangement entered into between a
12 hospital or physician and an insurer.
13 (c) This section may not be construed to require hospitalization or medical care
14 as described under (a)(1) or (2) of this section if the mother giving birth and the

1 mother's health care provider agree that the mother and any newborn child of the
2 mother should be discharged earlier than required under (a)(1) or (2) of this section.
3 (d) In this section,
4 (1) "health care provider" means a person licensed in this state to
5 provide health care services;
6 (2) "insurer" includes
7 (A) an insurer, as defined in AS 21.90.900;
8 (B) a group health plan, as defined in 29 U.S.C. 1167(l)
9 (Employee Retirement Income Security Act of 1974);
10 (C) a health maintenance organization, as defined in
11 AS 21.86.900;
12 (D) a hospital service corporation or medical service
13 corporation, as defined in AS 21.87.330;
14 (E) a writing carrier, as defined in AS 21.55.500; and
15 (F) an entity offering a service benefit plan, as referred to in 42
16 U.S.C. 1396g-1.
17 * Sec. 2. APPLICABILITY. This Act applies to a policy of insurance issued or renewed
18 on or after the effective date of this Act.
19 * Sec. 3. This Act takes effect immediately under AS 01.10.070(c).

HOUSE CONCURRENT RESOLUTION NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced:
Referred:

A RESOLUTION

1 **Suspending Uniform Rules 24(c), 35, 41(b), and 42(e) of the Alaska State**
2 **Legislature concerning Senate Bill No. 193, relating to insurance coverage for**
3 **certain costs of birth.**
4 **BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:**
5 That under Rule 54 of the Uniform Rules of the Alaska State Legislature, the
6 provisions of Rules 24(c), 35, 41(b), and 42(e) of the Uniform Rules, regarding changes to the
7 title of a bill, are suspended in consideration of Senate Bill No. 193, relating to insurance
8 coverage for certain costs of birth.

MEMORANDVM.

TO: Cynthia

FROM: Ben

IN RE: insurance coverage for new mothers and babies

DATE: 25 March '96

Janet Keough at Ætna in Seattle (800 842 4866 or 206 426 2171) said that standard coverage, in the absence of limitations imposed by the plan sponsor (usually the employer) includes home health care. She said a mom and an infant discharged together, within 24 hours of birth, qualify for a follow-up home visit. If the mother and child are in the hospital longer than 24 hours after the birth, then a home follow-up is not covered as a necessary medical expense. If a condition merited it, the infant would qualify as a dependent for any further medically necessary services, such as medications & C. Similarly, the mother would be covered for new medical conditions as they arose, but not for any further 'maternity' coverage. Post-partum examinations (usually in an OB/GYN's office) are customarily covered in the 'global' fee for the delivery of a newborn.

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 these 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.

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NCSL • LEGISBRIEF

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QUALITY CARE OR DRIVE-THROUGH DELIVERIES?

By Kelly E. Perez

Diane Mensch had a quick labor and uncomplicated delivery, so she and baby Shimon went home the day after delivery. Her insurer does not pay for more than a 24-hour stay. Three days later Mensch detected a yellowish tint to her son's face. He had jaundice. She rushed him to a clinic, where Shimon recovered well. Untreated jaundice can cause mental retardation and brain damage. Mensch has no doubt that the problem would have been caught sooner if her insurer had paid for another hospital day.

The average length of a hospital stay for a new mother has dropped from 4.1 days in 1970 to 2.6 days in 1992.

Explanations abound as to the origins of what critics call "drive-through deliveries." Some say that they began as a consumer movement in the 1970s to shorten hospital stays, making childbirth more natural. Others say they are the result of attempts to decrease a newborn's contact with contagious diseases in the hospital. Whatever the reasons, critics say in the last five years the practice of early discharge has evolved into a push by insurers, typically health maintenance organizations (HMOs), to save money.

The average length of stay for hospital deliveries dropped from 4.1 days in 1970 to 2.6 days in 1992, according to the Centers for Disease Control and Prevention (CDC), and the decline continues. A few HMOs authorize only eight-hour postpartum stays.

Early discharge presents potential problems.

Providers and maternal and child health experts have divided the potential problems of early discharge into three categories:

- A new mother can face postpartum complications, breast feeding problems, and concerns over self care and baby care.
- Many infant problems such as jaundice, dehydration, fever and poor feeding do not occur in the first 24 hours. Follow-up is critical to an infant's safety. Early detection allows for less expensive treatment that can eliminate the need for readmission to the hospital for more costly therapy.
- Newborn screening requires a series of tests that can be invalidated by short stays.

Outpatient follow-up can be difficult and expensive. About 14 percent of women and 11 percent of newborns experience complications after they have been released from the hospital, according to the CDC.

Not So Fast, States Say

Enacted legislation or regulation: Maryland, Massachusetts, New Jersey, New Mexico, North Carolina

Pending legislation: California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Michigan, Minnesota, Missouri, New Hampshire, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Washington, Washington, D.C., Wisconsin

Anticipated action: Arizona, Hawaii, Iowa, Kansas, Nebraska, Maine, Virginia

Source: NCSL

State Action

Five states have mandated insurance coverage for postpartum hospital stays and set minimum time requirements. New Mexico used a regulatory procedure through the state Corporation Commission. Maryland's

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Additional Backup

Infants' Health Security Act amends the mandated benefits law and requires HMOs to cover maternity stays according to the guidelines for perinatal care developed by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG). A newborn and mother may be released within 24 hours if the baby meets certain "medical stability" criteria and if the insurer provides a follow-up home visit. The NEW JERSEY law requires all health plans in the state (not just HMOs) to provide 48 hours of care for vaginal deliveries and 96 hours after a Caesarean section, if requested by the doctor or the mother. NORTH CAROLINA's measure amends the state's insurance statutes and requires coverage similar to New Jersey's. MASSACHUSETTS law is similar in scope to New Jersey's except that it specifically addresses the Employee Retirement Income Security Act of 1974 (ERISA), which currently exempts self-insured plans from state regulation.

Federal Action

U.S. Senators Bill Bradley of New Jersey and Nancy Kassebaum of Kansas cosponsored the Newborns' and Mothers' Health Protection Act of 1995 (S. 969) last June. A key feature of the proposed federal law is that it would apply to ERISA plans. The American Medical Association, ACOG and AAP have united to support S. 969. The bill, which closely resembles NEW JERSEY's law, would establish a uniform policy. The Coalition Against Mandated Hospital Stays opposes the bill. Its members include the American College of Nurse-Midwives, the National Business Group on Health and the National Association of Childbearing Centers. It has spoken out against mandating what it calls a "costly and unnecessary benefit." The coalition argues that the law would:

- Raise health care costs,
- Stifle innovative and cost-effective practices such as birthing centers,
- Not guarantee optimal care, which is not defined by a predetermined length of stay,
- Micromanage health care in an unprecedented way.

The proposed federal law would apply to ERISA plans.

As many states move toward managed care for their Medicaid recipients, questions about the costs, efficacy and quality of care continue to arise. Although the average length of stay for all women and babies has dropped, hospital stays for Medicaid-funded deliveries (one-third of all deliveries nationwide) decreased the most significantly. This supports the view of critics who say that early discharge is almost strictly an issue of cost.

The length of hospital stays for women on Medicaid have decreased the most.

But cost is not the primary consideration, according to the Group Health Association of America (GHAA), an association representing a majority of the nation's 584 HMOs. GHAA says that no empirical evidence exists to support the need for longer stays and that shorter hospital stays work well for families. If a patient needs longer hospitalization, the doctor may authorize it. Medical decisions should be made by medical providers on a case-by-case basis and not by legislators, says GHAA (a member of the Coalition Against Mandated Hospital Stays).

Many providers and HMOs, often on different sides of this issue, agree that these decisions should not be "arbitrary policies." Providers argue that discharge timing should be decided by the physician and mother. HMOs object to the idea of setting one standard for all members because it undermines "utilization review," a method used to evaluate health care on the basis of appropriateness, necessity, quality and cost.

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LEGAL ISSUES IN MEDICINE

WOMEN AND CHILDREN FIRST

GEORGE J. ANNAS, J.D., M.P.H.

IN the lore of the sea there are few events that have so exemplified heroism and self-sacrifice as the acts of the soldiers and sailors of the British ship *Birkenhead* when it sank in 1852. The soldiers of the 74th Highland Regiment stood at attention on deck (with the band playing) "while the women and children were saved and the captain very properly went down with his ship."[1] More than 450 lives were lost, and the phrase "women and children first" was introduced into the language as part of the "*Birkenhead* drill." As Kipling put it in his poem "Soldier an' Sailor Too": "to stand an' be still to the *Birken'ead* drill is a damn tough bullet to chew."[2]

In the rapidly evolving lore of managed care, the *Birkenhead* drill's rule of women and children first has taken on a new meaning with respect to childbirth as so-called drive-through deliveries are required by more and more health plans. (Elsewhere in this issue of the *Journal,* Parisi and Meyer discuss the question of the length of stay after delivery.[3]) These plans often restrict hospitalization benefits to 24 hours after a vaginal delivery and 48 hours after a cesarean section. The primary rationale is not to benefit mother and child, but to enable the health plan to retain more insurance-premium dollars. The new drill is that the passengers must sacrifice for the captain and crew; women and their newborns are expected to chew the tough bullet.

THE CURRENT CULTURAL CONTEXT

Why have women and children become the focus of the first major public debate over market-driven managed-care medicine? The answer is that this population group is an irresistible target for both health care entrepreneurs and politicians. In the current budget-cutting fever in Congress, welfare "reform," which directly affects mainly poor women and their children, was passed by both the House and Senate as a way to reduce spending on the current programs. Similar strategies are to abolish Medicaid and to push more poor women into managed-care settings. The only group for which mandatory screening for the human immunodeficiency virus has been seriously proposed is pregnant women and their newborns. Poor women and children, who do not have the political influence or financial resources to resist even draconian actions against their interests, are easy targets. Although drive-through deliveries also affect only women and children, the affected women are not limited to the poor but also include the insured middle class, who can fight back. Moreover, politicians have found middle-class women and their children "telegenic and sympathetic," in a way that allows this issue to serve as a surrogate for more pervasive (and dangerous) problems with market-driven medicine.[4]

The rush to embrace the ideology of the marketplace is based on the theory that Americans are motivated primarily by money; therefore, changing financial incentives will change behavior. True believers in the market think this is so in every phase of life. Women will decide not to have more children, at least at the margin, if the government refuses to increase welfare payments; physicians will discharge women and their newborns from hospitals early if the insurance company refuses to pay the physician and hospital for longer stays. It is difficult to predict how the 24-hour rule (or even a 12-hour or 6-hour rule) will affect the health of mothers and newborns, because there is little more than anecdotal data available to help determine the appropriate length of stay after delivery. One retrospective study, however, has shown no increase in readmissions for babies discharged within 24 hours after vaginal delivery, but a very large increase (from 1.3 percent to 4.3 percent) in readmissions for babies delivered by cesarean section who were discharged within 24 hours.[5] In the absence of conclusive data, it is not surprising that health plans push to minimize their costs and that physicians fight to retain decision-making authority over hospital discharges.

IN-HOSPITAL DELIVERIES

Childbirth in the hospital was not widely promoted until the 20th century. Th[illegible] major reasons for the shift from home delivery were greater safety for mother and child, relief from pain, convenience for physicians, efficiency, the rise of scientific medicine, and the need for a regular supply of patients to train medical students.[6] But gains for women were purchased "at the expense of being processed as possibly diseased [illegible]jects."[6] By the 1950s, in-hospital delivery had be[illegible] "unpleasant and alienating. . . . women were po[illegible]less . . . playing a social role of passive dependen[illegible]e and obedience."[6] A movement to regain some control began. Women were behind the shift to natural childbirth, to the routine participation of fathers in the delivery room, and to drastic cuts in the length of stay in the hospital after delivery.

By the 1990s, as Ellen Goodman has put it, "with shorter and shorter hospital stays, the postpartum world isn't just like home, it is home."[7] If this trend continues, we could move full circle, with home birth again becoming the norm. This is not necessarily bad for women at low risk for complications of labor and delivery. Hospitals are expensive, and long stays are often, perhaps almost always, unnecessary. The central issue, however, is not only the cost, but also the quality of care: how can we make the experience of childbirth responsive to the needs and wishes of women, rather than to the wishes of health care entrepreneurs or politicians?

The proponents of discharging new mothers and

their babies more quickly from the hospital argue that the long hospitalizations of the past were both unnecessary and potentially dangerous (because of the increased risk of nosocomial infections) for both mother and child. They point, quite rightly, to past excesses in terms of the length of stay and argue that increases in efficiency can be achieved without adverse effects on mother and child. The average length of the hospital stay for childbirth has already fallen from approximately four days in 1970 to two days in 1992 for all vaginal deliveries and from eight to four days for cesarean deliveries.[8] Since childbirth is the most common reason for inpatient care in the United States, billions of health care dollars could potentially be saved if the average length of stay for mothers and babies were further shortened. Nor is it only the for-profit plans that have cut the length of stay. Kaiser Permanente, a nonprofit health plan that has a solid track record of taking care of its patients over the long run, also sees shorter stays after delivery as cost-effective, safe medical care. Its physicians and nurses have reportedly been instructed to encourage new mothers to leave the hospital by saying that "hospital food is not tasty," that the mother can have "unlimited visitors at home," and that she will sleep better in her own bed.[9] This is all true, and almost all women will prefer to leave the hospital as soon as possible, especially if good follow-up care at home is available.

Opponents of early discharge have turned to the law to change the practice. At both the state and federal levels, legislation has been introduced (and some has already been enacted) to modify or limit drive-through deliveries by requiring health plans to pay hospitals for longer stays under certain conditions. The early success of these efforts is worth examining, because it may hold lessons for other legislative action in the managed-care arena.

