ALASKA LEGISLATURE COMMITTEE FILES 1995-1996 8672
8935 SENATE LABOR & COMMERCE

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CS FOR SENATE BILL NO. 186(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATE LABOR AND COMMERCE COMMITTEE BY REQUEST

A BILL

FOR AN ACT ENTITLED

"An Act relating to partnerships; and providing for an effective date."

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

*** Section 1.** AS 32.05.010(a) is amended to read:

(a) A partnership is an association of two or more persons to carry on as co-owners a business for profit, **and includes a registered limited liability partnership**.

*** Sec. 2.** AS 32.05.030 is amended by adding a new subsection to read:

(c) A registered limited liability partnership shall hold title to all partnership property in the name of the registered limited liability partnership.

*** Sec. 3.** AS 32.05.100 is amended to read:

Sec. 32.05.100. JOINT AND SEVERAL LIABILITY OF PARTNERS. **Except as provided in (b) of this section, all** [ALL] partners are liable

(1) jointly and severally for everything chargeable to the partnership under AS 32.05.080 and 32.05.090;

(2) jointly for all other debts and obligations of the partnership; but any

partner may enter into a separate obligation to perform a partnership contract.

* Sec. 4. AS 32.05.100 is amended by adding new subsections to read:

(b) A partner in a registered limited liability partnership that is in substantial compliance with AS 32.05.416 and 32.05.500 - 32.05.860 is not liable, directly or indirectly, including through indemnification, contribution, assessment, or other manner, for the debts, obligations, and liabilities of, or chargeable to, the partnership, whether in tort, in contract, or under another theory, that arise from negligence, wrongful acts, wrongful omissions, malpractice, or misconduct committed by another partner or by an employee or agent of the partnership

(1) while the partnership is a registered limited liability partnership; and

(2) in the course of the partnership business.

(c) The liability limitation in (b) of this section does not affect the liability of a partner in a registered limited liability partnership for the

(1) partner's own negligence, wrongful acts, wrongful omissions, malpractice, or misconduct;

(2) negligence, wrongful acts, wrongful omissions, malpractice, or misconduct in the course of the partnership business of a person under the partner's direct supervision and control; or

(3) loans, leases, and other ordinary commercial debts and obligations entered into by the partnership or by a partner with apparent authority to bind the partnership, even if the partner lacked actual authority or acted in breach of the partnership agreement or of a duty owed to the partnership or other partners, unless the creditor knew, or in the exercise of reasonable diligence should have known, that the partner was acting without actual authority or in breach of the partnership agreement or of a duty owed to the partnership or other partners.

(d) The liability limitation in (b) of this section may be waived by a registered limited liability partnership. The waiver may not be made unless made by the agreement of at least a majority in interest of the partners, or in a manner otherwise provided in a written partnership agreement. The waiver is valid and binding upon all partners, and may be relied upon by a person dealing with the partnership under AS 32.05.040(a). The waiver may be modified or revoked by the agreement of at least

a majority in interest of the partners, or in a manner otherwise provided in a written partnership agreement, except that the modification or revocation does not affect the liability of a partner for the debts, obligations, or liabilities incurred, created, or assumed by the partnership before the modification or revocation.

* Sec. 5. AS 32.05.130 is amended to read:

Sec. 32.05.130. RULES DETERMINING RIGHTS AND DUTIES OF PARTNERS. The rights and duties of the partners in relation to the partnership shall be determined, subject to any agreement between them, by the following rules:

(1) each partner shall be repaid the partner's contributions, whether by way of capital or advances to the partnership property, and **shares** [SHARE] equally in the profits and surplus remaining after all liabilities, including those to partners, are satisfied; and, **except as provided in AS 32.05.160(b),** shall contribute towards the losses, whether of capital or otherwise, sustained by the partnership according to the partner's share in the profits;

(2) the partnership shall indemnify every partner in respect of payments made and personal liabilities reasonably incurred by the partner in the ordinary and proper conduct of its business, or for the preservation of its business or property;

(3) a partner who in aid of the partnership makes a payment or advance beyond the amount of capital that the partner agreed to contribute shall be paid interest from the date of the payment or advance;

(4) a partner shall receive interest on the capital contributed by the partner only from the date when repayment should be made;

(5) all partners have equal rights in the management and conduct of the partnership business;

(6) a partner is not entitled to remuneration for acting in the partnership business, except that a surviving partner is entitled to reasonable compensation for services in winding up the partnership affairs;

(7) a person may not become a member of a partnership without the consent of all the partners;

(8) any difference arising as to ordinary matters connected with the partnership business may be decided by a majority of the partners; but an act in

contravention of an agreement between the partners may not be done rightfully without the consent of all the partners.

* **Sec. 6.** AS 32.05.290 is amended to read:

Sec. 32.05.290. PARTNER'S RIGHT TO CONTRIBUTION FROM COPARTNERS AFTER DISSOLUTION. Where the dissolution is caused by the act, death, or bankruptcy of a partner, each partner is liable to the copartners for the partner's share of any liability created by a partner acting for the partnership as if the partnership had not been dissolved unless

(1) the dissolution being by act of a partner, the partner acting for the partnership had knowledge of the dissolution; [OR]

(2) the dissolution being by the death or bankruptcy of a partner, the partner acting for the partnership had knowledge or notice of the death or bankruptcy; or

(3) the liability is for a debt, obligation, or liability for which the partner is not liable under AS 32.05.100(b).

* **Sec. 7.** AS 32.05.310(d) is amended to read:

(d) The individual property of a deceased partner is liable for the [ALL] obligations of the partnership incurred while the decedent was a partner **and for which the partner is liable under AS 32.05.100** but subject to the prior payment of the decedent's separate debts.

* **Sec. 8.** AS 32.05.350 is amended to read:

Sec. 32.05.350. RULES FOR SETTLING ACCOUNTS FOLLOWING DISTRIBUTION. In settling accounts between the partners after dissolution, the following rules shall be observed, subject to any agreement to the contrary:

(1) the assets of the partnership are

(A) the partnership property;

(B) the contributions of the partners as [NECESSARY FOR THE PAYMENT OF ALL THE LIABILITIES] specified in (4) [(2)] of this section;

(2) the liabilities of the partnership [SHALL] rank in order of payment as follows:

(A) those owing to creditors other than partners;

(B) those owing to partners other than for capital and profits;

(C) those owing to partners in respect of capital;

(D) those owing to partners in respect of profits;

(3) the assets shall be applied in the order of their declaration in (1) of this section to the satisfaction of the liabilities;

(4) **except to the extent the liability of a partner is limited under AS 32.05.100(b),**

(A) the partners shall contribute, as provided by AS 32.05.130(1), the amount necessary to satisfy the liabilities;

(B) [, BUT] if any, but not all, of the partners is [ARE] insolvent, or not being subject to process, refuses [REFUSE] to contribute, the other partners shall contribute their share of the liabilities, and, in the relative proportions in which they share the profits the additional amount necessary to pay the liabilities;

(5) an assignee for the benefit of creditors or any person appointed by the court may enforce the contributions specified in (4) of this section;

(6) a partner or the legal representative of a partner may enforce the contributions specified in (4) of this section, to the extent of the amount that the partner has paid in excess of the partner's share of the liability;

(7) the individual property of a deceased partner is liable for the contributions specified in (4) of this section;

(8) when partnership property and the individual properties of the partners are in the possession of a court for distribution, partnership creditors shall have priority on partnership property and separate creditors on individual property, saving the rights of lien or secured creditors as heretofore;

(9) where a partner has become bankrupt or the estate of a partner is insolvent the claims against the partner's separate property [SHALL] rank in the following order:

(A) those owing to separate creditors;

(B) those owing to partnership creditors;

(C) those owing to partners by way of contribution.

* Sec. 9. AS 32.05 is amended by adding a new section to read:

Sec. 32.05.405. COMMERCE OUTSIDE THE STATE. (a) A partnership that is formed and operates under an agreement governed by this chapter may conduct its business, carry on its operations, and has and may exercise the powers granted by this chapter in a state, territory, district, or possession of the United States or in a foreign country.

(b) It is the intent of this chapter that the legal existence of a partnership be recognized outside the boundaries of the state and that a partnership transacting business outside the state be granted the protection of art. IV, sec. 1, Constitution of the United States, subject to a reasonable requirement of registration.

(c) The liability of the partners in a partnership for the debts, obligations, and liabilities of the partnership shall at all times be determined solely and exclusively by the laws of this state.

(d) In this section, "partnership" means a partnership that is formed and operates under an agreement governed by this chapter.

* Sec. 10. AS 32.05 is amended by adding a new section to read:

Sec. 32.05.416. FINANCIAL RESPONSIBILITY. (a) A registered limited liability partnership shall at all times have and maintain liability insurance or qualifying assets in an amount of value not less than $1,000,000 to satisfy liabilities described in AS 32.05.100(b). To the extent the partnership maintains liability insurance that is subject to a deductible, it shall maintain qualifying assets in the deductible amount, but the sum of the liability insurance and the qualifying assets is not required to exceed $1,000,000.

(b) A foreign limited liability partnership may conduct business in this state under this chapter if it has and maintains liability insurance or qualifying assets in an amount of value not less than $1,000,000 to satisfy liabilities that arise from acts or omissions in this state of the type described in AS 32.05.100(b).

