Drive-Through Deliveries: Is Consumer Protection Just What the Doctor Ordered

David A. Hyman

DRIVE-THROUGH DELIVERIES: IS "CONSUMER PROTECTION" JUST WHAT THE DOCTOR ORDERED?

DAVID A. HYMAN*

Although consumer protection against managed care has become extraordinarily popular in the last few years, Professor David Hyman demonstrates in this Article that there are good reasons to be skeptical about the merits of legislative and regulatory efforts in this area. Professor Hyman analyzes one of the most popular consumer protection initiatives to date: legislation limiting or eliminating the economic incentive for "early" postpartum discharges—commonly referred to as "drive-though deliveries." Once the issue came to public attention, laws limiting drive-through deliveries were enacted throughout the nation with breathtaking speed. Despite overwhelming legislative enthusiasm, Professor Hyman argues that the case in favor of such laws is actually quite flimsy. Professor Hyman demonstrates that the case for extended postpartum stays was based on unrepresentative horror stories and reluctance to make explicit cost/benefit tradeoffs in matters of public health and safety.

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* Professor of Law, University of Maryland School of Law. B.A. 1983, J.D. 1989, M.D. 1991, University of Chicago. This Article was improved by comments received during presentations at Columbia University, Harvard University, the University of Missouri at Columbia, the University of Virginia, and the University of North Carolina Schools of Law. Michael Heise, Russell Korobkin, Bill Reynolds, and Bill Richman provided detailed written comments. As always, errors of omission and commission are mine alone.

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> "Should we let a bunch of HMO bureaucrats push women and infants out of the hospital at their most vulnerable moment? Or should we stand up for motherhood?"[1]

INTRODUCTION

Although managed care has essentially captured the health insurance market, it has had less success with the hearts and minds of the American people.[2] Complaints about avoidable death and disability, delay, inconvenience, micro-management, profiteering, declining quality, and petty bureaucracy are legion.[3] Calls to do something about the "excesses" of managed care have rung out from interest groups as disparate as the editors and columnists of the nation's newspapers, representatives of academic medical centers, medical ethicists, lawyer-academics, physicians and nurses, the plaintiffs' bar, unions, and various self-styled consumer advocates.[4]

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1. Geoffrey Cowley & Karen Springen, *Are Drive-Through Deliveries So Bad?*, NEWSWEEK, Aug. 4, 1997, at 65, 65; *see also* Barbara Vobejda, *"Moms and Babies" Prove to Be Irresistible Force on Capitol Hill*, WASH. POST, Sept. 20, 1996, at A17 ("It's mothers and babies .... They're sacrosanct .... It's a politician's dream issue.").

2. *See* David A. Hyman, *A Second Opinion on Second Opinions*, 84 VA. L. REV. 1439, 1460 (1998) (noting the lack of popular enthusiasm for managed care); *see also* Robert J. Blendon et al., *Understanding the Managed Care Backlash*, HEALTH AFF., Sept.–Oct. 1998, at 80, 80–82 (presenting survey data indicating public concern about performance of managed care organizations).

3. *See* David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 409–18 (1998) [hereinafter Hyman, *Consumer Protection*] (cataloging complaints).

4. *See id.* at 410–11, 414–18 (documenting calls for action).

Hostility toward managed care is so widespread that one of the biggest applause lines in the recent movie *As Good as It Gets* comes when a character uses a string of obscenities to describe her health maintenance organization (HMO).[5]

Predictably, the response to this animosity has been a virtual blizzard of legislation. In the last four years, most states have considered consumer protection legislation, and a majority of states have enacted consumer protection statutes.[6] At the federal level, both Republicans and Democrats have offered competing versions of a "Bill of Rights" for people enrolled in managed care plans.[7] President Clinton has used executive orders to implement a variety of consumer protections in the Medicare and Medicaid programs.[8] A Presidential Commission has weighed in on the subject as well.[9] The issue appeared in 1998 campaign ads,[10] was featured by President

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5. *See* Steve Chapman, *How Did HMO Become a Four-Letter Word?*, CHI. TRIB., May 21, 1998, at 31.

> Actress Helen Hunt has always been adorable, but audiences have never found her more charming than in the scene in "As Good as It Gets" when her character angrily disparages her health maintenance organization in terms so vile I cannot repeat them. The tirade invariably prompts a round of applause.

Id.; *see also* Ellen Goodman, *Managed Care Gets Thumbs Down From Just About Any Audience*, BALT. SUN, Mar. 31, 1998, at 9A (noting that "audiences ... spontaneously burst out into applause" after viewing the scene).

Perhaps inevitably, in some circles in Washington, Ms. Hunt is now seen as an expert on the need for consumer protection against managed care. *See* Lizette Alvarez, *Nasty, Costly Battle Shapes up over Changing Managed Care*, N.Y. TIMES, June 3, 1998, at A1 ("Not long after Senator Edward M. Kennedy introduced a bill this spring to overhaul managed care, his staff put out a feeler to the unwitting heroine of the movement, Helen Hunt .... Would she be interested in promoting the bill?"). This is not the first time actors have been tapped for such roles on the strength of their performance in a film. Current Senate Minority Leader (and then-Representative) Tom Daschle arranged for Jane Fonda, Jessica Lange, and Sissy Spacek to testify before the House Democratic Caucus Task Force on Agriculture on the "Human Dimensions of the Farm Crisis." *See* 131 CONG. REC. S11298–S11300 (daily ed. May 9, 1985) (Sup. Docs. No. X.99/1.131/Pt.9). The principal qualification of these witnesses was that each had appeared in a movie about the farm crisis.