State Legislation

In May 1995, Maryland became the first state to enact legislation to curtail 24-hour–discharge policies. As one of its primary reasons for acting, the legislature noted that "hospital stays of less than 24 hours after childbirth typically result in unsatisfactory PKU specimens [for phenylketonuria testing] as a result of insufficient milk feedings" and that "the state's statutes and regulations direct the screening of newborn infants for hereditary and congenital disorders in the hospital prior to discharge"[10] (Maryland is perhaps the country's leader in newborn screening). The law, entitled the Mothers' and Infants' Health Security Act, specifically requires insurance plans to provide coverage for maternity and newborn care, including inpatient stays "in accordance with the medical criteria outlined in the most current version of the *Guidelines for Perinatal Care* prepared by the American Academy of Pediatrics [AAP] and the American College of Obstetricians and Gynecologists [ACOG]."[10] Because the AAP and ACOG now recommend a 48-hour stay for uncomplicated deliveries, the law, which took effect on October 1, had the effect of eliminating provisions for shorter lengths of stay by insurance companies and health plans.

Also in May 1995, the ACOG urged a moratorium on further shortening of hospital stays after delivery until their safety is established, saying:

> The routine imposition of a short and arbitrary time limit on hospital stay that does not take maternal and infant need into account could be equivalent to a large, uncontrolled, uninformed experiment that may potentially affect the health of American women and their babies.[11]

The second state to enact legislation was New Jersey. On June 29, Governor Christine Todd Whitman went to Holy Name Hospital in Teaneck to sign a bill that specified minimal lengths of stay that insurance companies must cover. She told the audience at the hospital, "I have two children — one by C-section — and I know that 24 hours is not enough."[12] She added that the new law used "common sense to give women a chance to recover and babies a chance to get a good head start."[12] Unlike the Maryland law, which followed medical standards as set by the AAP and ACOG, the New Jersey law specified that insurance plans must cover "a minimum of 48 hours of in-patient care following a vaginal delivery and a minimum of 96 hours of in-patient care following a cesarean section for a mother and her newly born child in a health care facility."[13] The law further specifies that such coverage is not required unless the care either is "determined to be medically necessary by the attending physician" or "is requested by the mother."[13] The provision that women themselves make the final decision represents a legislative determination that their obstetricians and pediatricians cannot exercise appropriate medical judgment when under intense pressure to contain costs. From the physicians' and patients' perspective, however, it will probably be more important how the financial incentives are structured and whether any financial benefit accruing to the health plan goes to enrich investors or to improve services.

North Carolina became the third state to enact legislation on July 28, providing simply that "a health benefit plan that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly-born child for a minimum of forty-eight hours after vaginal delivery and a minimum of ninety-six hours after delivery by cesarean section."[14] On November 21, Governor William Weld of Massachusetts signed legislation similar to the New Jersey law. Other states with legislation pending or under study on this topic include California, Connecticut, Delaware, Illinois, Kentucky, Michigan, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, and Wisconsin.

States probably do not have the legal authority to require this type of benefit for employee group plans provided by corporations that are self-insured, because the Employee Retirement Income Security Act (ERISA)

precludes the application of state mandated-benefit laws to self-insured employee-benefit plans.[15] On the other hand, courts may consider this a health-and-safety measure (especially laws like Maryland's) rather than a mandated-benefit law.[16] Whatever the final outcome, however, ERISA does not limit the ability of the federal government to require uniform health care benefits across the country. Accordingly, federal legislation would be most effective in this area.

Federal Legislation

Shortly after New Jersey adopted its law, Senator Bill Bradley (D-N.J.), together with Senator Nancy Kassebaum (R-Kans.), introduced a proposed federal law to be entitled the "Newborns' and Mothers' Health Protection Act." At the Senate hearing on the bill in September, Bradley argued that uniform federal legislation that covered all American women and children was needed. Horror stories help drive legislation. In dramatic testimony, Michelle and Steve Bauman of New Jersey told the committee how their daughter had died from a streptococcus B infection two days after she was born. She and her mother had been discharged 28 hours after the baby's birth. Although there may be no way to know for sure, the Baumans believe that their daughter would have been properly cared for had they spent another 24 hours in the hospital. Mrs. Bauman said that "her death certificate listed the cause of death as meningitis when it should have read: 'Death by the system.'"[17]

Senator Bradley's bill follows the New Jersey model in that it requires all insurance plans that provide benefits for childbirth "to ensure that coverage is provided for a minimum of 48 hours of in-patient care following a vaginal delivery and a minimum of 96 hours of in-patient care following a cesarean section for a mother and her newly born child in a health care facility." The bill also contains the same waiver of the minimal lengths of stay when care is not deemed medically necessary and is not requested by the mother. The managed-care industry opposes the bill on the grounds that government should not interfere with the market in this area. Silent on similar legislation until very recently, the American Medical Association supports the bill as "a good first step" to ensure that women are not discharged until they and their physicians think it appropriate.[18]

When Legal Regulation Is Necessary

In the most general sense these bills represent classic government regulation of the market and can be seen as following in the tradition of child-labor laws, laws protecting workers' health and safety, and minimum-wage laws. Because the market has no inherent morality, whenever the market is used to produce and distribute goods and services, government regulation is required to protect the welfare of both workers and consumers. Specific regulations, like those outlined in these bills, are inevitable when society sees industries, especially for-profit corporations, going too far in pursuing their own goals at public expense.

These bills also reflect a concern about power. At least since World War II, physicians have held most of the decision-making power in medicine. The informed-consent doctrine has sought to move decision making toward a model of partnership between physicians and patients, and at least in situations like childbirth, when the woman is not sick, there have been notable successes, including the increase in natural childbirth. In most managed-care settings, insurance companies and health maintenance organizations (HMOs) are attempting to take decision-making authority away from physicians and their patients and to put more of it in the hands of managers, who base their rules on cost–benefit analysis. But cost–benefit analysis in medicine is still rudimentary, and it is now being used primarily on a trial-and-error basis, seeing how much can be cut before physicians and their patients begin complaining bitterly.

Neither organized medicine nor the public wants managers to decide how individual patients will be treated. The Maryland legislation attempts to put decision making back in the hands of physicians by requiring that health plans and insurance companies accept as necessary any care that is so designated by physicians and that is consistent with professional medical guidelines. Since both the AAP and ACOG also endorse collaborative decision making grounded in informed consent, this approach may be seen as the traditional model. The New Jersey law (and the federal proposal based on it) is different, however. Although it bows to the historical ability of physicians to determine medical necessity, it moves beyond this concept by directly empowering patients to make their own decisions, based on their own values, regardless of their physicians' views of medical necessity. Specifically, even if 48 hours in the hospital after delivery is determined not to be medically necessary by a woman's attending physician (and the child's pediatrician), the woman and her child may still stay 48 hours if this is what the woman wants. This is a powerful endorsement of patients' rights. Of course, the hospital is not a prison, and women are not required to stay for the entire authorized time period. Doctors and hospitals can also use incentives, such as improved prenatal education and home care and child care after delivery, to make leaving the hospital early more attractive to women. If they do so, this could be an example of a change that benefits both patients and the health plan's bottom line.

Cost, Quality, and Access

But what about cost containment? Do not laws like these undercut efforts to save money? The answer to this question, of course, is that it depends on your perspective. Specifically, it depends on such things as the contract that the insurance company has with the hospital, and whether the hospital is owned by the HMO.

In terms of actual cost to the hospital for a healthy woman and her baby to spend an additional 24 hours in the hospital, the amounts in question are probably closer to $100 than $1,000, at least if the hospital has excess maternity-bed capacity. University Medical Center in Stony Brook, New York, for example, has adopted a new policy guaranteeing mothers a stay of at least 48 hours if they wish it.[3] If the insurance company does not pay for the second day, the hospital will absorb the estimated $300 in added cost.[19] At least one major hospital, Tampa General, in Florida, has gone even further by offering all its maternity patients an extra 48 hours of post-delivery care after discharge from the hospital, at no cost to the patient.[20] The patients who opt for this program will be cared for in a hotel-like unit, named the Family Suites, which can now accommodate eight women and could be expanded. The local competitors of this hospital have charged that the program is simply a marketing technique to attract more obstetrical patients. Nonetheless, to the extent that it meets the needs of women and children in a reasonable and compassionate way, it is to be applauded. It is also consistent with the New Jersey model of putting more control in the hands of women, and thus forcing managers to deal directly with women when refashioning obstetrical care.

Drive-through delivery legislation is a sideshow in the debate over health care–financing reform that will have little real effect on cost, quality, or access to health care by women and their children. Although the length of stay is important, especially after a cesarean section, it is not a sufficient measure of the quality of care. It has, nonetheless, taken on a life of its own for the public and politicians because it can be easily understood and because it illustrates the general problem of premature hospital discharge. Moreover, and perhaps most important, action on this front permits politicians to appear to be doing something positive to protect women and children that costs the government no money.

We cannot solve either the real or the perceived problems with market-driven medicine by passing statutes dealing with single aspects of care (e.g., the length of stay) or single reasons for hospitalization (e.g., childbirth). No one, I take it, would consider it reasonable for Congress to enact legislation on types of treatment and minimal stays for coronary bypass or treatment of head injuries, although these will probably have a much greater impact on the overall quality of care than stays after childbirth.

Unlike the proposals regarding hospital stays after childbirth, which arbitrarily use the total number of hours in the hospital as a surrogate for quality, Congress was on much firmer ground when it adopted the Emergency Medical Treatment and Active Labor Act, requiring hospitals to admit women in active labor for childbirth whenever there was either "inadequate time to effect safe transfer to another hospital prior to delivery" or when a "transfer may pose a threat [to] the health and safety of the patient or the unborn child."[21] Under this law, judgments about the health and safety of the woman in labor must be made by a physician, and a hospital may not lawfully transfer a woman in active labor (or any other patient requiring emergency care) unless the patient requests the transfer or the physician, in exercising reasonable medical judgment, determines that the benefits to the patient that could be "reasonably expected" to result from transfer outweigh the increased risks.[21] This legislation puts the protection of patients first and does so by supporting decisions made within the doctor–patient relationship.

If Congress and the states are serious about protecting the welfare of women and children, there are clear steps that should be taken, the most important of which is the guarantee of basic health care services to all children and their mothers. Moreover, although it makes no sense for Congress to regulate the details of specific medical interventions, it is reasonable for Congress to require all health plans to offer the same minimal benefit package to all subscribers; this requirement could help protect patients both by guaranteeing this minimum and by encouraging health plans to compete on the basis of the quality of care and their responsiveness to patients' needs and wishes, rather than on the basis of cost alone.

CONCLUSIONS

In the Navy it is traditional to fire a shot across the bow of a ship before taking more aggressive action. The symbolic legislative initiatives on the length of hospital stays after childbirth, which will almost certainly sweep the country state by state if federal legislation is not soon enacted, are a shot across the bow of marketplace medicine. The signal can be ignored only at the peril of the new health care industry; politicians will not remain their captives forever. The message is that patients are patients, not customers. Patients need care, not management. And patients should have a central role in deciding how our new health care system will operate.

The 74th Highland Regiment went down with the ship to save the women and children aboard. We expect no such heroics from our government leaders. It should not be too much to expect of ourselves, however, that instead of helping to raise symbolic flags like legislation regulating drive-through deliveries, we renew our efforts to provide decent health care for all Americans. Since this effort must be made piecemeal, it seems reasonable to pass legislation to guarantee the right to a decent minimum of health care for women and children first.

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BOOK REVIEWS

Stroke Therapy

Edited by Marc Fisher, with contributions by 33 others. 490 pp., illustrated. Boston, Butterworth–Heinemann, 1995. $90. ISBN 0-7506-9575-7.

An early chapter of this book begins with a scenario that is played out every day in emergency rooms throughout the country:

> A patient has arrived who had a sudden onset of aphasia and right hemiparesis three hours before. A CT scan of the brain is performed; perhaps an MRI scan is done if that is fortuitously available on short notice. The scans are normal. Since normal scans are consistent with the diagnosis of acute ischemic infarction at three hours, this clinical diagnosis is made. The patient is admitted to the hospital, the lesion is allowed to ripen for several days, the scan is repeated. . . .

Therapy is not immediately available, and irreversible neuronal injury is assumed to have already occurred.

As the reader explores the 19 chapters in this book, it becomes clear that cases such as this may be handled very differently in the near future. A chapter on the pathophysiology of stroke describes the recently identified biochemical features of the ischemic cascade of neuronal injury and relates recent experimental findings indicating that patients with a stroke that began only three hours earlier may still have a large rim of viable tissue, the ischemic penumbra. The chapter on animal models of stroke therapy reveals that a myriad of new compounds can be administered to "rescue" neurons in the ischemic penumbra and restore function in drug-treated animals.

A chapter on cytoprotective therapy for ischemic stroke chronicles the preclinical and early clinical development of these new neuroprotective medications. A similar chapter on thrombolytic therapy succinctly summarizes the recent clinical experience with both intraarterial and intravenous thrombolytic agents to treat patients within the first few hours after the onset of stroke.

But which of these therapies should be offered to the patient described above, who had negative neuroimaging studies three hours after the onset of symptoms? The answer may be facilitated by the use of new techniques of magnetic resonance imaging that immediately allow the identification of areas of brain ischemia at presentation, as well as the status of brain perfusion. With these techniques, known as diffusion-weighted imaging and perfusion imaging, the ischemic penumbra may be imaged as an area of delayed or decreased perfusion that extends beyond the region of the diffusion abnormality. These techniques are described in a well-written chapter in terms understandable to the nonradiologist. Impressive examples of their use in patients with acute stroke are also provided.

Besides the chapters described above, which provide a road map into the future of stroke therapy, there are numerous other chapters that are useful for the clinician caring for patients with stroke. These include a nice description of risk factors for stroke, medical therapies (anticoagulant and antiplatelet agents) for stroke prevention, intensive care of cerebrovascular disorders, and a summary of the recent trials of carotid endarterectomy.

The book is not limited to the discussion of ischemic stroke; concise summaries of the diagnosis and treatment of subarachnoid hemorrhage and intracranial hemorrhage are also included. New neurointerventional approaches to the treatment and diagnosis of stroke, including endovascular treatments for intracranial aneurysms and vascular malformations, as well as the emerging field of cerebral angioplasty, are summarized and accompanied by numerous excellent figures.