(c) To the extent that a registered limited liability partnership or a foreign limited liability partnership maintains liability insurance or qualifying assets under the laws of another jurisdiction, the liability insurance or qualifying assets maintained

under those laws satisfy (a) - (b) of this section if the amount of the insurance or assets is equal to or greater than the amount required by (a) - (b) of this section.

(d) In a court action against a registered limited liability partnership or foreign limited liability partnership in the courts of this state, upon request of a party to the court action and subject to an order of the court, the partnership shall provide a certification stating that the partnership is in compliance with this section, describing the method by which the partnership has complied with (a) - (c) of this section, and identifying the depository institution holding the qualifying assets or insurance carrier issuing the liability insurance specified in (a) - (c) of this section.

(e) If a registered limited liability partnership or foreign limited liability partnership fails to maintain the insurance or qualifying assets required by (a) - (c) of this section, the partners are jointly and severally liable for the debts, obligations, and liabilities of the partnership, except that the aggregate amount for which the partners are jointly and severally liable is limited to the amount of insurance or qualifying assets that would have been required to satisfy the requirements of (a) - (c) of this section.

(f) In this section, "qualifying assets" means

(1) cash, federally insured deposits of a bank or other financial institution, and obligations of the United States or one of its instrumentalities having a maturity of not more than one year, if the partnership segregates the cash, deposits, or obligations from other partnership property and specifically designates the cash, deposits, or obligations for the exclusive purpose of satisfying liabilities described in AS 32.05.100(b); or

(2) a letter of credit issued by a federally insured depository institution for the benefit of persons in whose favor a judgment has been entered against the partnership arising from liabilities described in AS 32.05.100(b).

* **Sec. 11.** AS 32.05.420 is amended to read:

Sec. 32.05.420. DEFINITIONS. In this chapter,

(1) "bankrupt" includes bankrupt under the Federal Bankruptcy Act or insolvent under any state insolvent act;

(2) "business" includes every trade, occupation, or profession;

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

(4) "conveyance" includes every assignment, lease, mortgage, or encumbrance;

(5) [(4)] "court" includes every court and judge having jurisdiction in the case;

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

(7) "foreign limited liability partnership" means a partnership that is formed and operates under an agreement governed by the laws of another jurisdiction and that is registered as a limited liability partnership in that jurisdiction;

(8) "partnership" includes a registered limited liability partnership unless the context indicates otherwise;

(9) [(5) "PERSON" INCLUDES INDIVIDUALS, PARTNERSHIPS, CORPORATIONS, AND OTHER ASSOCIATIONS;

(6)] "real property" includes land and any interest or estate in land;

(10) "registered limited liability partnership" means a partnership that is registered under AS 32.05.510 and that is formed and operates under an agreement governed by this chapter.

* **Sec. 12.** AS 32.05 is amended by adding new sections to read:

ARTICLE 7. LIMITED LIAB' .ITY PARTNERSHIPS.

Sec. 32.05.500. PARTNERSHIP AGREEMENT. The partners of a limited liability partnership may adopt a partnership agreement for the partnership and may amend and repeal the agreement.

Sec. 32.05.510. REGISTRATION REQUIRED. A partnership that is formed and operates under an agreement authorized by AS 32.05.500 may not conduct affairs in this state unless it registers as a registered limited liability partnership with the department. To register, the partnership must submit a registration document and the identification code statement required by AS 32.05.530 with the department.

Sec. 32.05.520. CONTENTS OF REGISTRATION DOCUMENT. (a) A

registration document under AS 32.05.510 must provide

(1) the name of the partnership;

(2) the address of the partnership's principal office, if the partnership's principal office is not located in this state;

(3) the address of the partnership's registered office in this state;

(4) the name and address of the partnership's registered agent in the state for the service of process;

(5) a brief description of the purpose for which the partnership is formed, which may be stated to be or to include the conduct of all lawful affairs for which a limited liability partnership may be formed under this chapter;

(6) the name and address of each general partner maintaining an office in this state;

(7) a statement that the general partners executing the registration document acknowledge the responsibility of the partnership under AS 32.05.416;

(8) if an election has been made that the existence of the partnership will continue until a certain date or event, a statement of the election and the date or event;

(9) a statement that the partnership is applying for registration.

(b) A partnership formed under AS 32.05.500 may include other information in the registration document.

Sec. 32.05.530. DISCLOSURE OF PARTNERSHIP PURPOSES. An application for registration under this chapter must be accompanied by a separate statement of the codes taken from the identification codes established under AS 10.06.870 that most closely describe the activities in which the corporation intends to engage.

Sec. 32.05.540. EFFECTIVE DATE AND DURATION OF REGISTRATION. Registration under AS 32.05.510 is effective immediately when the registration document is filed under AS 32.05.510. The registration remains effective until the earlier of the date when

(1) the partnership voluntarily withdraws its registration under AS 32.05.700; or

(2) the partnership's registration is cancelled under AS 32.05.710 - 32.05.720.

Sec. 32.05.550. AMENDMENT OF REGISTRATION DOCUMENT. (a) A registration document filed under AS 32.05.510 is amended by filing an amended registration document with the department. The document must state

(1) the name of the limited liability partnership;

(2) the date of the filing of the original document of registration;

(3) the amendment to the document.

(b) An amendment may be filed at any time for any purpose that the partners determine to be proper.

(c) A restated registration document may be executed and filed in the same manner as an amendment.

Sec. 32.05.560. STATUS UNAFFECTED BY ERRORS OR SUBSEQUENT CHANGES. The registration status of a registered limited liability partnership is not affected by errors in the information provided in a registration application or by changes that occur in the information provided in the registration application after the application is filed.

Sec. 32.05.570. NAME. (a) The name of a registered limited liability partnership must contain the words "Limited Liability Partnership," the abbreviation "L.L.P.," or the abbreviation "LLP," as the last words or letters of its name.

(b) The name of a city, borough, or village may be used in a limited liability partnership name; however, the name may not contain the word "city," "borough," or "village," or otherwise imply that the partnership is a municipality.

(c) A person may not adopt a name that contains the words "Limited Liability Partnership," the abbreviation "L.L.P.," or the abbreviation "LLP" unless the person has been issued a certificate of registration under this chapter.

Sec. 32.05.580. DISTINGUISHABLE NAMES. The name of a limited liability partnership must be distinguishable on the records of the department from

(1) the name of a limited liability partnership, limited liability company, limited partnership, or corporation organized under the laws of this state;

(2) the name of a foreign limited liability partnership, foreign limited

liability company, foreign limited partnership, or foreign corporation authorized to transact business in this state;

(3) a name reserved or registered by the department under the provisions of this title or AS 10.

Sec. 32.05.590. RIGHT TO RESERVE NAME. The exclusive right to use a name may be reserved by a

(1) person intending to register a limited liability partnership and to adopt the name;

(2) person intending to register a foreign limited liability partnership under this chapter;

(3) limited liability partnership or a foreign limited liability partnership registered under this chapter that intends to change its name.

Sec. 32.05.600. APPLICATION TO RESERVE NAME. Reservation of a name under AS 32.05.590 is made by filing an application with the department. If the department finds that the name is available for use by a limited liability partnership, the department shall reserve it for the exclusive use of the applicant for a period of 120 days.

Sec. 32.05.610. REGISTRATION OF NAME. (a) A foreign limited liability partnership not intending to conduct affairs in this state may register its name if the name is distinguishable on the records of the department.

(b) Registration of a name by a foreign limited liability partnership under (a) of this section is made by filing with the department

(1) a signed application for registration setting out the name of the partnership, the state or territory under the laws of which it is formed and the date the partnership was formed; and

(2) proof from the jurisdiction where the partnership is formed indicating that the partnership was formed in that jurisdiction.

(c) The registration of a name under this section is effective until the close of the calendar year in which the application for registration is filed.

(d) The registration of a name under this section may be renewed each year by filing

(1) an application for renewal setting out the facts required in an original application; and

(2) proof of formation as required by (b)(2) of this section.

(e) An application for renewal must be filed between October 1 and December 31 in each year. The renewal extends the registration for the following calendar year.

Sec. 32.05.620. USE OF NONDISTINGUISHABLE NAME Registration or reservation under this chapter gives the person who has registered exclusive right to the use of the name. The person may enjoin the use of a name that is not distinguishable from the name to which the person has the exclusive right, and the person has a cause of action for damages against a person who uses a name that is not distinguishable from the name to which the person has the exclusive right.

Sec. 32.05.630. REGISTERED AGENT AND OFFICE. A registered limited liability partnership and a foreign limited liability partnership shall maintain in the state a registered office and an agent for the service of process.

Sec. 32.05.640. CHANGE OF REGISTERED OFFICE OR AGENT. (a) A registered limited liability partnership may change its registered office, agent, or both, by filing with the department a verified signed statement that includes

(1) the name of the partnership;

(2) the address of its registered office;

(3) the address of its new registered office if the registered office is to be changed;

(4) the name of its registered agent;

(5) the name of its new registered agent if the registered agent is to be changed; and

(6) a statement that the change was authorized by one or more of the partners.

(b) If the department finds that the statement filed under (a) of this section complies with this chapter, the department shall file the statement in the department's office. The change becomes effective when the statement is filed.

(c) A registered agent of a limited liability partnership may change the location

of the agent's office from one address to another in this state. The agent may change the registered office for each limited liability partnership for which the person is acting as registered agent by filing in the department a statement setting out the name of the agent, the address of the agent's office before change, the address to which the office is changed, and a list of companies for which the person is the registered agent. The statement shall be executed by the registered agent in the individual name of the agent, or, if the agent is a corporation, it shall be executed and verified by its president or vice-president. The statement shall be delivered to the department and the limited liability partnership, and, if the department finds that the statement complies with this chapter, the department shall file it. The change becomes effective when the statement is filed.

Sec. 32.05.650. RESIGNATION BY REGISTERED AGENT. A registered agent may resign by filing a written notice and an exact copy of the notice with the department. The written notice of resignation must set out the latest address of the principal office of the partnership and the names and addresses of the general partners known by the agent. The department shall immediately mail a copy of the notice to the partnership at its principal office. The resignation becomes effective 30 days after the filing of the written notice unless the partnership appoints a successor registered agent before the resignation becomes effective.

Sec. 32.05.660. SERVICE OF PROCESS. (a) The registered agent of a registered limited liability partnership is an agent upon whom process, notice, or demand required or permitted by law to be served upon the partnership may be served.

(b) If a limited liability partnership fails to appoint or maintain a registered agent in this state or if its registered agent cannot with reasonable diligence be found at the registered office, the commissioner is an agent of the partnership upon whom the process, notice, or demand may be served. A person may serve the commissioner under this subsection by

(1) serving on the commissioner or the designee of the commissioner a copy of the process, notice, or demand, with any papers required by law to be delivered in connection with the service, and a fee established by the department by regulation;

(2) sending to the partnership being served by certified mail a notice that service has been made on the commissioner under this subsection and a copy of the process, notice, or demand and accompanying papers; notice to the partnership shall be sent to the address

(A) of the last registered office of the partnership as shown by the records on file in the department; and

(B) the use of which the person initiating the proceedings knows or, on the basis of reasonable inquiry, has reason to believe is most likely to result in actual notice; and

(3) filing with the appropriate court or other body, as part of the return of service, the return receipt of mailing and an affidavit of the person initiating the proceedings that this subsection has been complied with.

(c) The commissioner shall keep a record of processes, notices, and demands served upon the commissioner under this section.

(d) This section does not affect the right to serve process, notice, or demand required or permitted by law to be served upon a limited liability partnership in another permitted manner.

Sec. 32.05.670. BIENNIAL REPORT REQUIRED. A registered limited liability partnership and a foreign limited liability partnership shall file a biennial report within the time established by AS 32.05.

Sec. 32.05.680. CONTENTS OF BIENNIAL REPORT. A biennial report required under AS 32.05.670 must state

(1) the name of the limited liability partnership and the state or country where it was formed;

(2) the address of the registered office of the partnership in this state, the name of its registered agent in this state at that address, and, in the case of a foreign limited liability partnership, the address of its principal office in the state or country where it was formed; and

(3) the names and addresses of the partners.

Sec. 32.05.690. FILING OF BIENNIAL REPORT. (a) A biennial report required by AS 32.05.670 shall be filed with the department and is due before

January 2 of the filing year. A domestic limited liability partnership and a foreign limited liability partnership registering during an even-numbered year shall file the biennial report each even-numbered year. A domestic limited liability partnership and a foreign limited liability partnership registering during an odd-numbered year shall file the biennial report each odd-numbered year. The biennial report is delinquent if not filed before February 1 of each odd- or even-numbered year as provided in this subsection.

(b) Proof to the satisfaction of the department that on or before February 1 the report was deposited in the United States mail in a sealed envelope, properly addressed with postage prepaid, satisfies the deadline of (a) of this section.

(c) The department shall file the report if it conforms to the requirements of this chapter. If the department finds that the report does not conform to the requirements of this chapter, the report shall promptly be returned to the partnership for necessary corrections.

Sec. 32.05.700. VOLUNTARY WITHDRAWAL OF REGISTRATION. A registered limited liability partnership may withdraw its registration by filing with the department a written withdrawal notice that is signed by a partner authorized to execute the withdrawal notice.

Sec. 32.05.710. CANCELLATION OF REGISTRATION UPON DISSOLUTION. The registration of a registered limited liability partnership shall be cancelled upon the dissolution and the commencement of winding up of the partnership. A notice of cancellation shall be filed with the department and must state

(1) the name of the registered limited liability partnership;

(2) the date of filing of its initial registration;

(3) the reason for cancellation;

(4) the effective date, which must be a date certain, of cancellation if the cancellation is not to be effective upon the filing of the application; and

(5) other information the general partners determine to be appropriate.

Sec. 32.05.720. INVOLUNTARY CANCELLATION. (a) A registered limited liabi ''y partnership's registration may be cancelled involuntarily by the commissioner if

(1) the partnership is delinquent six months in filing its biennial report or in paying a fee or penalty;

(2) the partnership has failed for 30 days to appoint and maintain a registered agent in the state;

(3) the partnership has failed for 30 days after change of its registered office or registered agent to file in the office of the commissioner a statement of the change; or

(4) a misrepresentation of material facts has been made in an application, report, affidavit, or other document submitted under this chapter.

(b) Before a registration may be cancelled under this section, the commissioner shall give the partnership written notice of its delinquency, failure, or misrepresentation by certified mail addressed to its registered agent, registered office, or partners at the last known address as shown by the records of the commissioner. If the partnership fails, within 60 days after the notice is sent by certified mail, to contest the alleged delinquency, failure, or misrepresentation, the partnership may be dissolved under (d) of this section.

(c) If a registered limited liability partnership contests the proposed cancellation, the partnership may request a hearing. If, following a hearing, the commissioner decides there are grounds, under (a) of this section, for involuntary cancellation under this section, the partnership may appeal the decision to the superior court.

(d) If the registration of a registered limited liability partnership is subject to cancellation under (a) - (c) of this section, the partnership fails to correct the delinquency, failure, or misrepresentation as provided in this section, and there is no controlling order of the superior court, the commissioner shall cancel the partnership by issuing a certificate of involuntary cancellation. The certificate must contain a statement that the partnership's registration has been cancelled, and the date and the reason for the cancellation. The original certificate shall be placed in the department's files and a copy of it mailed to the partnership at its registered office or in care of its registered agent, at the last known address shown on the records of the department. Upon the issuance of the certificate of involuntary cancellation, the existence of the

partnership ceases, except as otherwise provided in this chapter, and its name shall be available for use and may be adopted by another limited liability partnership on a date that is six months or more after the cancellation.

(c) If the registration of a registered limited liability partnership is cancelled under this section, the registration may be reinstated within two years from the date of the certificate of cancellation if it is established to the satisfaction of the commissioner that in fact (1) there was no cause for the cancellation, or the delinquency, failure, or misrepresentation resulting in cancellation has been corrected; and (2) the partnership pays two times the amount of any delinquent fee and the amount the partnership would have paid had it not been cancelled during the two-year period. Unless the partnership being reinstated amends its registration to change its name to comply with AS 32.05.570 - 32.05.620, reinstatement may not be authorized if the name of the partnership is not distinguishable in the records of the department.

Sec. 32.05.730. FOREIGN LIMITED LIABILITY PARTNERSHIPS. (a) In addition to the requirements of AS 32.05.416, before a foreign limited liability partnership conducts affairs in this state, the partnership must submit to the department an application for registration.

(b) Subject to the constitution of this state, and except that a partner in the partnership is liable for acts and omissions in this state of the type described in AS 32.05.100(c), the law of the state or other jurisdiction under which a foreign limited partnership is formed governs the affairs of the partnership.

(c) The department may not deny registration to a foreign limited liability partnership because of differences between the law of this state and the law of the state or other jurisdiction under which the foreign limited liability partnership is formed.

Sec. 32.05.740. CONTENTS OF REGISTRATION APPLICATION. (a) An application for the registration of a foreign limited liability partnership must state

(1) the name of the foreign limited liability partnership and, if different, the name the partnership proposes to use in this state;

(2) the state or other jurisdiction where the partnership was formed and the date of its formation;

(3) the name and address of its registered agent;

(4) that the department is appointed the agent of the partnership for service of process if the foreign limited liability partnership fails to appoint or maintain a registered agent;

(5) the address of the office that is required by the state or other jurisdiction of the partnership's formation to be maintained in that state or other jurisdiction, or, if the state or other jurisdiction does not require an office to be maintained in that state or other jurisdiction, the principal office of the partnership;

(6) the purpose the partnership proposes to pursue in the conduct of its affairs in this state and the codes from the identification code established under AS 10.06.870 that most closely describe the activities in which the partnership intends to engage in this state; and

(7) the names and addresses of the general partners.

(b) In addition to the information required by (a) of this section, an application must include proof from the jurisdiction where the partnership was formed that indicates that the partnership was formed in that jurisdiction.

Sec. 32.05.750. NAME OF FOREIGN LIMITED LIABILITY PARTNERSHIP. The department may not file the application for registration of a foreign limited liability partnership unless the name of the partnership satisfies the requirements of AS 32.05.570 - 32.05.620. If the name under which a foreign limited liability partnership is formed does not satisfy the requirements of AS 32.05.570 - 32.05.620, the partnership may register under AS 32.05.730 if the partnership uses an assumed name that is available to the partnership under this chapter and that satisfies the requirements of AS 32.05.570 - 32.05.620.

Sec. 32.05.760. AMENDMENT OF REGISTRATION OF FOREIGN LIMITED LIABILITY PARTNERSHIP. (a) A foreign limited liability partnership may amend its registration by filing an amendment of registration with the department that is signed by a partner authorized to execute the amendment.

(b) The amendment of registration filed by a foreign limited liability partnership must state

(1) the name of the partnership;

(2) the date the original registration was filed; and

(3) the amendment.