One of the final chapters describes therapy for unusual causes of stroke, such as the antiphospholipid-antibody syndrome, patent foramen ovale, arterial dissection, and cerebral venous thrombosis. Although studies have not provided definitive therapeutic guidelines for most of these, the chapter provides an excellent overview of the data currently available.

The chapters in this book are brief, but generally well referenced and almost uniformly well written. This is not a comprehensive textbook about the diagnosis and management of stroke. It is, however, a book that conveys tremendous optimism, documenting the substantial advances in the diagnosis and therapy of stroke that have occurred over the past decade and promising even more remarkable progress in the years to come.

Gregory W. Albers, M.D.
Stanford, CA 94305 Stanford University Medical Center

The Axon: Structure, Function, and Pathophysiology

Edited by Stephen G. Waxman, Jeffery D. Kocsis, and Peter K. Stys. 692 pp., illustrated. New York, Oxford University Press, 1995. $175. ISBN 0-19-508293-1.

This book is an excellent new contribution to the expanding field of neurobiology. Although a number of neuroscience

for each Medicare enrollee, and county-to-county variations can be great.

Medicare beneficiaries particularly are attracted to HMOs if they do not charge Medicare's normal deductibles and coinsurance and when they provide services not offered by the traditional program, such as prescription drug coverage, the report stated.

Over the past three years, the number of HMOs charging Medicare beneficiaries no premiums increased from 26 percent to 49 percent, GAO found. And while 32 percent of HMOs provided an outpatient prescription drug benefit to Medicare beneficiaries in 1993, 49 percent did so by the end of 1995.

Some beneficiaries also joined HMOs under an agreement with their former employers to continue receiving health care coverage, it added.

The first copy of the report, "Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States" (GAO/HEHS-96-63), is free; additional copies are $2 each from GAO, P.O. Box 6015, Gaithersburg, Md. 20884-6015; (202) 512-6000.☐

Plan Regulation

Maryland Lawmakers Consider Stricter Law For Maternity Hospital Stays

ANNAPOLIS, Md.—One year after passing a law that appears not to have achieved its intended effect, the Maryland General Assembly is considering stricter legislation (SB 433/HB 614) on minimum hospital stays for childbirth in order to close a loophole through which health insurers and health maintenance organizations are purportedly making shorter stays the rule and not the exception.

"We thought we addressed this problem last year, but apparently we did not," Sen. Finance Committee Chairman Thomas L. Bromwell (D), the lead sponsor of SB 433, said at a Feb. 15 hearing. He was referring to the "Mothers' and Infants' Health Security Act" passed during the Assembly's 1995 legislative session (1 MACR 24, 7/5/95).

The 1995 law, which was the first of its kind in the nation, requires insurers, HMOs, and utilization review agents to follow the *Guidelines for Perinatal Care* published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, which recommend 48-hour and 96-hour hospital stays for uncomplicated vaginal and cesarean-section births, respectively. However, an exception in the 1995 law allows insurers and HMOs to authorize a shorter stay if newborns meet the guidelines' criteria for medical stability and if the insurer or HMO covers one post-partum home visit.

Bromwell noted that, despite passage of the 1995 law, most insurers and HMOs in Maryland are routinely limiting coverage to 24 hours after delivery. In addition, "some members of the insurance industry took a punitive response to last year's legislation by reducing their customary hospital stay for cesarean-section births from 72 to 48 hours," Bromwell said.

Exception Created A Loophole

From: ALASKA LEGISLATIVE RESEARCH AGENCY

Sen. Delores G. Kelley (D), the prime sponsor of last year's legislation, said during the Feb. 15 hearing that the exception [illegible] and HMOs to authorize a shorter hospital stay if they cover one home visit "turned out to be a giant loophole."

Kelley explained that this provision was added to the 1995 law to ensure that any infants who were sent home in less than 48 hours would receive PKU screening to prevent mental retardation. "We intended that the single home visit in lieu of a 48-hour hospital stay would be the exception, not the rule, but it turns out we were wrong," she stated.

In many cases, the home visit is not even being conducted when women are discharged from a hospital less than 48 hours after delivery, according to Howard J. Birenbaum, chairman of the Fetus and Newborn Committee of the American Academy of Pediatrics' Maryland Chapter, which supports the stricter legislation. Birenbaum told the Senate committee that a survey of women delivering at St. Agnes Hospital in Baltimore after Maryland's law took effect Oct. 1, 1995, "revealed that 50 percent were not aware that they were entitled to a home visit if they were discharged prior to 48 hours. Of the remaining women, over 50 percent refused the home visit because of a reluctance to meet a deductible or copayment requirement," he said.

Legislation Would Add Restrictions

As currently drafted, the stricter legislation being considered by the Assembly would bar insurers and HMOs from imposing a deductible or copayment for three—not one—home visits that would have to be provided to mothers who agree to a shorter hospital stay. The measure also would prohibit insurers and HMOs from penalizing physicians who order the longer hospital stays called for under the legislation. In addition, insurers and HMOs would be required to provide annual notice to insureds and enrollees regarding the post-natal coverage mandated by the state. If enacted, the legislation would take effect July 1.

The Maryland Association of Health Maintenance Organizations said it opposed SB 433 unless it is amended to give the attending physician the authority to decide whether a shorter hospital stay is appropriate. As drafted, the legislation would allow the mother to make that decision, in consultation with her attending physician. In another area, MAHMO's position paper said the legislation's home visit requirements are "too prescriptive."

As an alternative, MAHMO endorsed the concepts embodied in SB 717, a broader bill that addresses hospitalization benefits for post-delivery care. SB 717 would require 48 hours and 96 hours of hospitalization after vaginal and cesarean-section deliveries, respectively, only if the attending physician determines that such hospitalization is necessary under AAP and ACOG guidelines. The bill would establish an expedited appeal process for physicians in the event that an insurer or HMO renders an adverse decision regarding the hospitalization coverage ordered by the physician.

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The House Environmental Matters Committee has scheduled a Feb. 27 hearing on the matter.□

Mental Health

San Diego County Begins Conversion To Managed Mental Health System

SAN DIEGO—San Diego County plans to begin converting its $95 million mental health system to a managed care model in 1997.

The first phase will cover programs for adults and older adults and include a system redesign. To date, San Diego County is the largest county in California to have contemplated such a change.

On Feb. 6, the San Diego County Board of Supervisors agreed to hire a technical expert to help with its request for proposals, and county officials hope by year's end to have completed the RFP process.

"Privatization is not quite the way to look at it, since 70 percent of our services are already contracted out to private companies or community groups," Joan Friedenberg, San Diego County's deputy director for mental health services, told BNA. And the reorganization may not result in total privatization, with the county continuing to run certain services for its target users, the severely mentally ill, she noted.

Integration Is Goal Of Reorganization

"We're really looking at it as to what good can be learned from managed care and applying those managed care principles and organizing them into a well-run system," Friedenberg said.

And because of the county's number of providers and funding streams, there's been no integration and no organization of different levels of care into a seamless system to guarantee ease of access, Peter Panzarino, chief clinical officer for Vista Behavioral Health Plans, a nonprofit mental health HMO based in San Diego, told BNA.

"If managed care is about cutting costs, and it almost invariably is, our concern is that it becomes the overriding thrust," Laura Lee Hall, National Alliance for the Mentally Ill's deputy director for policy and research, told BNA. "It becomes a way to cover up underfunding."

On the other hand, Hall said she is guardedly optimistic. "Maybe managed care can help improve the system. Managed care is supposed to use scientifically proven treatments for people who need them," she said.

To assist entities like San Diego County, NAMI by April will complete a model RFP for government entities planning to use managed care companies to run public mental health programs. And by October, NAMI should complete a report card on public sector managed care for the mentally ill.

"I don't know that we expect a heck of a lot of savings," Friedenberg said. Any savings will be reinvested in new services for the target population including vocational education and meeting space for self-help groups, she explained.

Strong Financial Hits

"Publicly funded mental health systems have been taking strong financial hits over the last several years," Friedenberg said.

San Diego County has suffered from California's recession, as well as a proportionately smaller pot of funding from the state than many other counties, due to a faulty funding formula that has been partially repaired, she said.

In addition, San Diego County recently took over state responsibility for the private hospitalization of patients qualifying for Medi-Cal, the state's Medicaid program. It receives $25 million yearly to run the program. In January, it also will assume risk for outpatient Medi-Cal patients.

The county wants to improve its management of information systems, making sure resources are used in the best possible way, Friedenberg said.

Managed care organizations have developed the systems to perform intensive case management, thereby ensuring that treatment regimes are being followed, Panzarino said.

Monitoring Quality Of Care

The county's contract should target utilization numbers and create a system for complaints and grievances, Panzarino said. The contract also should assure it receives regular reports on ease of access to different levels of care.

"You want to create the correct incentives and not provide the incentive to deny care," Panzarino said. "There should be bonuses not only for utilization of care but for quality of care," including outcomes and compliance.

The county likely will contract with a managed care organization that either would contract with its network of service providers or provide the services itself. San Diego County may share risk with that contractor or have the contractor assume all the risk.

There are special challenges to applying managed care principles to the target population. "A lot of managed care was appropriately developed for people who are basically healthy," Friedenberg said. "We are dealing with an adverse risk population. These are not people for whom prevention works. We have to make sure we preserve services and improve services for people who need them."□

In Brief

SOUTH DAKOTA GOVERNOR SIGNS UR BILLS: South Dakota Gov. William Janklow (R) Feb. 16 signed legislation that will require utilization review organizations operating within the state to register with it and to establish grievance procedures for their members.

One bill (HB 1059) requires all utilization review organizations operating within South Dakota to register with the state health department; the other (HB 1057) requires both

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The health care world is changing, Voss said. "I'm not sure insurance is the right place to regulate health care. Only 25 percent of the consumers are in the insurance market. The rest are in Medicaid, Medicare, and employee plans. We don't license the majority of what people are receiving out there," she added.

Maine And California

The Maine Bureau of Insurance met Feb. 9 with various industry groups to address the issue of regulating risk-bearing entities, said Alice Knapp, staff attorney for the State of Maine Bureau of Insurance, noting a consensus that there are some legitimate regulatory concerns with regard to downstream risk contracting.

"I don't think we'll have a problem carving out some standards. But there are a lot of details that need to get hashed out," she said. The bureau will look at the experience of other states and pose hypothetical situations at the next meeting March 8, she added.

In California, a bill in the state Legislature would permit providers to offer full risk capitation coverage (4 HCPR 250, 2/12/96). Currently, in order to offer capitation, requirements for a health plan under the Knox-Keene Act, including licensure, must be met.

Under the bill, hospitals and medical groups would be authorized to contract with HMOs to provide a comprehensive range of hospital, physician, and other health care services normally handled by licensed plans, on a full-risk, or "global" capitation basis.

State HMOs view the bill as an attempt by providers to get into the rapidly expanding managed care business without having to comply with all Knox-Keene Health Service Plan Act. The act requires financial disclosure and equity requirements to guard against health plans becoming insolvent.☐

—*By Jeannine Mjoseth*

Vermont

DEAN SIGNS BILL TO CONTINUE STATE'S EXPANDED MEDICAID PROGRAM

MONTPELIER, Vt.—A plan to enroll low-income Vermonters in an expanded Medicaid program will continue without interruption under a bill signed by Gov. Howard Dean (D) Feb. 14.

The program, which began Jan. 1, had been threatened because some lawmakers said it was not what the legislature intended when it passed the enabling legislation (H 159) last year (3 HCPR 626, 4/17/95).

The administration and the Legislature had envisioned the plan as a managed care program, administered by a private firm or firms. But since Jan. 1, the state has been running the program itself as a scaled back fee-for-service program partly because the only private bidder for the program, AssureCare, has yet to be granted a certificate of need from the state.

Shortly after the plan was kicked off, Senate Republicans attached a provision to the 1995 budget reconciliation bill (H 534) to halt the program. The move drew fire from Dean, for whom health care reform has long been a priority.

A House/Senate conference committee then worked out a compromise to allow the plan to continue but require the state to adopt rules by April 15 for the interim plan, according to Paul Wallace-Brodeur, senior health policy analyst with the Office of Health Access. He said the state had not developed rules sooner because of uncertainty over federal changes to Medicaid.

Sen. Tom Macaulay (R-Rutland), who spearheaded the push to delay the program, told BNA he still thinks the intent of the legislature is not being met by the interim program, but that he could not get House negotiators to agree.

The rules, which will be filed by March 8, would be changed to accommodate the anticipated, permanent, full-blown managed care plan, Wallace-Brodeur said.☐

Virginia

LAWMAKERS APPROVE LEGISLATION SETTING STANDARDS FOR MATERNITY STAYS

CHARLOTTESVILLE, Va.—Both chambers of the Virginia General Assembly recently joined several other states in approving legislation setting minimum standards for health plan coverage of hospital stays for childbirth.

The legislation (HB 97, SB 148) passed both chambers unanimously, approved by the House Feb. 8 and the Senate Feb. 12.

Both the House and Senate bills originally were written to allow women to stay 48 hours after a vaginal delivery and 98 hours after a cesarean, with their health plans picking up the tab for the entire stay. Currently, most insurers will only cover 24 hours for a vaginal delivery and 48 hours for a cesarean.

However, both bills were amended to require the state set up a provision for "inpatient treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care," prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or the "Standards for Obstetrical Gynecological Services," prepared by the American College of Obstetricians and Gynecologists.

The legislation requires payment for any home visits or office visits recommended by the health care provider subsequent to the birth.

In addition, insurers and health maintenance organizations will be required to develop optional coverage for obstetrical services that meet the same standards described above, including coverage of follow-up home or office visits.

The conference bill is expected to arrive on Gov. George Allen's (R) desk sometime in mid-March.☐

Ohio

GOVERNOR CREDITS AGGRESSIVE EFFORTS WITH SLASHING MEDICAID COST INCREASES

CINCINNATI—Ohio has cut growth in Medicaid spending to a historic low—1.4 percent for fiscal 1995—by ensuring that state dollars work "harder and smarter," Gov. George Voinovich (R) said Feb. 13 in his sixth State-of-the-State address.