(c) The application for registration may be amended if the application for registration as amended contains only provisions that this chapter allows to be contained in an application for registration at the time the partnership amends the registration.

Sec. 32.05.770. REVOCATION OF REGISTRATION OF FOREIGN LIMITED LIABILITY PARTNERSHIP. (a) The registration of a foreign limited liability partnership authorizing the partnership to conduct affairs in this state may be revoked by the commissioner if

(1) the partnership is delinquent for six months in filing its biennial report or in paying a fee or penalty imposed under this chapter;

(2) the partnership has failed for 30 days to appoint and maintain a registered agent in the state;

(3) the partnership has failed for 30 days after change of its registered office or registered agent to file in the office of the commissioner a statement of the change; or

(4) a misrepresentation of material facts has been made in an application, report, affidavit, or other document submitted under this chapter.

(b) Before a registration may be revoked under this section, the commissioner shall give the partnership written notice of its delinquency, failure, or misrepresentation by certified mail addressed to its registered agent, registered office, or partners at the last known address as shown by the records of the commissioner. If the partnership fails, within 60 days after the notice is sent by certified mail, to contest the alleged delinquency, failure, or misrepresentation, the registration may be revoked under (d) of this section.

(c) If a partnership contests the proposed cancellation, the partnership may request a hearing. If, following a hearing, the commissioner decides there are grounds for revocation under this section, the partnership may appeal the decision to the superior court.

(d) If the registration of a foreign limited liability partnership is subject to revocation under (a) - (c) of this section, the partnership fails to correct the

delinquency, failure, or misrepresentation as provided in this section, and there is no controlling order of the superior court, the commissioner shall revoke the partnership by issuing a certificate of revocation containing a statement that the partnership's registration has been revoked, and the date and the reason for the revocation. Upon cancellation, the original certificate of cancellation shall be placed in the department's files and a copy of the certificate mailed to the partnership at its registered office or in care of its registered agent at the last known address shown on the records of the department. Upon the issuance of the certificate of revocation, the foreign limited liability partnership's authority to conduct affairs in this state ceases.

Sec. 32.05.780. VOLUNTARY WITHDRAWAL OF FOREIGN LIMITED LIABILITY PARTNERSHIP. (a) A foreign limited liability partnership registered in this state may withdraw its registration by filing an application for withdrawal with the department.

(b) An application for withdrawal filed by a foreign limited liability partnership must state

(1) the name of the partnership and the state or other jurisdiction where the partnership was formed;

(2) that the partnership is no longer conducting affairs in this state;

(3) that the partnership is withdrawing;

(4) that the partnership revokes the authority of its registered agent for service of process in this state and agrees that service of process may subsequently be made on the partnership by service on the commissioner for a cause of action arising in this state during the time the partnership was registered in this state; and

(5) an address for mailing a copy of the process to the partnership.

(c) The application for withdrawal must be in the form and manner designated by the department and shall be signed on behalf of the foreign limited liability partnership by a partner authorized to execute the application for withdrawal.

Sec. 32.05.790. CONDUCTING AFFAIRS WITHOUT REGISTRATION. (a) A foreign limited liability partnership conducting affairs in this state may not maintain an action or other proceeding in a court of this state until it has registered in this state.

(b) A foreign limited liability partnership that conducts affairs in this state

without registration is subject to a civil penalty payable to the state not to exceed $10,000 for each calendar year, including a partial year, that the partnership conducts affairs in this state without being registered under this chapter. The civil penalty imposed may be recovered in an action brought in the superior court by the attorney general.

(c) The failure of a foreign limited liability partnership to register in this state does not

(1) impair the validity of a contract or act of the partnership;

(2) affect the right of another party to a contract of the partnership to maintain a suit or proceeding on the contract; or

(3) prevent the partnership from defending an action or other proceeding in a court of this state.

Sec. 32.05.800. TRANSACTIONS NOT CONSTITUTING CONDUCTING AFFAIRS. The activities of a foreign limited liability partnership that are not considered to be conducting affairs in this state for the purposes of AS 32.05.720 include

(1) maintaining, defending, or settling a court action or other proceeding or claim;

(2) holding partnership meetings in this state.

(3) maintaining bank accounts;

(4) selling through independent contractors;

(5) soliciting or procuring orders by mail, through employees, agents, or other persons if the orders require acceptance out ide the state before becoming binding contracts;

(6) creating as borrower or lender, or acquiring, indebtedness or mortgages or other security interests in real or personal property;

(7) securing or collecting debts, or enforcing rights in property securing debts;

(8) conducting an isolated transaction that is completed within 30 days and that is not part of a course of repeated transactions of a similar nature; or

(9) conducting affairs in interstate commerce.

Sec. 32.05.810. EXECUTION OF DOCUMENTS. A registration document filed under AS 32.05.510 or a biennial report filed under AS 32.05.670 shall be executed by a partner authorized to execute the registration document or biennial report.

Sec. 32.05.820. SUBMISSION OF DOCUMENTS TO THE DEPARTMENT. When a document is required or allowed to be delivered to or filed with the department under AS 32.05.500 - 32.05.860, the person delivering the document shall deliver to the department the required fee, the original signed document, and an exact copy of the document.

Sec. 32.05.830. FILING OF DOCUMENTS BY THE DEPARTMENT. (a) If the department determines that a document filed under AS 32.05.500 - 32.05.860 conforms to the filing requirements of AS 32.05.500 - 32.05.860, the department shall

(1) mark on the original signed document and on the exact copy the word "filed" and the date of the document's acceptance for filing;

(2) retain the exact copy in the department's files; and

(3) return the original signed document to the person who filed the document or to that person's representative.

(b) The department may not file a document that does not meet the requirements of this section.

Sec. 32.05.840. DISAPPROVAL OF WRITING BY DEPARTMENT; APPEAL. If the department fails to approve applications for registration, amendment, cancellation, or withdrawal, or another document required by AS 32.05.500 - 32.05.860 to be approved by the department, the department shall, within 10 days after the delivery of the document to the department, give written notice of disapproval to the person delivering the document. The notice must specify the reasons for disapproval. The person may appeal the disapproval to the superior court.

Sec. 32.05.850. FILING AND OTHER FEES. The department shall charge fees established by the department by regulation for the following under AS 32.05.500 - 32.05.860:

(1) filing applications for registration;

(2) filing amendments to registration;

(3) filing applications for cancellation or withdrawal;

(4) issuing a document not otherwise covered by this section;

(5) furnishing a copy of a document;

(6) accepting an application for reservation or registration of a name;

(7) filing a statement of change of registered agent or registered office;

(8) accepting service of a process, notice, or demand upon the department;

(9) filing another document allowed or required under this chapter.

Sec. 32.05.860. DEPARTMENT FORMS. The department may provide forms for filing documents under AS 32.05.500 - 32.05.850.

* **Sec. 13.** ADOPTION OF REGULATIONS. The department of Commerce and Economic Development may adopt regulations to implement AS 32.05.660(b)(1), added by sec. 12 of this Act. The regulations take effect under AS 44.62, but not before the effective date of AS 32.05.660.

* **Sec. 14.** A foreign limited liability partnership conducting affairs in this state shall comply with AS 32.05.730(a), added by sec. 12 of this Act, on or before 30 days after the effective date of sec. 12 of this Act.

* **Sec. 15.** Section 13 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 16.** Sections 1 - 12 and 14 of this Act take effect January 1, 1997.

SB

193

Senator Judith E. Salo

Alaska State Legislature

Sponsor Statement

Senate Bill 193

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

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

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

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

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

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

❑ Interim Anchorage: 7[illegible] [redacted] 8-8183 • (907) 258-5571 FAX

❑ Interim [redacted] (907) 283-7996

OB-GYN ASSOCIATES
GEORGE STRANSKY, MD, FACOG
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LYNN HARTZ, RN, MSN, ANP
Advanced Nurse Practitioner

4215 Lake Otis Parkway, Anchorage, Alaska 99508-6293
(907) 562-[illegible], Fax (907) 561-[illegible]

January 17, 1996

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

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

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

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

Thank you for caring.

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

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 14, 1996

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

Re: Support, SB 193
Insurance Cost of Birth

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

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

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

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

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

Sincerely,

Harlan R. Knudson
President/CEO

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

ALASKA WOMEN'S LOBBY

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

11 February 1996

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

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

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

We urge the passage of this legislation.