Speaking before a joint session of the Ohio General Assembly, Voinovich said Ohio's rate of Medicaid

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STATE DEVELOPMENTS

Maryland

LAWMAKERS CONSIDERING STRICTER LAW FOR POST-DELIVERY HOSPITAL STAYS

ANNAPOLIS, Md.—One year after passing a law that appears not to have achieved its intended effect, the Maryland General Assembly is considering stricter legislation (SB 433/HB 614) that would require health insurers and health maintenance organizations to cover a minimum hospital stay of 48 hours for uncomplicated vaginal births and 96 hours for uncomplicated cesarean-section deliveries.

If a mother agrees to a shorter hospital stay, the legislation would require coverage for at least three home visits by a registered nurse who has at least one year of experience in maternal and child health care.

"We thought we addressed this problem last year, but apparently we did not," Sen. Finance Committee Chairman Thomas L. Bromwell (D-Baltimore), the lead sponsor of SB 433, said at a Feb. 15 hearing. He was referring to the "Mothers' and Infants' Health Security Act" passed during the Assembly's 1995 legislative session (3 HCPR 905, 6/5/95).

The 1995 law, which was the first of its kind in the nation, requires insurers, HMOs, and utilization review agents to follow the Guidelines for Perinatal Care published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, which recommend 48-hour and 96-hour hospital stays for uncomplicated vaginal and cesarean-section births, respectively. An exception in the 1995 law allows insurers and HMOs to authorize a shorter stay if the newborn meet the guidelines' criteria for medical stability and if the insurer or HMO covers one post-partum home visit.

Bromwell noted that, despite passage of the 1995 law, most insurers and HMOs in Maryland are routinely limiting coverage to 24 hours after delivery. In addition, "some members of the insurance industry took a punitive response to last year's legislation by reducing their customary hospital stay for cesarean-section births from 72 to 48 hours," Bromwell said. He described this as "totally irresponsible."

The chairman predicted that "we will pass this new bill." Although the Senate Finance Committee has not scheduled a vote on SB 433, the measure is expected to be reported favorably because the bill's 26 sponsors include every member of the committee, which has jurisdiction over insurance matters. In the House of Delegates, 84 of that chamber's 141 members co-sponsored the companion bill, HB 614. The House Environmental Matters Committee has scheduled a Feb. 27 hearing on the matter. Sen. Bromwell remarked that "members in both houses generally agree that 1996 is going to be the year for quality-of-care issues. Passing this bill is the first step in that direction," he said.

Exception Created A Loophole

Sen. Delores G. Kelley (D-Baltimore), who was the prime sponsor of last year's legislation, said during the Feb. 15 hearing that the exception in the law that allows insurers and HMOs to authorize a shorter hospital stay if they cover one home visit "turned out to be a giant loophole."

Kelley explained that this provision was added to the 1995 law to ensure that any infants who were sent home in less than 48 hours would receive PKU screening to prevent mental retardation. "We intended that the single home visit in lieu of a 48-hour hospital stay would be the exception, not the rule, but it turns out we were wrong," she stated.

In many cases, the home visit is not even being conducted when women are discharged from a hospital less than 48 hours after delivery, according to Howard J. Birenbaum, chairman of the Fetus and Newborn Committee of the American Academy of Pediatrics' Maryland Chapter, which supports the stricter legislation. Birenbaum told the Senate committee that a survey of women delivering at St. Agnes Hospital in Baltimore after Maryland's law took effect Oct. 1, 1995, "revealed that 50 percent were not aware that they were entitled to a home visit if they were discharged prior to 48 hours. Of the remaining women, over 50 percent refused the home visit because of a reluctance to meet a deductible or co-payment requirement," he said.

Legislation Would Add Restrictions

As currently drafted, the stricter legislation being considered by the Assembly would bar insurers and HMOs from imposing a deductible or co-payment for the three home visits that would have to be provided to mothers who agree to a shorter hospital stay. The measure also would prohibit insurers and HMOs from penalizing physicians who order the longer hospital stays called for under the legislation. In addition, insurers and HMOs would be required to provide annual notice to insureds and enrollees regarding the post-natal coverage mandated by the state. If enacted, the legislation would take effect July 1.

American Academy of Pediatrics representative Bobbi Seabolt noted during the Senate hearing that 33 states are considering some form of legislation regarding post-delivery hospital care and that four states, including Maryland, already have enacted legislation in this area.

HMOs, Doctors Group Opposed

The Maryland Association of Health Maintenance Organizations said it opposed SB 433 unless it is amended to give the attending physician the authority to decide whether a shorter hospital stay is appropriate. As drafted, the legislation would allow the mother to make that decision, in consultation with her attend-

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ing' physician. In another area, MAHMO's position paper said the legislation's home visit requirements are "too prescriptive."

As an alternative, MAHMO endorsed the concepts embodied in SB 717, a broader bill that addresses hospitalization benefits for post-delivery care. SB 717 would require 48 hours and 96 hours of hospitalization after vaginal and cesarean-section deliveries, respectively, only if the attending physician determines that such hospitalization is necessary under AAP and ACOG guidelines. The bill would establish an expedited appeal process for physicians in the event that an insurer or HMO renders an adverse decision regarding the hospitalization coverage ordered by the physician.

Mirroring MAHMO's position, the Medical and Chirurgical Faculty of Maryland, the state's leading physicians organization, also called for amendments to SB 433 while endorsing the approach embodied in SB 717. The two groups previously had agreed to advocate this position on post-delivery hospitalization as part of a unique alliance on this and other health care issues pending in the state (4 HCPR 203, 2/5/96).

Hospital's Free Second Day Causes Fury

While the General Assembly is considering the possibility of mandating longer hospital stays after delivery, St. Agnes Hospital in Baltimore ran into trouble with state regulators Feb. 12 by announcing that it would provide all new mothers and infants a full 48-hour post-partum hospital stay and would cover the second day at its own expense, regardless of the mother's insurance coverage.

Although the hospital's action drew praise from 48-hour-stay advocates, it ran afoul of hospital rate-setting regulations under Maryland's all-payer system, according to Robert Murray, executive director of the Health Services Cost Review Commission, the state's hospital rate-setting board.

Murray told BNA the state's rate-setting rules are intended to ensure that hospitals allocate costs equitably across all payers and do not shift costs from one group to another by offering reduced costs for certain services. Under state law, St. Agnes was required to obtain HSCRC approval before implementing a rate change of this nature, he said.

While mothers who deliver at St. Agnes may benefit from this in the short term, all Maryland residents could be harmed if the state's all-payer system collapses, Murray noted.

After several days of negotiations, the HSCRC and St. Agnes Feb. 20 announced an agreement under which the hospital will file an alternative rate application for the free second-day obstetric hospital stay. The structure of the application will be developed in cooperation with HSCRC staff and must be approved by the commission. In the interim, St. Agnes will be allowed to continue offering the free second day.

Murray told BNA that the HSCRC expects to review the hospital's application at its regularly scheduled March 6 public meeting. He noted that the HSCRC staff is examining the consequences associated with St. Agnes' action under the state's rate-setting mechanisms and plans to present a recommendation at the commission meeting.□

Managed Care

REGULATION OF RISK-BEARING NETWORKS DESCRIBED AS 'ALL OVER THE BOARD'

Most states still do not have a formal policy on the regulation of risk-bearing provider networks, but pressure to come up with consistent standards is intensifying, health attorneys and insurance regulators say.

At opposite ends of the regulatory continuum are trail-blazer Colorado, with its high managed care penetration, and Maine, which has just started to discuss the issue. Colorado requires all provider organizations that accept any type of risk to have an insurance license and meet minimum solvency standards, while Maine has not yet set any specific standards for risk-taking providers.

States are still "all over the board" in regulating risk-assuming provider networks, Daniel W. Krane, White and Williams, Philadelphia, told BNA.

Krane referred, for example, to New Jersey's policy, which he said is based on an "internally inconsistent" three-page memorandum that says if any entity not licensed as an HMO, insurer, or service corporation assumes risk from any source, even an employer exempt from state insurance laws under the Employee Retirement Income Security Act, that entity is in the business of insurance.

Meanwhile, Pennsylvania issued a "murky draft" on Sept. 21, 1995, in which the Department of Health said it will review provider networks for solvency and quality concerns. Earlier, a Group Health Association of America survey revealed that state oversight was erratic, and GHAA demanded state insurance commissioners crack down on provider entities taking on risk (3 HCPR 1141, 7/17/95).

Pressure Has Intensified

Pressure to resolve the matter has intensified as organizations such as physician-hospital organizations, integrated service networks, and provider cooperatives contract directly with employer groups. By direct contracting, network providers hope to bypass the health plan middleman and capture more of the managed care dollar. But direct contracting requires networks to assume the risks associated with providing health care to an insured population and—at least arguably—in many states, to assume risk is to be in the business of insurance and subject to state regulation.

That was the position taken by the National Association of Insurance Commissioners in a bulletin issued Aug. 10, 1995 (3 HCPR 1340, 8/21/95). The bulletin advised state insurance regulators that health provider networks accepting risk on a prepaid basis are in the business of insurance and should be regulated as such.

"States are now starting to grapple with the problem. We need some fairly general standards with which to assess these entities. We need some consistency," Krane said.

The NAIC is working on model legislation and regulation in this area, but that slow and laborious process has yet to result in standards that states can adopt. Many state insurance representatives have called for an interim "road map" that would indicate how direct

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The report also noted that the state since has improved its methodologies for reimbursing HMOs such that capitation rates for Medicaid are now adjusted by age of the recipient and geographic location. The state also is investigating the feasibility of using a risk-adjustment formula to modify HMO capitation rates.

Lawmakers were cautioned, nonetheless, to seek further study before expanding managed-care "carve outs" in such areas as mental health, long-term care, dental coverage, and prenatal services—given the difficulty of evaluating savings for acute-care services for Medicaid recipients and state employees in HMOs.

"Such studies are necessary not only to assure monetary savings to the state, but to determine how the populations in question may receive the highest possible quality of health care."

In the report—"Health Status of State-Sponsored Patients: A Comparison Between HMOs and Fee-For-Service"—House committee staffers examined computer files of 236,816 state employees and dependents and almost 1.5 million Medicaid recipients in the state.☐

Plan Conversions

Colorado Senate Resolves Consumer Concerns And Backs Blues' For-Profit Conversion

DENVER—The Colorado Senate approved a bill Feb. 29 that would allow Blue Cross and Blue Shield of Colorado to seek legal status as a for-profit company, after senators amended it a day earlier to answer consumer groups' concerns about conflicts of interest and other issues.

"The amendments resolve the questions the Consumers' Union had," Carl Miller, spokesman for Blue Cross and Blue Shield, told BNA. "We agreed to everything they raised as possible concerns. We're very optimistic it will pass in the House."

The company proposed the bill (SB 100) because it needs capital to finance acquisitions and computer-driven technology, expand reserves, and drive business, Miller said. Fueling the conversion request is the evolution of managed care, which increases the importance of forming alliances and making acquisitions of other managed care companies.

The bill outlines a process through which the nonprofit company would apply to the Colorado Division of Insurance for conversion, including public notice and a public hearing to be conducted by the division.

Consumer groups expressed concern over potential conflict-of-interest issues involving board members of both the new for-profit entity and of a new nonprofit foundation to underwrite charitable projects.

The stakes are high, consumer groups noted: The new private company would control potentially millions of dollars that could be given to charitable foundations serving the health care needs of the poor, Miller said.

The bill was amended to state that a majority of members could not serve on both the for-profit and the not-for-profit boards. In addition, members of both boards would be barred from voting on any issues that would be perceived as a conflict of interest under the amendment to the bill, Miller said.

Senators also tinkered with language concerning the valuation of the company, Miller said. Under the new wording, the Commissioner of Insurance may consider but will not be bound by market-based information in determining the company's fair-market value.

The company's net worth has been conservatively estimated at $100 million, Miller noted.

The bill also was amended to establish an appeals process for those believing they were adversely affected by actions taken during the public hearing process as the company goes through conversion.☐

Plan Regulation

Minnesota Senate Passes Maternity Length-Of-Stay Bill

ST. PAUL, Minn.—The Minnesota Senate Feb. 26 passed legislation that would require health care plans offering maternity benefits to cover at least 48 hours of inpatient care for new mothers and their babies.

The bill (HF 2008) was approved by the Senate on a 55-8 vote. Sen. Don Betzold (DFL-Fridley), the bill's sponsor, said it is nearly identical to a bill passed by the House of Representatives several weeks ago (2 MACR 151, 2/14/96). Like the House bill, the Senate version requires health care plans offering maternity benefits to cover a minimum of 48 hours of inpatient care for new mothers and their babies. New mothers who deliver their infants by cesarean section would be covered for a minimum of 96 hours of inpatient care, as would their babies.

The main difference between the two bills, Betzold said, is under the House health plans must only cover inpatient care up to the minimums specified if the care is determined to be "medically necessary" by the attending health care provider after consultation with the mother. The Senate version, he said, does not require a determination by the health care provider that the inpatient care is medically necessary.

Betzold said he did not include the "medically necessary" language in his bill because he viewed it as a loophole that would allow insurance companies to push for early hospital discharges.

The Senate version also contains a post-delivery provision, but, unlike the House version, it mandates that the care be delivered within four days of discharge. The precise timeframe was included, Betzold said, so there would be no question as to what a "reasonable time" constituted.

He added that the Senate bill also contains a provision that prohibits insurance companies from paying new mothers as an inducement to leave the hospital early.

The Senate bill could have been sent to the House for concurrence, Betzold said, but its House author, Rep. Joe Opatz (DFL-St. Cloud), has already indicated he will ask that a conference committee be appointed to resolve the differences in the two versions of the bill.

Sarah Stoesz, spokeswoman for Allina Health System Inc. of Minnetonka, Minn., one of the state's largest

h care systems, said it will not oppose either version .ne bill that is before the Legislature. However, she said, Allina does oppose setting health care policy in a piecemeal fashion.

She added that it is possible that the Legislature's mandating maternity stays may not fully resolve the issue of early discharges. The portion of the population covered by regulated health plans is decreasing, she said, as more employers turn to self-insurance to save money and save themselves from government regulations. She said less than 50 percent of the state's population is covered by regulated health plans.

Self-insured plans would not be bound by either bill, she said, nor would state residents covered by MinnesotaCare, the state's plan for the uninsured and underinsured.☐

Purchasing Coalitions

Colorado Bill Seeks To Preserve Ability Of Co-Ops To Obtain Discounts

DENVER—The Colorado House approved a bill Feb 27 that would allow health purchasing cooperatives to negotiate broad discounts with health plans.

The measure (HB 1264), sponsored by Rep. Steve Tool (R), was sent to the state Senate.

The bill seeks to correct a problem that if left alone [illegible]d wipe out the state's single co-op, The Alliance, Claire Brockbank, vice president of marketing for the cooperative, told BNA.

Authorizing legislation for The Alliance was approved in 1994. Then lawmakers approved House Bill 94-1193, allowing small employers—attempting to achieve the clout of larger companies—to buy health care coverage through cooperatives. Shortly after that, the Alliance was formed.

However, also in 1994, lawmakers approved a bill containing a provision that would bar insurers from offering discounts to cooperatives on medical and overhead costs as of Jan. 1, 1998. Because of a clause in HB 94-1210, insurance companies will have to add back into their rates brokers' fees and other administrative costs, although co-ops will continue doing some administrative work.

The Alliance will lose its clout and become irrelevant to prospective members, Brockbank told BNA.

Small insurance carriers will have to use a community rating if the provision in HB 1210 takes effect, she said. "We technically provide coverage in the small employe. market . . . that means we will not be able to negotiate in 1998."

'Oligopolies, Not Competition'

This year's HB 1264 would change that. "We have to y, 'Yes, co-ops can go out and negotiate,' " Brockbank said.

However, a lobbyist for the Colorado Group Insurance Association—representing brokers, agents, insurance companies, some managed care companies, and attorneys who work with employee benefits—told BNA The Alliance is trying to accomplish much more with HB 1264.

Right now, anybody in Colorado can form a co-op, said Peggy Sandbak, legislative chair of the Denver-based association. Attempts are under way to form a cooperative of state employees and local municipalities that could include upwards of 40,000 to 50,000 people, she said.

"If that mega co-op can go out and hammer down medical care costs," they will get discounts so deep smaller insurance companies would not be able to compete, Sandbak said. The end result could be only three or four health plans operating in Colorado, she warned.

"Health plans not chosen to participate in co-ops will leave the state, and your only choice of care will be cooperative health care," she said. "We'll wind up with oligopolies, not competition."

"It's a very short-term vision," she said, noting that the Colorado Association of Commerce and Industry, the state's leading business advocacy group, supports HB 1264 in its current form.

The Colorado Group Insurance Association also supports HB 1264, but thinks it should be amended, Sandbak said. "Both the insurance industry and co-ops agree [co-ops] ought to be able to negotiate" for discounts.

The association believes co-ops should retain the ability to negotiate better prices on the overhead piece of health care costs, she said. An adjusted community rating should be used for other costs, she said, so that costs for those outside a co-op are the same as for those inside.

The insurance association is hoping to amend HB 1264 when it reaches the Senate Health, Education, Welfare, and Institutions committee.

Brockbank said insurers are against the bill in its present form because what they have now amounts to a type of "government protection."

"Why would they want to negotiate?" she said. "It's in their total best interest not to negotiate."

The Alliance currently has some 7,500 covered lives from about 350 companies, she added.☐

In Brief

NORTH DAKOTA BLUES' UPDATE: In response to an early February decision by the board of directors of Blue Cross Blue Shield of North Dakota to convert the company from a health service corporation to a mutual insurance company (2 MACR 207, 2/28/96), Trent Heinemeyer, deputy commissioner and general counsel for the North Dakota Insurance Department, told BNA it is too early to say whether the department will agree to or oppose BCBS's plan. The company's petition has not been presented to the department yet, he said, so it does not yet know the particulars of how the mutualization will occur.

BCBS has indicated that its mutualization is not a first step toward demutualization, wherein it would become a for-profit company, he said, adding his understanding of the BCBS plan is that it would become a mutual insurance company, but it would remain nonprofit.

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Evelyn Murphy, executive vice president of Blue Cross and Blue Shield of Massachusetts, said her organization strongly supports the issuance of the guidelines. "These guidelines take the spirit and tradition of community-oriented non-profits, such as Blue Cross, and set the standard of giving back to the community as expected practice for all HMOs that want to do business in Massachusetts," Murphy said.

The guidelines establish nine principles for HMOs to follow. These include developing and making public a policy statement outlining an HMO's commitment to a formal community benefits program and calling on senior HMO officials to oversee the development and allocation of resources for such a program.

It also calls on the HMO to involve community members in defining the target population and the specific needs of that population. Each organization is called on to develop its program based on an assessment of the health care needs and the resources of the identified population.

The guidelines then direct the HMO to develop and market products that would attract all segments of the population, including direct enrollment for non-group coverage. HMOs should work to promote insurance reforms to make managed care an option for all working people, take steps to reduce cultural, linguistic, and physical barriers to health care, strive to assist consumers who are about to lose their coverage to maintain it as long as possible at reduced or subsidized rates, and issue an annual community benefits report.☐

Insurance Regulation

NAIC CHIEF RENEWS CALL FOR PSO RULES; ASSOCIATION TO EXAMINE STATE LAWS

Provider-sponsored organizations (PSOs) that take on risk should be subject to state insurance regulation to ensure an adequate level of consumer protection, Brian K. Atchinson, president of the National Association of Insurance Commissioners, said Feb. 26.

At a meeting of managed care health plans, Atchinson reiterated NAIC's view that risk-bearing, integrated provider groups—whether they take the form of physician-hospital organizations or independent practice associations—must be regulated. "We're going to ensure an appropriate level of regulatory oversight," he told the first annual policy conference of the American Association of Health Plans, held Feb. 25-27.

NAIC also will examine "how to regulate managed care in the marketplace without adding too many [regulatory] layers," Atchinson said, adding that state laws and regulations will be evaluated in terms of their efficiency and responsiveness to consumers and the managed care industry.

NAIC To Issue White Paper On Risk

Last summer, NAIC advised insurance regulators that PSOs accepting risk by providing care on a prepaid basis are in the business of insurance and should be regulated as such (3 HCPR 1340, 8/21/95). Within the next six weeks, NAIC plans to issue a white paper defining what a risk-bearing entity is, Atchinson said.

NAIC also is developing model acts for PSOs that would address such issues as solvency, rate regulation, state guaranty funds, and the development of a common form PSOs would file with state insurance regulators, he said.

NAIC model acts are not mandatory but may be voluntarily adopted by states and incorporated into their legislation. Most states still do not have a formal policy on the regulation of risk-bearing provider groups, but pressure to develop consistent standards is increasing (4 HCPR 324, 2/26/96).

Atchinson noted that PSOs have become a "lightning rod" for debate since they were included in Republican Medicare reform legislation. Bills approved by both the House and Senate would have allowed PSOs to bypass health maintenance organizations and health insurers and contract directly with the government to provide Medicare services (3 HCPR 2042, 11/27/95).

While congressional action on Medicare reform legislation is on hold, the debate over the appropriate degree of regulation for PSOs continues. Atchinson noted that "many of these entities will operate outside the Medicare arena," adding to the need for regulatory oversight.

State regulators and groups representing the HMO industry have consistently argued in favor of regulation, while the American Hospital Association and provider groups have argued against it.

State Health Regulation Increases

William T. Pound, executive director of the National Conference of State Legislatures, told conference attendees a "climate of deregulation" exists in state capitols today—except in the area of health care.

Some legislative and regulatory changes are being driven in part by efforts to reduce the growth of Medicaid spending, Pound said. States are facing the possibility that federal funds for public programs such as Medicaid will be capped or eliminated. At the same time, state expenditures on Medicaid, which have increased from 9.1 percent in 1990 to 12.8 percent in 1994, are "driving out spending in other areas," he said.

There also is a movement in the states to increase health insurance portability and to increase the availability of insurance while reducing the cost for small employers, Pound said.

States continue to enact legislation designed to prohibit managed care plans from including "gag provisions" in contracts with their network physicians, he observed. Federal legislation recently was introduced (*see related report in this issue*) following activity at the state level, including a new law enacted in Massachusetts (4 HCPR 138, 1/29/96) and similar initiatives pending in New York, Georgia, and Indiana.☐

Minnesota

SENATE APPROVES POST-NATAL BILL, MEASURE MOVES TO CONFERENCE COMMITTEE

ST. PAUL, Minn.—The Minnesota Senate Feb. 26 passed legislation that would require health care plans offering maternity benefits to cover at least 48 hours of inpatient care for new mothers and their babies.

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HF 2008, approved by the Senate on a 55-8 vote, is now expected to head for conference committee. The House passed a similar bill several weeks ago (4 HCPR 246, 2/12/96) and the conference committee will address the differences in the two pieces of legislation.

Sen. Don Betzold (DFL-Fridley), the Senate sponsor of HF 2008, said it is nearly identical to the bill passed by the House. Like the House bill, he said, his bill would require health care plans offering maternity benefits to cover a minimum of 48 hours of inpatient care for new mothers and their babies. New mothers who deliver their infants by cesarean section would be covered for a minimum of 96 hours of inpatient care, as would their babies.

The main difference between the two bills, Betzold said, is the House bill's requirement of medical necessity. Under the House version of the bill, health plans only would have to cover inpatient care up to the minimums specified if the care is determined to be medically necessary by the attending health care provider after consultation with the mother. The Senate version, he said, would not require a determination by the health care provider that the inpatient care is medically necessary.

'Medically Necessary'

Betzold said he did not include the "medically necessary" language in his bill because he viewed it as a loophole that would allow insurance companies to push for early hospital discharges of new mothers and their infants. Since the phrase "medically necessary" is rather vague, he said, he had concerns that new mothers only would have coverage provided them for 48- or 96-hour stays if they were hemorrhaging or facing other serious health problems related to their deliveries.

According to Betzold, his concerns are based on the fact that no policies now require new mothers to be discharged within 24 hours of their deliveries. There are protocols, however, he said, and physicians are encouraged to adhere to them. He said he believes that if the "medically necessary" language is included in the bill, insurance companies will continue to make medical decisions in place of doctors.

The House version of the bill would require that new mothers who are discharged prior to what their policy covers be provided with post-delivery care. The bill states that the care would be a minimum of one house visit by a registered nurse, who would be required to provide parent education, train the mother on breast and bottle feeding, and conduct any necessary clinical tests. Under the House version of the legislation, the post-delivery visit must be made within a reasonable time after the mother's discharge.

Betzold said the Senate version contains the same provision on post-delivery care, but would mandate that the care be delivered within four days of discharge. The precise timeframe was included, he said, so there would be no question as to what a "reasonable time" constituted.

He added that the Senate bill contains a provision that would prohibit insurance companies from paying anything to new mothers as an inducement to leave the hospital early.

The bill could have been sent to the House for concurrence, Betzold said, but its House author, Rep. Joe Opatz (DFL-St. Cloud), already has indicated he will ask that a conference committee be appointed to resolve the differences in the two versions of the bill.

Plan Won't Oppose

Sarah Stoesz, spokeswoman for Allina Health System of Minnetonka, Minn., one of the state's largest health care systems, said it will not oppose either version of the bill that is before the Legislature. However, she said, Allina does oppose setting health care policy in a piecemeal fashion.

She added that it is possible that the Legislature's mandating maternity stays may not fully resolve the issue of early discharges. The portion of the population covered by regulated health plans is decreasing, she said, as more employers turn to self-insurance to save money and save themselves from government regulations. She said less than 50 percent of the state's population is covered by regulated health plans.

Self-insured plans would not be bound by either bill, she said. State residents covered by MinnesotaCare, the state's plan for the uninsured and under-insured, also would not be covered by the legislation's mandates, she said.□

District of Columbia

MEDICAID PILOT LAUNCHED TO IMPROVE, COORDINATE CARE FOR DISABLED CHILDREN

The District of Columbia is moving forward with its innovative managed care program for disabled children who qualify for Medicaid and more than 100 children already enrolled in the voluntary program will begin receiving enhanced benefits and coordinated services soon.

The District has contracted with Health Services for Children with Special Needs Inc. (HSCSN), a non-profit organization that developed a coordinated care system designed to work with families of children with physical and emotional disabilities to arrange comprehensive care and pay participating health providers a prepaid monthly capitation rate. HSCSN is part of the HSC Corp., which has been serving District families for more than 110 years through the Hospital for Sick Children. HSCSN has contracts with 1,200 health care providers to serve about 3,200 eligible children.

Program Elements

The HSCSN program features six major elements: a comprehensive benefit package (including long-term care), capitation-based financing, community-oriented service delivery, individualized care management, quality management, and information technology, according to an HSCSN fact sheet on the program.

Enhanced benefits beyond those currently available under Medicaid are offered to program enrollees, including transportation, appointment scheduling, and respite care. Each child enrolled has a designated primary care doctor and a care manager who coordinates all care, the fact sheet said.

Heinemeyer said BCBS's proposal will be thoroughly scrutinized once it is submitted. The department's obligation is to protect policyholders and subscribers in the state, he said, and it will ensure BCBS's plan is fair and equitable to them before it approves the plan.

The petition is subject to a public hearing, he said, although the department commissioner will have final say on whether the mutualization will occur.

■ ■ ■

MEDICARE AND MSAs: Medicare beneficiaries who spend less than $1,000 on health care annually probably would benefit from using medical savings accounts, but Medicare would then lose about $2,400 per beneficiary—the amount that would be transferred to beneficiaries and their insurers, according to a draft chapter of an upcoming report from the Physician Payment Review Commission.

"Beneficiaries who expect high expenditures should find MSAs unattractive: it is cheaper to purchase Medigap insurance than to spend up to a large deductible," said the draft of PPRC's report due to Congress in April.

PPRC considers highly possible the situation in which only younger, healthy beneficiaries chose MSAs—in which case, the average medical costs for the relatively sicker beneficiaries remaining in traditional Medicare would increase, costing the program more.