Sincerely,

Leah L. Burton
for the Alaska Women's Lobby

Legislative Research Services

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

130 Seward Street, Suite 218
Juneau, Alaska 99801-2196
Phone: (907) 465-3991
Fax: (907) 463-3351

January 22, 1996

MEMORANDUM

TO: Senator Judith Salo

FROM: Maureen Weeks MW
Legislative Analyst

RE: **Childbirth: States Restricting 24-Hour Hospital Discharge**
Research Request 96.029

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

States Which Restrict 24-Hour Discharge Policies

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

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

- **New Jersey** on June 29, 1995, enacted legislation requiring insurers to cover "a minimum of 48 hours of in-patient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newly born child in a health care facility" (New Jersey Session Law Service Ch. 138, 1995)

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

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

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

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

States Considering Laws to End 24-Hour-Discharge Policies

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

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

URANCE COVERAGE FOR POST-DELIVERY CARE

9/26/95

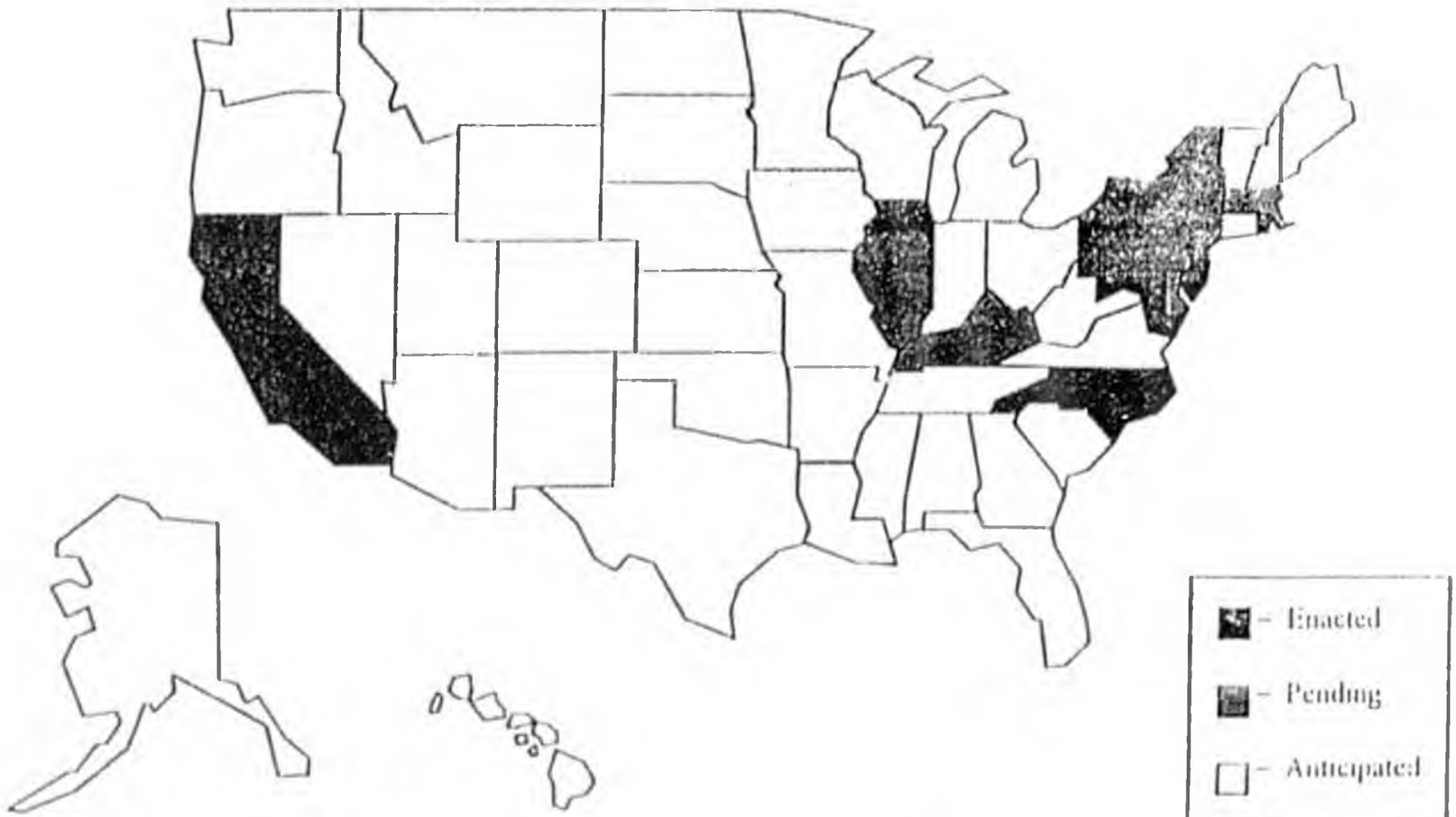
STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
ALABAMA					
ALASKA					
ARIZONA					
ARKANSAS					
CALIFORNIA	AB 1841	Carry Over	Requires min. of 48 hrs. inpatient	Requires coverage of 1 in-	
	AB 1978	Carry Over	care; permits earlier discharge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

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

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

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

1995-1996 State Legislation
Insurance Coverage for Postpartum Care



American College of Obstetrics and Gynecologists

The American College of Obstetricians and Gynecologists

May 23, 1995

STATEMENT ON DECREASING LENGTH OF HOSPITAL STAY
FOLLOWING DELIVERY

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

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

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

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

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

...0 Main Street, SW Washington DC 20024-2688 (202)638-55...

With critical legislative elections taking place later this year, [illegible] any issues deemed too controversial would be acted upon by the General Assembly.

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

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

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

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

Second Failure For Notification Law

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

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

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

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

New Notification Bills Proposed

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

One bill would require minors to notify a parent or legal guardian before having an abortion, and would impose civil court penalties on physicians who violate the rule. The other would require [illegible] 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 [illegible] save the state an estimated $17

Post-Natal Care

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

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

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

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

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

A stricter bill (A 2224) that requires insurers to pay for a 48-hour hospital stay after vaginal deliveries and 96 hours of inpatient care after a caesarean section was signed by New Jersey Gov. Christine Whitman (R) June 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

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

North Carolina

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

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

The amendment covering maternity stays, offered by Rep. Arlene Pulley (R-Wake and Durham Counties), was added to the Senate bill during consideration by the House. The House passed the bill July 27 by a vote of 72-11. 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 1341) by Assemblywoman Liz Figueroa (D-Fremont) would apply to every health care service plan contract, non-profit hospital service plan contract, and certain disability insurance policies, and is intended to reduce the risk of readmissions for common neonatal problems such as jaundice or dehydration, according to the bill's author.

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

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

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

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

A companion bill (HR 948) was introduced in the House June 23 by Rep. George Miller (D-Calif.).

Risks v. Costs

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

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

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

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

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

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

Guidelines Allow Flexibility

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

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

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

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

Concern in Maryland

What promoted 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, 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 10 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-AAP perinatal guidelines are revised every three to five years.

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

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

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

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

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

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

Post-Natal Care

ABBREVIATED HOSPITAL STAYS SPUR INNOVATIONS IN AFTER-DELIVERY CARE

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

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

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

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

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

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

Birthcare Inn

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

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

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

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

—By Thom Wilder

Medicaid

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

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

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

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

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

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

TennCare More About Saving Costs

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

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

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

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

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

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

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

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

Post-Natal Care

RAPID DISCHARGES AFTER C-SECTIONS LEAD TO MORE HOSPITAL READMISSIONS

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

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

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

Health plans increasingly have been paying only for 24-hour hospital stays after childbirth, prompting several states to pass or consider laws requiring insurers to pay for longer stays (3 HCPR 1275, 6/7/95).

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, promoting 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.

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 15 to 110 the number of life-prolonging drugs available at no charge to people with the human immunodeficiency virus or acquired immune deficiency syndrome who do not have adequate insurance coverage or are not eligible for Medicaid.

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

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

The department anticipates the program will serve an average of 250 to 300 persons a month at a cost of $2.8 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)

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-

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 31.5 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.

May 5, 1995

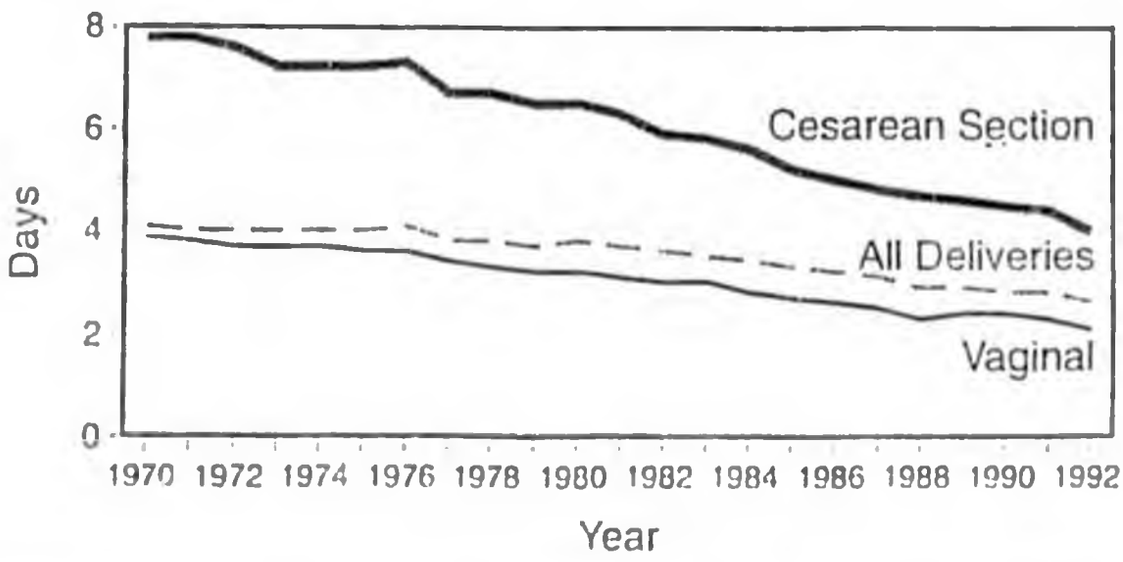
Trends in Length of Stay for Hospital Deliveries — United States, 1970–1992

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

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

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

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



Status of State Action
As of November 29, 1995

Bills Enacted

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

Bills Pending

California
Delaware
Illinois
Kentucky
New Jersey
New York
Ohio
Pennsylvania
Wisconsin

Intent to Introduce Bill

Maine
Rhode Island
Washington

Task Force Established to Study Issue

Rhode Island

Regulatory Action Pending

New Mexico

(Information from the American Academy of Pediatrics)

The Washington Times

* TUESDAY, OCTOBER 24, 1995 / PAGE A23

(28)

Don't send babies home so soon

By Betsy McCaughey

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Betsy McCaughey is lieutenant governor of New York State.

Longer Hospital Stays for Childbirth Are Needed, Pediatricians Say

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

New York Times
p. A17
October 11, 1995

Check in, deliver, go home

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

Nicole Jundanian, 28, an annuities company co-owner and manager from Chevy Chase, Md., did everything by the book to prepare for the arrival of her first child in October. She 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 did the hospital staff picked up the baby's problems.

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

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

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 in Europe (box) to a national average of just 2½ days in 1992, the latest available figure. That's roughly five hours shorter than the 1991 average but still sufficient compared with the 24 to 36 hours most health care plans now stipulate for routine vaginal deliveries—which can mean a late-night discharge. Four days is standard for Caesarean births. Some providers, primarily on the East Coast, are working toward turnarounds as short as six hours—a practice obstetrical hands jokingly refer to as "drive-through OB."

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

"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: 2 to 3 days, with midwife home visit
United States: 24 to 36 hours

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 5 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

NEWS YOU CAN USE

ful 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 Gomez 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 $1,200, 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

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 Mornwaki, 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 [illegible] 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

es. 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 elated 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 allow new mothers to remain in the hospital for a minimum 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 7:52 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

_____

_____

address

SB

197

SENATOR DAVE DONLEY
ALASKA STATE LEGISLATURE

Sponsor Statement
SB 197
Prohibiting Increases in Health Insurance Premiums if the Insured is a Victim of Domestic Violence
1/24/96

SB 197 prohibits insurance companies from increasing premiums on disability insurance because of claims filed as a result of spousal abuse. SB 197 protects victims of domestic violence who are applying for and who are renewing nsurance policies.

Currently, there is no protection for victims of domestic violence against having their insurance premiums increased. While we know of no specific instances of this occurrence in Alaska, it has been a problem in other states.

Florida, Connecticut, Iowa, Delaware, California and Massachusetts have adopted legislation similar to SB 197 because of discrimination insurers were practicing against victims of abuse in those states. In fact, this legislation passed the California legislature with only one opposing vote. Similar legislation is also pending in Congress.

SB 197 prevents unfair discrimination of insurance companies against victims of domestic violence before it can begin in Alaska.

SB 197 is necessary because victims of domestic violence oftentimes can not afford an insurance premium increase. These victims should not pay a higher price on insurance premiums simply because they are innocent victims of abuse.

In summary, SB 197 will protect victims of spousal abuse from having a premium increase because they are victims of domestic violence.

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

DD/aa

January-May: STATE CAPITOL • JUNEAU, AK • 99801-1182 • (907) 465-3892 • FAX: (907) 465-6595
June-December: 716 W. 4TH A[redacted] • FAX: (907) 258-1648

MEMB[redacted] ffice

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

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

The department supports this legislation.

William L. Hensley, Commissioner

Date: 1/24/96

WLH/JH/dgl/4
012296a

ALASKA NETWORK
ON
DOMESTIC VIOLENCE
AND
SEXUAL ASSAULT

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

Comments on SB197 February 1996

The Alaska Network on Domestic Violence and Sexual Assault (Network) is the statewide coalition of community domestic violence and sexual assault intervention programs for Alaska Twenty-one full member and five supporting member programs provide shelter, advocacy, crisis intervention, and, information and referral services to victims seeking assistance in ending the violence being perpetrated against them. The Network works to promote institutional and systemic change necessary to end violence against women.

The Network supports SB197. It is a proactive step in ensuring the insurance needs of Alaskan victims of domestic violence continue to be met. An informal survey by the staff of the Subcommittee on Crime and Criminal Justice of the United States House Judiciary Committee in 1994 revealed that eight of the sixteen largest insurers in the country were using domestic violence as a factor when deciding whether to issue and how much to charge for an insurance policy. This practice threatens to undo over twenty years of work to protect victims of domestic violence.

In states across the nation, victims of domestic violence are being denied access to coverage, having their coverage canceled, having their domestic violence-related injuries excluded, and facing rate increases when insurers obtain medical or other documentation that identifies the applicant or insured as a victim of domestic violence. Insurance companies are using information they obtain from medical records; reports of legal intervention and other forms of assistance; and, insurance claims that have been filed to deny or reduce coverage or charge higher premium rates. These practices discourage victims from seeking appropriate and necessary medical treatment, legal intervention, and other assistance.

Under federal (ADA) law, insurers are already restricted from considering disability and medical conditions in issuance and rating of policies, domestic violence victims should not be treated more harshly than current law requires.

Efforts are being made on both state and federal levels to stop insurers discriminatory practices. The American Bar Association and the National Association of Attorneys General, as well as a number of other local and national organizations, have called for a stop to insurance discrimination against victims of domestic violence. Please join these efforts and keep Alaskan victims free from the abuse victims in other states suffer at the hands unscrupulous insurers.

WOMEN'S
L • A • W
PROJECT
125 South Ninth Street, Suite 401
Philadelphia, PA 19107
215/928-9801 Fax: 215/928-9848

CASES OF INSURANCE DISCRIMINATION AGAINST VICTIMS OF DOMESTIC VIOLENCE

California

A Santa Cruz woman was repeatedly turned down for health insurance following review of medical records which detailed beatings by her husband.

A California hospital reports denial of payment by HMOs for repeated treatment for injuries caused by domestic violence.

Delaware

In August, 1994, Nationwide Insurance Company denied an application for life insurance based on medical records "indicating an unstable family environment" because they included documentation of three assaults by the husband against the wife and counseling.

Iowa

Prudential Insurance Company denied a woman a life insurance policy in November, 1993, because the woman had a history of multiple assaults from her boyfriend.

A woman was sexually abused as a child and received some counseling. Despite a clear record and good health since then, when she applied for disability insurance, she was turned down on the basis of the earlier treatment.

Minnesota

Three insurance companies denied health insurance to a women's shelter because "as a battered women's program we were high risk."

A women's shelter in Rochester was told that it was considered uninsurable because its employees are almost all battered women.

A woman who sought the services of Women House in St. Cloud because the abuse during her 12-year marriage had escalated to such an extent that she was hospitalized for a broken jaw and spent 2 weeks in a mental health unit of a hospital, was denied health insurance by two companies, one saying they would not cover any medical or psychiatric problems that could be related to the past abuse.

Oregon

In 1994, Allstate Insurance Company canceled the homeowners' insurance of a woman whose former spouse set fire to the home twice. The woman had been abused by the former spouse throughout the marriage and left the marriage in 1992. Following cancellation, the woman was referred to the Oregon Fair Plan and was quoted a price for insurance that was eight times what she had previously been paying. After the former spouse was convicted and imprisoned for arson, the woman applied for insurance with Hartford, but was rejected for a poor credit record which was a result of the her former husband's failure to pay family debts for which he was responsible.

Pennsylvania

In October, 1993, a resident of Cumberland County, Pennsylvania was denied life, health and mortgage disability insurance by State Farm Insurance Company and life insurance by First Colony Life Insurance Company because of information in medical records revealing an incident of domestic violence.

An employee of a self-insured employer has been unable to obtain reimbursement for health care expenses resulting from abuse because of an exclusion for expenses arising from or related to a domestic dispute.

Washington

A woman's homeowner's policy was canceled by Safeco Insurance Companies in May, 1993 by letter reciting 5 claims filed over the 12 year life of the policy and noting concern that the most recent three occurred within a span of four months, but "more importantly", the most recent one "involved a domestic violence situation of individuals that are living with" the insured. The angry ex-wife of her boyfriend's brother damaged her door.

A landlord's policy was canceled because the insurer learned that the landlord intended to rent a home to a woman's shelter.

A child was twice denied health insurance because he had been abused in a day care facility.

A woman was twice denied insurance due to treatment received for physical, emotional and sexual abuse inflicted on her by her family during her childhood and by her spouse during marriage. In the late 1980's her employer's disability insurance carrier denied her disability coverage because of a nervous condition related to abuse. In 1993, Cigna denied her application for an increase in life insurance coverage provided through her employer based on a diagnosis of dissociative disorder related to counseling received for abuse. Although she also suffers from obesity, Type II diabetes and a seizure disorder, the abuse related counseling is the only reason given by the insurers as grounds for denial. She has divorced her abuser, has no further contact with her family of origin and is not on any medications.

A man who was physically attacked by his wife was denied $1500 to $2000 worth of health coverage for injuries he sustained. He was told that his wife, who owned the company that purchased the group coverage, instructed the insurer not to cooperate with him. Following divorce, he obtained an individual policy with exclusions for pre-existing conditions relating to domestic violence.

TESTIMONY OF TERRY FROMSON - Attorney, Women's Law Project (Philadelphia)

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

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

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

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

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

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

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

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

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

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

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

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

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

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

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

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

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

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

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

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

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

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

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

Thank you for the opportunity to testify today.