Based on the theory it is Medicare's responsibility to avoid overpaying plans that attract favorable selection, PPRC recommended, in part, that:

- MSA enrollment and disenrollment rules be structured to reduce potential for favorable selection, such as longer enrollment periods or requiring beneficiaries to announce disenrollment one year in advance;
- MSAs should have at least the same standard as Medicare risk contract health maintenance organizations for data reporting; and
- Current-law restrictions on HMOs offering high deductibles should be removed if MSAs are allowed.

Congress may want to consider means testing for MSAs, suggested Roger S. Taylor, executive vice president and chief medical officer of PacifiCare Health Systems Inc.

Under the GOP Medicare reform proposal, the MSA option would include a catastrophic insurance policy and a savings account. Medicare would pay a premium directly to the insurer, and any remaining funds would be deposited into the beneficiary's account. Medicare's total payment would vary based on age or sex of the beneficiary.

Deductibles would be less than $6,000, and the beneficiary would pay for all medical care below the deductible themselves. Costs above the deductible could be subject to balance billing.

■ ■ ■

SOUTH DAKOTA MATERNITY STAY BILL: A bill that would establish minimum requirements for maternity health benefits in South Dakota was forwarded to Gov. William Janklow (R) Feb. 24.

SB 192, authored by Sen. Pam Nelson (D-Sioux Falls), requires that all health insurance policies offering maternity benefits base coverage upon standards established by the American College of Obstetricians and Gynecologists, she said. At present, the standards call for coverage of at least 48 hours for regular deliveries and 96 hours for cesarean deliveries, according to Nelson.

The bill does not mandate that new mothers and their babies remain in the hospital for the specified timeframes, Nelson said. Instead, she said, it mandates coverage minimums. Decisions on discharge will still be up to new mothers and their attending physicians, she said.

SB 192 also includes an exception to its coverage requirements. Nelson said health plans need not cover the specified minimum stays if they offer postdelivery care for both new mothers and infants. While the bill originally called for post-delivery care to be defined as three home visits by a registered nurse within five days of the family's discharge, it now calls for one visit, she said.

However, she said, the bill also provides that health plans offering post-delivery care are not exempt from the 48 and 96-hour requirements if the attending physician determines that inpatient care is medically necessary.☐

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From:
ALASKA LEGISLATIVE
RESEARCH AGENCY

Quality Assurance

NCQA RELEASES FINAL VERSION OF MEDICAID PERFORMANCE MEASURES

The National Committee for Quality Assurance Feb. 1 announced the availability of the final version of performance guidelines for assessing Medicaid health care services.

"The release of Medicaid HEDIS heralds a new era in which all health plans, whether they serve privately or publicly insured members, will be held accountable for the quality of the care and services they deliver," NCQA President Margaret E. O'Kane said in a statement. "And it ensures that [the Health Care Financing Administration] and the state Medicaid agencies will have the tools they need to assist health plans in continuous improvement."

The new performance measures were based on NCQA's Health Plan Employer Data and Information Set, known as HEDIS, and were designed to assess specifically health plan performance in providing services to children and pregnant women. According to NCQA, 75 percent of Medicaid managed care enrollees are under age 20, which is why the Medicaid HEDIS focuses on child and maternal health, and on measuring access to care for Medicaid beneficiaries—a traditional area of concern.

NCQA worked with HCFA, the American Public Welfare Association, and a coalition of private and public sector groups over 18 months to develop the Medicaid HEDIS measures using $400,000 in grant monies from the David and Lucile Packard Foundation's Center for the Future of Children.

The draft version of Medicaid HEDIS was released for review in July 1995 (3 HCPR 1116, 7/17/95); the final version incorporates the comments of the 120 organizations and individuals who reviewed the draft. State Medicaid agencies will receive the final version of Medicaid HEDIS the week of Jan. 29, NCQA said.

Promising to "aggressively promote the use of Medicaid HEDIS," HCFA Administrator Bruce C. Vladeck called the release of the new performance measures "a significant event in our common drive to pursue and fulfill the promise of managed care in improving access and quality for this vulnerable population."☐

Post-Natal Care

CONNECTICUT LAWMAKERS CRAFTING BILL THAT WILL NOT RAISE ERISA CONCERNS

BOSTON—Connecticut lawmakers are seeking a way to compel longer hospital stays for all women after giving birth, without raising ERISA preemption issues or leaving patients covered by self-insured plans outside the mandate, according to a co-chairwoman of the Committee on Public Health.

Connecticut State Rep. Anne McDonald (D) said the legislature will give early consideration to a bill that would require insurers to offer coverage for up to 48 hours after a regular delivery and 96 hours after a cesarean section. The legislation, which is still in the form of a draft measure (LCO No. 2), will be a top priority when the General Assembly convenes Feb. 7. "The issue is like motherhood, apple pie and the Fourth of July," McDonald told BNA. It is supported by a majority. Even the insurance companies are going along, she said.

But McDonald said concern has been raised about the portion of the population that would not be covered if the mandate applies only to the insured and not the self-insured segment of the marketplace. "We would like it to cover everybody," she said Jan. 30. According to McDonald, approximately 50 percent of the population would not be covered by the mandate if the legislation is written only to require insurance carriers to pay for the extended stay.

However, she noted, if the state requires self-insured plans to provide similar coverage, it would raise the ERISA preemption issue. Under the Employee Retirement Income Security Act, states are barred from imposing regulations on self-funded plans.

Placing Burden on Hospitals

As a result, McDonald said, lawmakers are considering an approach under which hospitals would be required to allow patients to stay 48 or 96 hours after delivery. The question then arises over who would pay for the cost of the care, she said.

Washington, D.C., attorney Michael S. Gordon agreed that requiring all health plans, including self-insured plans, to provided extended care would "definitely run afoul of ERISA." Gordon specializes in pension and employee benefit law.

Gordon suggested that if the mandate was laid on the hospital, and the cost of extended care was then covered by a surcharge on payers, that would meet the test set forth in the most recent U.S. Supreme Court ruling on ERISA preemption.

In that decision, *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, (3 HCPR 704, 5/1/95), the U.S. Supreme Court ruled that a provider tax which raised funds to cover the costs of the non-insured and to compensate hospitals for state-imposed rate limits was not preempted by ERISA.

Gordon explained that because the item at issue was a tax and not a state regulation, it was allowed. Similarly, he suggested, a state might be able to avoid an ERISA preemption of a regulation mandating self-insured plans to offer extended maternity stay by requiring hospitals to provide that coverage and recover the costs through a surcharge arrangement. There is nothing in ERISA that preempts states from legislating rules on hospitals and then creating an

arrangement for hospitals to recoup their costs, Gordon explained.

AG Studying

Richard Kehoe, general counsel for Attorney General Richard Blumenthal, said his office is studying the issue and expects to make a recommendation on the issue in early February. He said he hopes a simple approach to ensuring extended maternity stays can be reached without developing another "uncompensated care pool" arrangement involving a hospital tax.

New York State is searching for a similar solution. In that state, a conference committee of the Assembly and Senate is attempting to reconcile differences between two bills that passed in January.

The Assembly-passed bill would set minimum stays of two days for a regular delivery and five days for a cesarean delivery (4 HCPR 104, 1/22/96). In an attempt to cover all deliveries, the bill would impose the requirement on hospitals, not insurers and health maintenance organizations (A 8125).

The bill which passed the Senate would set minimum stays of two days and four days. The legislation would impose the requirement on insurance policies and HMO contracts (S 5742).

New York Assemblyman Richard Gottfried (D), chairman of the Assembly Health Committee and sponsor of the Assembly measure, said the Senate bill would not cover women in self-insured plans, women with no health insurance, and certain others.

"The Senate bill would not help more than half the newborns and women in working families," Gottfried said in a statement. "Without the hospital clause in the Assembly legislation, these mothers and newborns would be left out in the cold."

Rhode Island Bill

Similar legislation pending in Rhode Island only would apply to health insurers and HMOs. Two bills, S 2074 and H 1723, appear primed and ready to move, according to Blue Cross and Blue Shield of Rhode Island lobbyist Scott Fraser. Those bills, which are virtually identical, do contain language that would allow the stay to be shorter than 48 hours for regular delivery and 96 hours for a cesarean delivery in cases where both the doctor and the mother feel a brief stay is appropriate.

Fraser said he believes the number of Rhode Island residents covered by the law would be greater than 50 percent since Blue Cross and Blue Shield alone provides coverage for more than half the state's population.

In Massachusetts, legislation was passed in 1995 requiring health insurers and HMOs to pay for 48 or 96 hours of care following birth (3 HCPR 2055, 11/27/95). It also contains language allowing for shorter stays with physician and patient approval.

That bill, however, also amends the hospital licensing requirements to require that all women entering the hospital for the purpose of giving birth be allowed to stay the 48 or 96 hours after delivery. It does not specify who must pay for the cost of the care if the patient is covered by a self-insured plan which declines to pay for extended coverage.

"This is not an end-run around ERISA," explained Sean Fitzpatrick, a spokesman for the Massachusetts Department of Public Health, which is charged with overseeing the law. "It is simply an attempt to establish in the hospital licensing regulations policy regarding what is good treatment of a patient," regardless of by whom that patient is insured, he said.

Other states that have enacted laws requiring postnatal hospital stays include Maryland (3 HCPR 905, 6/5/95), New Jersey (3 HCPR 1091, 7/10/95), and North Carolina (3 HCPR 1275, 8/7/95).☐

—By Martha Kessler

Colorado

INSURERS VOLUNTARILY AGREE TO COMPLY WITH PROPOSED MATERNITY STAY STANDARDS

DENVER—Insurance companies and a Colorado state lawmaker have made a "voluntary arrangement" in which the insurers agreed to comply with maternal length-of-stay standards a proposed bill would have required (HB 1015).

In exchange, state Rep. Marcy Morrison (R) withdrew House Bill 96-1015, which would have required insurers to provide 48 hours of inpatient care for mothers and newborns without the attending physician having to obtain authorization from the insurer for such care.

Under the "arrangement," nine insurers agreed to voluntarily provide the health care benefit for vaginal births. For casarean-section births, mothers can receive up to 96 hours of inpatient care, Morrison told BNA.

Also, the insurers said they would follow standards set by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology in conducting utilization reviews, said Barbara Yondorf, director of policy and research for the Colorado Division of Insurance, which helped facilitate the agreement.

And, Morrison said, the companies said they would "make a great effort to direct information to pregnant women, their pediatricians, and new moms about the use of these guidelines."

Morrison said the legislation's goal was to ensure new mothers are not released from the hospital prematurely.

Carriers that were involved in the legislation wrote letters to the division of insurance signaling their willingness to comply with the arrangement, Yondorf said. "We will hold them to it," she said.

Carl Miller, spokesman for Blue Cross and Blue Shield of Colorado, said the company was pleased with the process of forging the arrangement.

"That's one we'd like to go through on every piece of legislation," he said. "Why pass a law that can be misconstrued by lawsuits and all kinds of things down the road? We knew what the sponsors intended, and we knew there wasn't a problem responding to what they were doing."

He said the insurers are going to work with the Colorado chapter of the professional provider organizations to implement education and outreach programs.☐

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tionate share payments. Once the state collects this $116 million, it plans to turn around and apply it to Medicaid, generating another $298 million in federal funding, according to DHH Secretary Bobby Jindal and Undersecretary David Hood.

"It turns out the state, as a health care provider, was not properly compensated for indigent care it has provided," Jindal said in a statement. According to Hood, "The money is owed to us from prior years. It is money that is in excess of that budgeted. It creates a surplus."

But the money may not be coming to the state from the federal government as quickly as Louisiana might hope. Pamela Gentry, a press officer at the Health Care Financing Administration, told BNA that HCFA does not know what the state is talking about regarding over $400 million in money Louisiana says Washington owes it.

"The dollars quoted, ... we're not sure what is involved," said Gentry. "We're in the process of getting together with the state to see what they're referring to."

HCFA plans to "get together with state [officials] and get documentation of what money they're referring to. We don't know what it is," Gentry added.

'A Legitimate Collection'

Hood told BNA that HCFA has not yet contacted DHH. If and when it does, the state will make the point that the money is "a legitimate collection we can make. We would be remiss if we didn't." Hood went on to say that there is "nothing too mysterious about this. We are collecting what is legally owed to our state hospitals. Medicaid has a liability to pay these hospitals."

Specifically, DHH plans to submit with its regular Medicaid request next quarter, claims against the federal government totaling $116 million. This money will be generated from three areas:

- paying prior year cost settlements;
- paying additional uncompensated care costs for the current and prior fiscal years; and
- reopening cost reports dating from fiscal year 1988-90 to allow additional disproportionate share payments, according to a DHH statement and Hood.

Hood, who serves as chief financial officer of DHH and oversees the Medicaid program, explained that when his office conducted an audit of the Medicaid program going back to 1988, he found that charity hospitals run by the Louisiana Health Care Authority and facilities operated by the DHH are owed prior year cost settlements totaling $49 million. Of this, $38 million is federal Medicaid money that the state never collected.

This money is owed to the state from prior fiscal years, Hood said, and is based on the fact that hospitals "file cost reports because they are on a retrospective budget." At the end of the year, hospitals "file cost reports where the true costs are listed," Hood said.

Retrospective Budget

"Private hospitals do it all the time," Hood explained. "When you're on a retrospective budget, there is no limit on how far back you can go." He noted that there "are many private companies who do a very good business on a contingency basis" doing cost settlement reports for private hospitals and collecting "every nickel" the states and federal government owes to these h[illegible] doing the same thing, Hood said.

From: ALASKA LEGISLATIVE RESEARCH AGENCY

The state also believes it is owed [illegible] million from the federal government for "uncompensated care costs," mostly from fiscal year 1994-95, according to Hood. Hood said this is a "recalculation of the total amount we can pay based on the number of indigent care patient days." The total amount owed to LHCA and DHH for indigent care is $86 million, Hood said, but because the costs are shared by the state and the federal government, HCFA owes $62 million.

The state has also "reopened cost reports" dating as far back as fiscal year 1988-89. "There is additional money there as well [in] disproportionate share payments" totaling $39 million owed to the state, Hood said.

All told, the state Medicaid program has been underfunded by $139 million since fiscal year 1988-89, according to DHH. When the state's share is taken out, the federal government owes $116 million. Hood said that once this money is collected from the federal government it becomes the state's money to do with what it pleases.