[redacted] RT

First Committee of Referral

DATE: 1/8/96

FURTHER:

Date of 5-Day Notice: 2/15/96
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: 2/22/96

The Labor & Commerce Committee considered SENATE BILL NO. 197

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

and recommends:

[X] be **replaced** with ____ CS SB 197 (L&C)

[ ] adopt **previous** ____ CS _____ ( )

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to the _____ Committee

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

[ ] **House Bill:** same title / technical title / new: SCR*____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
Mike Miller	✓				
John Torgerson	✓				
[illegible]	✓				
J. E. Sale	✓				
CHAIR: Tim Kelly	✓				

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
DCED	1/8/96	X	

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal
DCED	1/11/96	Y	

[ ] APPROPRIATION -- no fiscal note

*Include fiscal notes accompanying Governor's bill

SENATOR DAVE DONLEY

ALASKA STATE LEGISLATURE

February 8, 1996

Senator Tim Kelly, Chair
Senate Labor & Commerce Committee
Capitol Building Room 101
Juneau, AK 99801

Dear Senator Kelly,

Thank you for scheduling SB 197 for a hearing in your committee.

SB 197 prohibits insurance companies from unfairly discriminating against victims of domestic violence. It is an important protection victims of domestic violence should have in our state.

Again, thank you for scheduling SB 197.

Sincerely,

Senator Dave Donley

DD/aa

January-May STATE CAPITOL • JUNEAU, AK • 99801-1182 • (907) 465-3892 • FAX (907) 465-6598
June-December 716 W 4TH AVE • STE 4 • ANCHORAGE, AK • 99501 • (907) 258-8181 • FAX (907) 258-1648

MEMBER Senate Finance Committee • Senate State Affairs Committee

9-LS1218\C
Ford
1/30/96

CS FOR SENATE BILL NO. 197( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DONLEY, Ellis, Salo, Duncan

A BILL

FOR AN ACT ENTITLED

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

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

* Section 1. AS 21.36 is amended by adding new sections to read:

Sec. 21.36.430. INSURANCE FOR DOMESTIC VIOLENCE VICTIMS; RECORDS. (a) An insurer may not (1) refuse to provide insurance coverage; (2) cancel an existing policy of insurance; or (3) increase the premium on an insurance policy if the refusal, cancellation, or increase results only from the fact that the applicant or insured was a victim of domestic violence.

(b) Records maintained by an insurer that reflect the fact that the insured was a victim of domestic violence are confidential and may not be disclosed by an insurer, except with the permission of the insured or as required by a court of competent jurisdiction.

Sec. 21.36.440. REQUIRED DISCLOSURE. An insurer who refuses to

provide insurance coverage to an applicant or who cancels existing coverage shall provide a written explanation of the refusal or cancellation to the applicant or insured.

* Sec. 2. This Act applies to a policy of insurance that is entered into or renewed on or after the effective date of this Act.

FISCAL NOTE

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

1996 LEGISLATIVE SESSION

Revision Date:

Title: Prohibit Increase in Ins for Domestic Violence

Sponsor: Senators Donley, Ellis, Salo

Requestor: Senate L&C 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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[redacted]

Fiscal Note

SB 202

FY 95 - LICENSING STATISTICS
(From Annual Performance Reports)
FY 96 ADMINISTRATIVE INDIRECT COSTS TO BE BASED ON THESE PERCENTAGES.

Add Biennial Fee

Board/Commission/Occupation:	Indirect LC	NEW	CURRENT	% of Licensees
Acupuncture	101	11	20	0.06%
AELS	107	354	5,094	15.74%
Athletic Commission	125	93	106	0.33%
Audiology/Hearing Aid Dealers	117	8	58	0.18%
Barbers & Hairdressers	139	286	3,698	11.43%
Chiropractors	161	19	176	0.54%
Clinical Social Workers	167	32	219	0.68%
Collection Agencies	173	56	145	0.45%
Concert Promoters	185	5	12	0.04%
Construction Contractors	188	714	4,222	13.05%
Dental	198	77	994	3.07%
Direct Entry Midwives	153	0	15	0.05%
Dispensing Opticians	207	29	115	0.36%
Mechanical Administrator	370	20	463	1.43%
Electrical Administrator	376	61	512	1.58%
Geologists	215	37	409	1.26%
Guide-Outfitters	221	250	1,350	4.17%
Marine Pilots	234	0	90	0.28%
Marital & Family Therapy	252	12	170	0.53%
Medical	242	262	2,028	6.27%
Mortuary Science	260	9	106	0.33%
Naturopaths	270	3	22	0.07%
Nursing	276	727	6,338	19.59%
Nursing Home Administrators	286	6	74	0.23%
Optometry	292	4	87	0.27%
Pharmacy	298	51	634	1.96%
Physical/Occupational Therapy	309	75	484	1.50%
Psychology	319	18	227	0.70%
Public Accountancy	327	59	1,049	3.24%
Real Estate	345	283	2,515	7.77%
Real Estate Appraisers	354	18	202	0.62%
Storage Tank Workers	364	54	399	1.23%
Veterinary	335	22	322	1.00%
Sub-Total:		**3,655**	**32,355**	**100.00%**
Business Licensing	383	34,534	67,289	
Nurse Aide Registry	384	660	2,288	
TOTAL:		**38,849**	**101,932**	

Sec. 44.23.020. Duties. (a) The attorney general is the legal advisor of the governor and other state officers.

(b) The attorney general shall

(1) bring, prosecute, and defend all necessary and proper actions in the name of the state for the collection of revenue;

(2) represent the state in all civil actions in which the state is a party;

(3) prosecute all cases involving violation of state law, and file informations and prosecute all offenses against the revenue laws and other state laws where there is no other provision for their prosecution;

(4) administer state legal services, including the furnishing of written legal opinions to the governor, the legislature, and all state officers and departments as the governor directs; and give legal advice on a law, proposed law, or proposed legislative measure upon request by the legislature or a member of the legislature;

(5) draft legal instruments for the state;

(6) make available a report to the legislature, through the governor, at each regular legislative session

(A) of the work and expenditures of the office; and

(B) on needed legislation or amendments to existing law;

(7) perform all other duties required by law or which usually pertain to the office of attorney general in a state; and

(8) prepare, publish, and revise as it becomes useful or necessary to do so an information pamphlet on landlord and tenant rights and the means of making complaints to appropriate public agencies concerning landlord and tenant rights; the contents of the pamphlet and any revision shall be approved by the Department of Law, division of consumer protection, before publication. (§ 9-1-5 ACLA 1949; am § 1 ch 128 SLA 1959; § 9 ch 64 SLA 1959; am § 1 ch 8 SLA 1976; am § 89 ch 21 SLA 1995)

Effect of amendments. — The 1995 amendment, effective August 8, 1995, inserted "av[illegible]" in paragraph (b)(6) and made minor stylistic changes.

NOTES TO DECISIONS

Authority to appoint special prosecutor. — The appointment of a special prosecutor by the attorney general as a remedy to a perceived conflict was both appropriate and authorized under paragraph (b)(7); prosecution of the alleged violations was a duty required by law under paragraph (b)(3), and if the attorney general in the attorney general's discretion chose to disqualify the attorney general's office and the Department of Law from prosecuting the violations, then the appointment of a special prosecutor to conduct the prosecution was also a duty required by law. State v. Breeze, 873 P.2d 627 (Alaska Ct. App. 1994).

Sec. 44.62.120. Voluntary submitting and publication. With the approval of the lieutenant governor, a state agency may submit to the lieutenant governor for filing a regulation or order of repeal of a regulation not required by AS 44.62.040 to be submitted. If the lieutenant governor accepts the regulation or order of repeal, the lieutenant governor shall endorse and file it as required in AS 44.62.080, and may publish the regulation or order of repeal in the manner the lieutenant governor considers proper. (§ 9 art II (ch 1) ch 143 SLA 1959; am § 5 ch 40 SLA 1969)

Sec. 44.62.125. Regulations attorney. (a) In the Department of Law a particular attorney, called the regulations attorney, shall be assigned, as the attorney's primary responsibility, the functions relating to the handling of administrative regulations.

(b) The department shall

(1) advise all state administrative agencies of the nature and use of administrative regulations;

(2) alert the agencies to statutes that need to be implemented, interpreted, or made clear by regulation;

(3) continually review the regulations, make recommendations to the respective agencies concerning deficiencies, conflicts, and obsolete provisions in and the need for reorganization or revision of the regulations, and prepare regulations to be adopted by the agencies, correcting or removing the deficiencies, conflicts, and obsolete provisions;

(4) work with all administrative agencies possessing regulation-making power in drafting all new regulations, advising the agencies of legal problems encountered, and ensuring compliance with the drafting manual for administrative regulations prepared by the Department of Law under AS 44.62.050;

(5) assist the agencies in holding public hearings under AS 44.62.210;

(6) to the extent necessary after regulations have been filed by the lieutenant governor, edit and revise them for consolidation into the Alaska Administrative Code in the manner provided for the revisor of statutes under AS 01.05.031;

(7) draft bills for consideration by the governor to transfer matter that should be statutory law from the Alaska Administrative Code to the Alaska Statutes and to clarify agency regulatory power when clarification is needed. (§ 2 ch 58 SLA 1969; am § 3 ch 64 SLA 1978)

Article 3. The Alaska Administrative Register and Code.

STATE BOARD OF REGISTRATION FOR ARCHITECTS, ENGINEERS AND LAND SURVEYORS

STATISTICAL OVERVIEW

Category	New - Issued During FY 95	As of 06/30/95
Civil Engineer	139	2,394
Electrical Engineer	63	474
Chemical Engineer	11	70
Mechanical Engineer	50	542
Mining Engineer	2	44
Petroleum Engineer	6	67

Examination Statistics

Category	Date	Total Candidates	No. Passed	No. Failed
Engineering:				
Fund. of Engineering	10/94	59	49	10
Fund. of Engineering	04/95	76	60	16
Prin. & Prac. of Engineering	10/94	98	51	47
Prin. & Prac. of Engineering	04/95	90	50	40
Prin. & Prac. Land Surveying	10/94	9	6	3
Prin. & Prac. Land Surveying	04/95	21	7	14
Alaska Land Surveying	10/94	14	4	10
Alaska Land Surveying	04/95	30	19	11
Fund. of Land Surveying	10/94	6	5	1
Fund of Land Surveying	04/95	13	8	5

SENATOR LOREN LEMAN

Northwest Anchorage

716 W 4th Ave, Suite 520, Anchorage, AK 99501 (907) 258-8189 Session: State Capitol, Juneau, AK 99801 (907) 465-2095

SPONSOR STATEMENT

Senate Bill 202

"An Act relating to the State Board of Registration for Architects, Engineers and Land Surveyors."

I introduced SB 202 at the request of the AELS Board to address its concerns with the operation of the Board under the Department of Commerce and Economic Development. The Board is asking the Legislature to allow it to become semi-autonomous from the state.

The Board believes it wou be beneficial to be an independent board managed by those that rely on its services. Currently, a licensing examiner is assigned by the Department, and is subject to change without Board action. Legal services are provided by the Department of Law. Inconsistent support is detrimental to the Board's role and goals. To help alleviate these challenges the Board wants authority to hire its own staff or contract for services. In addition, it wants to have control over the collection of revenues from licensing fees and the ability to set its own budget.

Furthe-more the Board wants the appointment process revised so professional societies have more input in professional appointments. The proposed change will require the Governor to consider professional nominees submitted by professional societies or by a petition signed by 20 licensees.

SECTIONAL ANALYSIS

Senate Bill 202

"An Act relating to the State Board of Registration for Architects, Engineers, and Land Surveyors."

SECTION 1: Amends 08.48.011(b)

- Deletes requirement that one of the board members be a mining engineer
- for the eight professional members the governor shall consider names submitted by
  1. a recognized professional society
  2. a petition signed by at least 20 members of a recognized professional society

SECTION 2: Adds new section to 08.48 (Per Diem and Expenses)

- 08.48.053 the board will establish per diem and expenses to be paid for official board duties
- 08.48.055 the board can hire staff or contract for services.
  - employees will be exempt under AS 39.25.110
  - cannot be a member of the board

SECTION 3: Amends AS 08.48.061(a)

- the board will collect fees, but the money will still be deposited in the general fund, subject to legislative appropriation

SECTIONS 4 & 5 & 6: Amends AS 08.48.071(a),(e)&(f)

- records will be kept and statistics assembled by the Board instead of the Department of Commerce and Economic Development

SECTION 7: Adds new paragraph to AS 39.25.110

- employees of the board will be exempt employees

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB 202

1996 LEGISLATIVE SESSION

Revision Date: 18-Jan-96 Dept Affected: Natural Resources

Title: An Act relating to the State Board of Registration for Architects, Engineers, and Land Surveyors BRU: Resource Development

Component: Land Development

Sponsor: Senator Leman

Requestor: Component Serial No. 431

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	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
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 (FY96) cost: $ None

POSITIONS

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

ANALYSIS: (Attach a separate page if necessary)

The passage of this bill will not increase the work load of the division. The passage of the bill will not increase the number of board members but will give the professional land surveyors a representative on the board and will require the board to maintain their files for a period of five years and appraise its performance. These duties are presently preformed by the Department of Commerce and Economic Development.

Prepared by: Ron Swanson DD Phone: 269-8503

Division: Land Date: 18-Jan-96

Approved by Commissioner:

Date: 18-Jan-96

Agency: Natural Resources

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FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. SB 202

Revision Date:
Department: Commerce and Economic Development
Title: An Act relating to the State Board of Registration for Architects, Engineers, and Land Surveyors
BRU: Occupational Licensing
Component: Operations
Sponsor: Senator Leman
Requestor: Senate Labor & Commerce
COMPONENT SERIAL NO. 1844

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDI URES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES	244.2	244.2	244.2	244.2	244.2	244.2
TRAVEL	78.1	78.1	78.1	78.1	78.1	78.1
CONTRACTUAL	183.6	183.6	183.6	183.6	183.6	183.6
SUPPLIES	6.7	6.7	6.7	6.7	6.7	6.7
EQUIPMENT	79.8	15.0	15.0	15.0	15.0	15.0
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	592.4	527.6	527.6	527.6	527.6	527.6
CAPITAL EXPENDITURES						
CHANGE IN REVENUES	592.4	527.6	527.6	527.6	527.6	527.6

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts	407.2	342.4	342.4	342.4	342.4	342.4
1006 GF/MHTIA						
Other 1007 IA Receipts	185.2	185.2	185.2	185.2	185.2	185.2
TOTAL	592.4	527.6	527.6	527.6	527.6	527.6

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

POSITIONS

FULL-TIME	5	5	5	5	5	5
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

SB 202 amends AS 08.48 to establish the State Board of Registration for Architects, Engineers, and Land Surveyors as a semi-autonomous board within the department. The bill grants significant fiscal authority to the board by allowing the board to establish the amount of *per diem (honorarium)* to be paid in addition to travel or other expenses; and authorizes the board to establish a *per diem* to be paid to members of an advisory council or peer review committee established by the board. (Continued on attached)

Prepared by: Jennifer Strickler, Administrative Officer
Phone: 465-2144
Division: Occupational Licensing
Date: January 18, 1996

Approved by Commissioner: William L. Hensley
Date: 1-18-96
Agency: Commerce and Economic Development

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SB 202 also authorizes the board to hire or contract for staffing services, and to establish the amount of compensation, qualifications, and duties of its staff by regulations, placing its employees in the exempt service of state government.

The costs identified in this fiscal note assume the regulatory program for architects, engineers, and land surveyors will be completely separated from centralized licensing; to be regulated as a separate State government agency and supported by its own licensing fees.

PERSONAL SERVICES (Positions placed in the Exempt Service of State Government)

1	Executive Secretary	PFT	Range 18	$57.6

This position is authorized in the bill presumably to oversee program operations. Although semi-autonomous agencies are often staffed by an Executive Director at higher rates, this fiscal note references the classification identified in the bill.

1	Investigator III	PFT	Range 18	$59.3

The cost of this position is based on known costs for an Investigator III position.

1	Accounting Clerk III	PFT	Range 10	$37.0

This position is needed to assume fiscal responsibilities such as accounting for licensing fees, preparing deposits, paying invoices, fiscal record-keeping, and budget preparation.

1	Occupational Licensing Examiner I	PFT	Range 12	$55.0

The program is currently supported by an Occupational Licensing Examiner I position. This fiscal note assumes the current support position will transfer to the new semi-autonomous board.

1	Administrative Clerk II	PFT	Range 8	$35.3

The program is currently supported by an Administrative Clerk II position. This position is anticipated to be transferred to the new semi-autonomous board.

Sub-Total Personal Services: $244.2

Inter-Agency Receipts: FY 95 Personal Services costs show $94,681 Board/Occupation Personal Services costs based on positive time-keeping. This amount is anticipated to be transferred to the to the semi-autonomous board from BRU: Occupational Licensing.

TRAVEL

The following is based on four meetings annually: two days for each meeting. The assumption is also made that staff attending the meetings are based in Juneau.
Section 2 of the bill allow a payment to be made to individuals while engaged in board business. An honorarium of $200 has been estimated in this fiscal note for each day of board meetings attended by board members.
(Note: The $200 is based on honorariums paid to agencies with similar statutory provisions.)

Anchorage Meeting			
PER DIEM at $115.00 per day:			
4 Anchorage area members		0	
5 Members Travelling (with 2 extra days before and after the meeting) at $115.00 x 4 days x 5 travellers		2,300	
3 Staff travelling at $381 per person (3 days @ $115 = $345 + 1 day @ $36 meal allowance = $381)		1,143	
$200 honorarium x 28 days (for 9 members)		5,600	
TRANSPORTATION:			
4 Anchorage area members		0	
5 Members travelling at $400.00 per person		2,000	
3 Staff travelling at $400.00 per person		1,200	
	Anchorage Meeting:	12,243	
Multiplied by 2 for two meetings in Anchorage	x	2	
	Total Anchorage Meetings:	24,486	
Juneau Meeting			
PER DIEM at $115.00 per day:			
1 Juneau member		0	
8 Travellers (with 2 extra days before and after the meeting) at $115.00 x 4 days x 8 travellers		3,680	
$200 honorarium x 34 days (for 9 members)		6,800	
TRANSPORTATION:			
8 Travellers at $400.00 per person		3,200	
	Anchorage Meeting:	13,680	
Multiplied by 2 for two meetings in Juneau	x	2	
	Total Juneau Meetings:	27,360	
	Cost of Board Meetings:		51,846

Out-of-State Conferences
These costs are based on the Board's Annual Report budget request.
It assumes that three members and the licensing examiner will attend at least two NCARB and two NCEES meetings. The costs are based on $1,125.00 per trip x 16 travellers. **18,000**

Member Board Administrator's Workshop
This funding will allow the licensing examiner to attend the MBA Workshop held in the fall - in accordance with request identified in the board's annual report. **2,000**