Generate Matching Funds

What the state plans to do is use this money to generate more federal matching dollars totaling $298 million. When it is all added together, the federal government will owe Louisiana $414 million that the state plans to collect during the next quarter, when the state essentially runs out of money in Medicaid, Hood said.

Jindal said he has "condemned this type of refinancing in the past [because] it was used as an excuse to make the budget grow." He said that using federal dollars to generate more federal dollars "is essentially how we found ourselves with an $820 million financing deficit in 1995: windfall money was treated as recurring revenue. We will not repeat that error. These are non-recurring funds and cannot be used to solve our enormous budget problem for the coming fiscal year," Jindal said.

For the next fiscal year, which begins July 1, the Medicaid program faces a shortfall of $1 billion, according to DHH. "Next year's problem remains huge—at least $330 million in state funds." Jindal said he remains "committed to reforming the entire system, rather than finding temporary solutions," like the one being employed for the current fiscal year. Jindal noted he only took office on Jan. 8 and "inherited a $475 million ... problem."

Even with the federal money, assuming it materializes, the Medicaid program is still $38 million over budget for the year in state money. Hood said he plans to submit in two weeks to the Legislature a list of cuts to Medicaid.☐

Georgia

BILL MANDATING MINIMAL HOSPITAL STAYS FOR POST-NATAL CARE APPROVED BY SENATE

ATLANTA—Legislation (SB 482) that would require insurers to cover a minimum hospital stay of two days

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for a mother and newborn after a vaginal delivery, and a minimum of four days following a cesarean section, was approved by the Georgia Senate Jan. 25 by a vote of 54-1.

Sen. Nadine Thomas (D), one of the bill's sponsors, said the bill had widespread support among state legislators and would likely be approved by the Georgia House and signed into law by Gov. Zell Miller (D). The bill currently is pending before the House Insurance Committee.

Bill Features Strong Provisions

Thomas, who is a registered nurse, said discharges of mothers and babies after 24 hours means many "have not had an opportunity to be given instructions on how to care for the baby, how to care for themselves, and the importance of follow-up." She modeled the legislation after similar bills in Maryland, New Jersey, and North Carolina and conformed it to meet the needs of Georgia residents.

Under the Georgia bill, new mothers have the option of going home after 24 hours if a patient's obstetrician approves early discharge, but insurers must pay for a follow-up visit, and a second one if necessary, by a registered nurse within 48 to 72 hours after birth. "We have a strong bill," Thomas said.

Thomas said the bill also will apply to Medicaid patients.

The bill was initially filed at the urging of nursing groups, she noted, but once it was publicized about 20 organizations ranging from the Junior League to Georgians for Children declared their support. Health maintenance organizations have mounted quiet opposition to the bill, but so far have not gained substantive support for their position, according to Thomas.□

New Jersey

WHITMAN PROPOSES CUTS IN PROGRAM SUBSIDIZING DRUG COSTS FOR SENIORS

PHILADELPHIA—Among the most controversial spending cuts in the $16 billion fiscal 1997 state budget recommended by New Jersey Gov. Christine Whitman (R) Jan. 29 is a proposal to cut $26 million from a state program that subsidizes prescription drugs for some 224,000 seniors and disabled people.

The annual cost of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program has ballooned from $8 million when it was established in 1975 to $170 million last year, Peter Verniero, Whitman's chief of staff, said during a Jan. 27 press briefing on the proposed budget.

"We must find ways to bring the cost of programs under control or we may lose the ability to provide these services to even the most needy in the future," Verniero said.

The Whitman administration is proposing an assets test on current PAAD participants, excluding nonliquid assets such as a house and car, with a goal of disqualifying 30,000 of them from the program. "We're not wedded to the assets test per se," Verniero noted, emphasizing that the governor will work with state lawmakers to identify alternatives if necessary.

The present income eligibility standard for seniors and the disabled under the PAAD program is $17,056 for single people and $20,913 for married couples. The program pays the full cost of prescriptions minus a $5 copayment paid by the recipient.

Minority Democrats in both houses of the General Assembly promptly denounced the proposal as unfair and mean-spirited and vowed to work with senior citizen groups to defeat it. In a statement issued Jan. 30, Senate Minority Leader John A. Lynch said the Senate Democratic caucus unanimously agreed to work to kill the proposed means test for PAAD eligibility.

Medicaid Managed Care

In her budget address, Whitman reaffirmed her commitment to shifting all New Jersey Medicaid recipients into managed care programs, asserting that the move will result in better health care for people on Medicaid as well as savings for the state's taxpayers. She also announced an initiative that aims to save money by cutting down on fraud and abuse in the Medicaid program through the use of standardized prescription forms and a requirement that all Medicaid recipients choose a single pharmacy to fill all their prescriptions.

In response to concerns expressed by frustrated senior citizens, Whitman proposed consolidating all senior services and funding into the state Health Department, which would be renamed the Department of Health and Senior Services. Currently, senior services are spread among three departments, with the Health Department handling long-term care, the Human Service Department dealing with Medicaid, and the Community Affairs Department responsible for housing.

Notably absent from the 1997 recommended spending plan is any provision for reimbursing New Jersey hospitals for charity care expenditures. Payroll taxes had been diverted from the state's unemployment fund since 1993 to pay for charity care, but that authorization expired Dec. 31, 1995. State lawmakers last year rejected Whitman's proposal to fund uncompensated care by increasing the cigarette tax by 25 cents a pack to raise about $400 million a year.

"Charity care as an issue is on the sidelines until the Legislature submits a proposal of its own for our review," Verniero said.□

Florida

BUDGET PLAN ESTIMATES SAVINGS OF $44.4 MILLION FROM MANAGED CARE

TAMPA, Fla.—Expanding delivery of managed-care services to Florida's poor in the coming fiscal year will save taxpayers an estimated $44.4 million, according to a summary of the 1996-97 budget proposal released Jan. 18 by the office of Gov. Lawton Chiles (D).

In the budget plan, the Chiles administration said it would save $33.5 million through increased use of managed-care for Medicaid recipients and another $10.9 million from managed-care techniques in providing services to persons with drug, alcohol, or mental-health problems.

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In Government

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 establsh 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 Stites, 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, 8/16/95). It "substantiates what they've [attorneys] been saying all along"—that risk-bearing entities will be regulated, Stites 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, Stites 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

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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) sign 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 8125, 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 28 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 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."

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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./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, 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

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From:
ALASKA LEGISLATIVE
RESEARCH AGENCY

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 Barbin, criminal justice director for Attorney General Betty Mongtomery, 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 allo[illegible] 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

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With critical legislative elections taking place later this year, however, it is doubtful that 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 8, 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 anyone under age 16 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 28 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 kind in the nation, will save the state an estimated $17

From:
ALASKA LEGISLATIVE
RESEARCH AGENCY

SPECIAL REPORT

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 28 (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

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the introduction of Curry's bill, Hironimus said. He d the change in policy a "progressive and proac- move to satisfy the Blues' southeastern Pennsyl- .a 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 common neonatal problems such as jaundice or dration, according to the bill's author.

.. 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 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 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 Pisaro, 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

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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 percent of infants with inadequate PKU tests in 1993 never 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" 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.

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 600 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.

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

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From:
ALASKA LEGISLATIVE
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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 12 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.

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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, 8/7/95).

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

MSAs COULD REDUCE MEDICAL COSTS; SAVINGS 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-pocket spending associated with the catastrophic-level deductibles," 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. 3 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.

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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 anticipa[illegible] the program will serve an average of 750 to 600 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 $29,880 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)

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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 8125, S 5322). 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.

Elizabeth 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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From:
ALASKA LEGISLATIVE
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Access

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 27.8 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 31.6 million), Medicare (12.9 percent or 33.9 million), and military health care coverage (4.3 percent or 11.2 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 has 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.

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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 circum- 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."

Articles

New York Times
p. A17
October 11, 1995

HEALTH

Check in, deliver, go home

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

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

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 ponied 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 1:25 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 had 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 just been in the hospital longer, I would have had an easier time."

Six 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 overseas (box) to a national average of about 2½ days in 1992, the latest available figure. That's roughly five hours shorter than the 1991 average but still munificent compared with the 24 to 36 hours most health care plans now stipulate for routine vaginal deliveries—which can mean a late-night discharge. Three days is standard for Caesarean births. Some providers, primarily on the West 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.

"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,

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 all-day nurse for a week
Sweden: 1 to 3 days, with midwife home visit
United States: 24 to 36 hours

USN&WR – Basic data: Embassies, health ministries, health plans and insurers

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 Johnson, 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 740,000 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 Doyle, 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 83 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 3 percent of some 7,000 crib deaths annually. "I'm thankful I stood my ground," says Mulhall.

Not all mothers are so insistent, nor their babies so fortunate. In 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

support. "It's unbelievable what we find on home visits," underscores obstetrical 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 opened the door to find a newborn vomiting meconium – its own fecal matter, swallowed in utero.

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

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 $800 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

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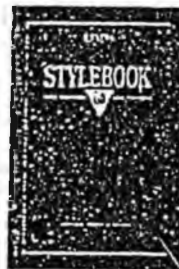

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Soon

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 Moriwaki, 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

Eric Shambroom/Black Star

ties, the average length of stay for mothers and babies dropped from 4.1 days in 1970 to 2.4 days by 1993.) In its statement, ACOG cited reports of two serious problems that doctors were suddenly seeing: babies suffering brain damage from untreated jaundice that parents weren't trained to recognize, and breast-fed babies suffering from dehydration because mothers didn't realize they weren't getting enough milk. Soon after, the American Medical Association passed a resolution saying that discharges should be "determined by the clinical judgment of attending physicians and not by economic considerations."

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

In May, Maryland passed a law requiring that infants who are discharged in 24 hours meet certain medical criteria and receive a home visit. In June, New Jersey legislators passed a stricter law mandating insurance companies and HMOs to cover a 48-hour stay in the hospital if the mother requests it. Alan Langsner, M.D., senior consultant of pediatric cardiology at St. Barnabas Medical Center in Livingston, NJ, told legislators that "it is only a matter of time before an infant with a correctable cardiac lesion dies in the name of early newborn discharge." Parents, doctors say, have no way of recognizing the subtle signs–bluish red or purplish blood or small changes in skin coloring–of that heart condition.

By summer, bills were introduced in New York, California, Pennsylvania, and Massachusetts. In June, Senator Bill Bradley (D-NJ) filed a bill to require health insurers [to a]llow new mothers to remain in the hospital for a mini[mu]m of 48 hours (96 hours for a cesarean); Senator Nancy Kassebaum (R-KS) signed on as a cosponsor. In the House, Congressman George Miller (D-CA) proposed a similar bill. Even the leading ladies in both political parties–First Lady Hillary Rodham Clinton and New Jersey's Republican 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 Burn-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 10:30. "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 12:12 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

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address

6TH STORY of Level 1 printed in FULL format.

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SECTION: HEALTH; Pg. Z10

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HEADLINE: Discharged Too Soon!; Doctors Across The Country Are Alarmed By An Increase In Complications In Newborns Who Have Left The Hospital After One Day

BYLINE: Sandra G. Boodman

BODY:

Mahiri G. MacDonald thought she'd seen her last case of kernicterus, a rare and devastating complication of advanced, untreated jaundice, during her medical training 25 years ago. But in the past two years MacDonald, director of the neonatal intensive care unit at Children's National Medical Center in Washington, has treated four newborns with the preventable disorder. One infant died and three others may have permanent brain damage. All had been discharged from area hospitals less than 48 hours after delivery.

The Washington cases are not isolated. Between 1992 and 1994 five newborns were admitted to the neonatal intensive care unit of San Francisco General Hospital for treatment of brain damage due to bilirubin encephalopathy, also caused by untreated jaundice. All five, who doctors say have suffered permanent brain damage, were born healthy, and all were discharged from California hospitals less than 28 hours after birth. When he searched records for similar cases, the hospital's chief neonatologist said he found only one case among 23 hospitals, including San Francisco General, between 1972 and 1991, when maternity stays were longer.

Between 1992 and 1994, a period when the average stay after a normal delivery dropped from 72 to 24 hours in Cincinnati, doctors at Children's Hospital Medical Center saw a 30 percent increase in readmissions for jaundice and a threefold increase in readmissions for severe dehydration in breast-fed infants less than 4 weeks old. Three babies suffered serious blood vessel problems, according to chief neonatologist Reginald Tsang; one required a leg amputation.

Michelina Alanna Bauman was discharged from Kennedy Memorial Hospital in Washington Township, N.J., on May 17, about 28 hours after her uneventful birth. She died at home a day later of a massive, undetected bacterial infection, a problem the hospital's vice president for medical affairs said probably would have been detected and treated with antibiotics had she remained in the hospital a day longer.

These infants and their families are part of a profound shift in medicine: the trend toward shorter hospital stays for virtually every ailment. In 1970, the average stay after an uncomplicated vaginal delivery was about four days. By 1992 it had been cut to about two days; today the average for an uncomplicated delivery is about 24 hours. In California, where short stays were pioneered by Kaiser Permanente, the nation's largest health maintenance organization, some insurers are authorizing only a 12-hour stay, according to officials at the American College of Obstetricians and Gynecologists (ACOG), which opposes the

ine imposition of early discharges.

Critics call these short hospitalizations "drive-through deliveries" and say speedy discharges amount to a dangerous, uncontrolled experiment by insurers and health maintenance organizations eager to cut costs. Insurance companies maintain, however, that short stays are both good medicine and good business. They note that hospitals, by their very nature, are teeming with germs that pose an unnecessary risk to healthy babies and mothers who don't need to be there.

There is no dispute that shorter stays represent an enormous cost savings. Childbirth is the most common cause of hospitalization -- about 4 million babies are born annually in the United States -- and an additional night in the hospital costs between $ 700 and $ 1,110.

States Strike Back

Last month ACOG, which recommends that new mothers spend at least 48 hours in the hospital after an uncomplicated birth and 96 hours after a Caesarean delivery, called for a moratorium on shorter stays and challenged insurers to prove that they are safe. That view was echoed last week by the American Medical Association, which passed a resolution urging that postnatal discharges be "determined by the clinical judgment of attending physicians and not by economic considerations."

These views have received a sympathetic hearing in the state legislatures of Maryland and New Jersey. Both states recently passed bills that prescribe postnatal care. Maryland's bill, signed into law several weeks ago by Gov. Parris N. Glendening (D), requires that mothers and infants discharged within 24 hours meet certain criteria and receive a home visit by a nurse.

New Jersey's more far-reaching bill, which sailed through the Republican-controlled legislature with strong bipartisan support, requires that insurers pay for a stay of at least 48 hours if requested by the doctor or mother. Gov. Christine Todd Whitman (R) is likely to sign the bill tomorrow. Lawmakers in New York are planning to introduce a similar measure in the next few months.

"I don't know if this is a trend or not," said Kathryn Moore, a lobbyist for ACOG. "It is indicative of the frustration with managed care and with insurance company edicts that make no sense."

Geni Dunnells, executive director of the Maryland Association of HMOs, said that the Maryland law, which takes effect Oct. 1, "sets a bad precedent" by legislating medical care. The chief reason for its passage, she said, was not evidence but emotion. "There are a lot of emotions surrounding how long a woman should stay in the hospital" after childbirth, she said.

Kylanne Green, executive vice president of the Health Insurance Association of America, the Washington-based trade association for 230 commercial insurers, agreed. "I don't think we have any empirical evidence one way or the other that it's safe," she said.

"Keeping a baby in what is essentially a high-risk situation [a hospital nursery] simply for observation is not wise," Green added. "I truly believe that a lot of what is stimulating all of this is that the mothers are pushing this.

t of mothers are working mothers. . . . They work up to the time of delivery . . . they're tired. While we can sympathize with that, do you use health insurance dollars to pay for this?"

Cost is not the primary consideration, added Susan Pisano, communications director for Group Health Association of America (GHAA), the trade association that represents the majority of the nation's 574 HMOs. Pisano said that shorter hospital stays work well for most families and that if a patient needs a longer hospitalization, a doctor can authorize it. "We think that medical decisions should be made by medical people on a case-by-case basis and not by legislators," Pisano said. "It comes down to this: providing the right care in the right place at the right time."

Few doctors would disagree with that premise, and even the most ardent critics of early discharge acknowledge that most babies and mothers are not going to have serious medical problems. "Most people are not going to have a catastrophic event," said Maureen Edwards, chief of neonatology at George Washington University Medical Center, who believes short stays have yielded mixed results. "We did one thing that probably wasn't bad, which was to shorten the stay of people who didn't need to be in the hospital. The problem is the piece that comes after the hospital -- we didn't have any other system in place" for noninstitutional care.

Nevertheless, the pressure by insurers to discharge patients as soon as possible is unremitting, Edwards added. "We have patients going home at 10 or 11 o'clock at night -- it's crazy," she said. In some cases when a mother develops an infection or other complication and requires an extra day or two of hospitalization, some insurance companies are demanding that the newborn be discharged, something Edwards said she refuses to do.

How Early Is Too Early?

The first experiments in early discharge occurred in the late 1970s and involved small, select groups of women who wanted to decrease the medical interventions that surround childbirth. The push to get women out faster began in earnest in the early 1990s with the rise of managed care.

Some doctors say 24 hours is too soon to accurately assess an infant's condition. "There are many things that go on after 24 hours of life, many transitions that occur in a newborn," said Augusto Sola, chief of neonatal clinical services at the University of California, San Francisco. "Jaundice doesn't start to happen until the second or third day of life, and dehydration never happens until after two to five days," he said. Certain infections and serious heart defects also do not show up during the first 24 hours and may occur after babies go home. Early discharges also mean that babies are being sent home before certain tests can be performed, such as the screening for phenylketonuria (PKU), an inherited disorder that is treatable in the early days after birth; if untreated, it causes mental retardation.

In addition, there is little or no time to teach women how to breast-feed or to care for a newborn; even if such instruction does take place, most babies are too sleepy to eat much on their first day of life.

"When mothers and babies are discharged early, they miss having somebody troubleshoot," said Carol Miller, director of San Francisco General's

-baby nursery. "Breast-feeding is less likely to be successful. It's not instinctive. It takes support and education and training. What happens is that mothers continue to breast-feed and it isn't until the babies are really sick [because they are getting little or no milk] that they are brought in."

Some doctors worry that home care, while it is touted as a substitute for longer hospital stays, may not be sufficient.

"The question is what kind of home care and by whom and with what frequency?" asked Michael Mennuti, chairman of obstetrics and gynecology at the University of Pennsylvania School of Medicine and of ACOG's committee on obstetrical practice. "This is not standardized. The component of these home-care elements needs to be systematically evaluated."

MacDonald of Washington's Children's Hospital agreed. She said the four babies she treated for kernicterus had an inherited enzyme deficiency that increased the risk of severe jaundice. Yet in all but one case no follow-up care had been arranged, she said. One infant was seen at home by a nurse who failed to recognize the severity of jaundice. Two days later, after the baby stopped eating, he was admitted to Children's, where doctors discovered he had sustained a profound hearing loss. That may not be his only problem.

"The trouble is that unless a baby is totally devastated, you really can't tell for about a year whether he or she has sustained permanent [brain] damage," she said.

Like its counterparts in San Francisco, Cincinnati and elsewhere, Children's has seen three recent cases of life-threatening dehydration in breast-fed babies.

"These cases used to be very few and far between," MacDonald said. Most of these babies are slightly older; they tend to be seen in the second week of life. At first they cry from hunger, then they get too weak to cry and sleep a lot. Some neophyte parents mistakenly regard this as the behavior of a good baby, not a starving baby.

Green said that HIAA has no policy on follow-up care. Educating prospective mothers about newborn care and breast-feeding before delivery might solve some problems, she said.

Ob-gyn Michael B. Grossman, vice president of Kennedy Hospitals in Cherry Hill, N.J., is skeptical. "It's one thing to practice on a mannequin in a class," he said. "It's quite another to do it with your own real, live baby."

Doctors Fear Challenging the System

Insurance industry officials say discharge guidelines are merely that: parameters from which doctors can deviate based on their clinical judgment.

Some doctors, however, say adherence to such guidelines is not a matter of clinical judgment but of economic survival.

Holly H. Roberts, an obstetrician-gynecologist in Red Bank, N.J., recently told a New Jersey Senate hearing that she was threatened with termination by a large HMO if she didn't reduce her patients' average length of stay from 48 to

ours after a normal delivery. "They told me the only thing keeping me in the s em was that I didn't do that many C-sections said Roberts, who added that the HMO, which she declined to name, provides more than half of her patients.

"If I had a patient with a 24-hour labor who had been torn from vagina to rectum, who was exhausted and in pain and catheterized and they wanted her out of the hospital just because she could be wheeled to the car, I would try to help her by keeping her an extra night," Roberts said.

Roberts said she concluded, "It was either me or the patient. If I was nice to them I would lose my practice."

Length of stays must be legislated, she said. "It can't come from us. We're indentured servants" to managed care.

To compensate for early discharges, some pediatricians are moving up the time of the first checkup from two weeks to three days after birth to spot potential medical problems that could become serious. The American Academy of Pediatrics recommends that babies sent home within 24 hours receive a medical checkup within 48 hours of discharge.

Mahiri MacDonald said she has received calls from Washington area pediatricians asking if they should see babies before the standard two-week visit. "I tell them, yes, by all means, if they want to avoid a fat malpractice suit."

But MacDonald said she's been told that some pediatricians are encountering another problem: Some managed care companies are refusing to pay for an early check-up.

One Family's Tragedy

Michelina Bauman was discharged from Kennedy Memorial Hospital in Washington Township, N.J. shortly after 4:30 p.m. on May 17, about 28 hours after her uneventful birth.

She seemed fine, her mother said, until 11:30 p.m., when she began making a moaning sound and refused to drink her bottle. "We thought she didn't know how to cry," her mother recalled.

Bauman and her husband, Steve, first-time parents, and Michelle's mother spent a sleepless night walking the floor, trying to soothe and feed the baby, who refused to eat or sleep. At 6 a.m., Steve Bauman made the first of what his wife said were four calls that day to the pediatrician's office. Michelle Bauman said the doctor told him that the baby probably wasn't eating because she had gas and wasn't sleeping because she had her days and nights confused. Two hours later, Steve Bauman called the pediatrician again to report that Michelina looked yellow and that her eyes were cloudy. The pediatrician said that the baby had a slight case of jaundice and not to worry.

At 3 p.m., after the baby had neither slept nor eaten in more than 15 hours, e Bauman called the pediatrician again to report that she had purple pricks on her hands. A nurse said that the problem was probably a newborn rash. At 5 p.m., Michelle Bauman said she put her daughter in an infant swing. Fifteen minutes later she noticed that the baby's lips were purple and that

Senate passes bill to protect new families

■ *House will weigh question of post-birth hospital insurance*

3.26.96

By JEANINE POHL
THE JUNEAU EMPIRE

If mothers and babies need more time to recover in the hospital after birth, insurance companies would have to cover the stay, under a bill passed by the Alaska Senate Monday.

Sen. Judy Salo introduced the bill to prevent mothers from being discharged earlier than needed when insurance companies refuse to pay for a longer stay.

Senate Bill 193 would require insurance companies to pay for hospital care for up to 48 hours after a regular delivery and up to 96 hours after a Caesarean section. The longer stay is not mandated, but must be covered if a mother or her doctor requests it.

Salo, a Kenai Democrat, said she's had calls and letters from women throughout Alaska who had to wait in hospital parking lots until after midnight to check in because their health plans wouldn't cover them until just before delivery.

Some states have passed laws requiring at least a day of care be covered by insurance companies. Salo stressed that the bill leaves the coverage as an option.

The measure passed on a 17-3 vote. Fairbanks Republican Sens. Bert Sharp and Steve Frank opposed the bill, as did Wasilla Republican Sen. Lyda Green.

Green and Sharp opposed mandating additional coverage, arguing it could boost insurance premiums.

Sharp also said Fairbanks hospital officials told him additional insurance coverage for women and their babies was not a problem, with an average stay of 36 to 48 hours for moms after delivery.

Salo said if the hospital officials are correct and mothers are already receiving enough care, costs won't go up.

Please see Baby, Page 10

Baby...

Continued from Page 1

Senate Minority Leader Jim Duncan said the bill could save money in the long term by preventing medical complications from possibly discharging a mother and baby too early.

Longer hospital stays are supported by several national medical associations, which contend some medical complications can't be detected until a day or two after birth.

While initially opposed to Salo's bill, health insurance companies have quietly dropped their objections.

Barring a reconsideration vote, the measure heads to the House. The bill will likely get a hearing before the House Health, Education and Social Services committee, where co-chairs Con Bunde and Cynthia Toohey, both Anchorage Republicans, said they oppose state-mandated insurance coverage.

Gov. Tony Knowles supports the measure and will probably sign it if it passes the House, said spokesman Bob King.

"It's a good piece of family legislation," King said.

The Washington Times • TUESDAY, OCTOBER 24, 1995 / PAGE A23

(88)

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.

Distributed by Senator Salo

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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 Br[illegible], 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.

Distributed by Senator Salo

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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

Other States / Trends

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.

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)

·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 care; permits earlier discharge if infant meets AAP/ACOG Guide-lines for Perinatal Care medical stability criteria.	Requires coverage of 1 in-home visit if mother and child discharged in less than 48 hrs.	
	AB 1978	Carry Over			
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 hrs. inpatient care if health care provider prescribes it.	Not addressed.	
FLORIDA					
GEORGIA					
HAWAII					
IDAHO					

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INSURANCE COVERAGE FOR POST-DELIVERY CARE

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
ILLINOIS	HB 2514	Intent to introduce	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.	Min. 3 visits by RN within 24 hrs. of discharge, between 25-48 hrs. & between 96-120 hrs., including parent ed., breast or bottle feeding, necessary clinical tests.	
INDIANA					
IOWA					
KANSAS					
KENTUCKY	HCR 6	In Hearings	Urges insurers to cover at least 72 hrs. of inpatient care.		
LOUISIANA					
MAINE					
MARYLAND	SB 677	Enacted 1995	Permits discharge of mother and infant if newborn meets AAP/ ACOG Guidelines for Perinatal Care medical stability criteria.	Requires coverage of 1 in-home visit if mother, child discharged in less than 48 hrs. Visit must include collection of sample for hereditary and metabolic screening.	
MASSACHUSETTS	SB 2000 formerly SB 1926	In Comm	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean. Prohibits earlier discharge unless in accordance with health dept. regulations, thus applying to ERISA plans also. Earlier discharge must also be in consultation with the mother.	To be addressed in health dept. regulations developed with advisory committee that includes pediatric representative.	"Attending physician" defined as obstetrician, pediatrician, nurse midwife, or other physician.
MICHIGAN					

[illegible]URANCE COVERAGE FOR POST-DELIVERY CARE

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.	

INSURANCE COVERAGE FOR POST-DELIVERY CARE					Page 4
STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
NORTH DAKOTA					
OHIO	HB 458	In Comm	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Not addressed.	
	SB 199	In Comm	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Requires coverage of 3 home visits by RN within 24 hrs., 25-48 hrs., & 96-120 hrs., including parent ed., breast/bottle feeding assistance, necessary tests.	
OREGON					
OKLAHOMA					
OREGON					
PENNSYLVANIA	HB 1747	In Comm	Requires min. of 48 hrs. for vaginal birth, 96 hrs. for cesarean.	If covered must consist of at least 3 visits conducted: within 24 hrs. of discharge; within 25-48 hrs., and within 96-120 hrs. by RN & include breast feeding assistance & medical evaluation.	
	HB 1977	In Comm	Requries coverage of min. 48 hrs. of inpatient care, excluding day of delivery. Permits coverage of shorter stay if mother and child meet medical criteria of Guidelines for Perinatal Care and if plan covers initial postpartum visit.		
PUERTO RICO					
RHODE ISLAND	HB 5858-A	Enacted 1995			Creates task force to study issue.

'SURANCE COVERAGE FOR POST-DELIVERY CARE					Page 5
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					
.ISCONSIN	AB 573	In Comm			
WYOMING					