6. *See* David A. Hyman, *Regulating Managed Care: What's Wrong with A Patient Bill of Rights*, 73 S. CAL. L. REV. (forthcoming January 2000) (manuscript at 10, on file with the *North Carolina Law Review*) [hereinafter Hyman, *Regulating Managed Care*]; David A. Hyman, *Managed Care at the Millennium: Scenes from a Maul*, 24 J. HEALTH POL. POL'Y & L. (forthcoming November 1999) (manuscript at 8, on file with the *North Carolina Law Review*) [hereinafter Hyman, *Scenes from a Maul*].

7. *See* Hyman, *Regulating Managed Care, supra* note 6, at 8.

8. *See id.*

9. *See id.*; *see also* David A. Hyman, *Consumer Protection and Managed Care: With Friends Like These ...* , *in* 1998 HEALTH LAW HANDBOOK 283, 290–93 [hereinafter Hyman, *With Friends Like These*] (reviewing the efforts of the President's Advisory Commission on Consumer Protection and Quality in the Health Care System).

10. *See* Howard Kurtz, *Attack Ads Carpet TV; High Road Swept Away*, WASH. POST,

Clinton in his 1999 State of the Union Address,[11] and has occupied a prominent part of the legislative agenda for the 106th Congress.[12]

Unfortunately, there are good reasons to question the value of many of these efforts. Few legislators have the necessary training or inclination to weigh the often conflicting evidence on the benefits of specific proposals.[13] Evidence on the cost of such proposals is frequently unavailable, and estimates are subject to considerable uncertainty.[14] Choosing among the universe of potential consumer protections presents complex distributional considerations.[15] In addition, the drafting of "consumer protections" is readily hijacked by entrenched health care providers, who have their own interests at heart.[16] When these factors are coupled with the emotional overlay accompanying health care issues and the government's unwillingness to bear the cost of many of the proposed reforms, it should come as no surprise that consumer protection in the field of managed care "is

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Oct. 20, 1998, at A1 ("Health maintenance organizations are an especially hot issue this year, with 'bureaucrats'—sometimes literally pictured as rubber-stamping boobs—drawing Democratic fire.").

11. *See Clinton Outlines His Vision for Nation's Transition to the 21st Century*, N.Y. TIMES, Jan. 20, 1999, at A22.

12. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 2 (discussing the proposed legislation).

13. *See* Jerome P. Kassirer, Editorial, *Practicing Medicine Without a License—The New Intrusions by Congress*, 336 NEW ENG. J. MED. 1747, 1747 (1997) ("[C]ongress is not the appropriate forum for making complex medical decisions. The data on which many important medical decisions are based are often contradictory and still in evolution. Legislators do not have the context nor the capacity to weigh medical evidence adequately.").

14. *See, e.g.*, Jonathan Cohn, *Managed Careless*, NEW REPUBLIC, Mar. 16, 1998, at 6, 6 ("Citing a study by the accounting firm of Muse and Associates, reformers say [the Patient Access to Responsible Care Act] would increase premiums by at most 2.6 percent; their opponents ... say the increase could top 22 percent."); Amy Goldstein & Helen Dewar, *Health Care Bill's Price Debated; CBO Says Democratic Plan Would Hike Premiums 4%; GOP Differs*, WASH. POST, July 17, 1998, at A7 (finding considerable variation in the estimated costs of consumer protection bills).

15. *See* Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 SETON HALL L. REV. 1007, 1025–26 (1996).

> If written to protect the most vulnerable consumers, regulations are likely to restrict some choices and impose costs that do not benefit the average consumer. For example, regulations that make MCOs [managed care organizations] offer certain benefits help those consumers who are most likely to use [the services] but raise insurance premiums for all consumers.

Id. (citations omitted).

16. *See* Hyman, *Consumer Protection*, *supra* note 3, at 456 ("When statutes are proposed and backed by those who provide the mandated services, it is a safe first approximation that any consumer benefit is largely incidental—and frequently nonexistent."); Peter T. Kilborn, *Bills Regulating Managed Care Benefit Doctors*, N.Y. TIMES, Feb. 16, 1998, at A1 ("The quip going around is that this is physician protection, not consumer protection.").

particularly prone to legislative posturing and overreaching."[17]

Consider what is easily the most popular "consumer protection" initiative to date: legislation mandating the coverage of a minimum length of stay after the birth of a child. Such laws limit or eliminate the economic incentive for an "early" postpartum discharge—commonly referred to as a "drive-through" or "drive-by" delivery.[18] Once the issue came to public attention, legislatures throughout the nation enacted such laws with breathtaking speed. Maryland was the first state to act, passing its law on May 25, 1995.[19] By the end of 1995, four more states had followed suit, and by the end of 1996, twenty-four additional states had passed laws.[20] Federal legislation, backed by cosponsors "as diverse as Ted Kennedy and Jesse Helms" was signed into law on September 26, 1996.[21]

Despite this overwhelming legislative enthusiasm, the case for the mandated coverage is actually extraordinarily flimsy. There is little evidence indicating that postpartum stays of the specified length provide *any* benefit, regardless of how one defines "benefit." Even if such stays provide a benefit, it does not follow that the benefit justifies the associated cost or that the same results could not be achieved in some other way at less cost.

Worse still, these laws treated drive-through deliveries as a narrow, free-standing problem. The legislation did nothing about the availability of post-discharge services; the quality of services rendered before, during, and after postpartum hospitalization; the distortions

17. Hyman, *Consumer Protection*, *supra* note 3, at 454 (" 'Mom and apple pie' legislation, of which consumer protection against managed care is clearly an example, is particularly prone to legislative posturing and overreaching.").

18. *See* William Safire, *Just Driving By*, N.Y. TIMES, Nov. 3, 1996, § 6 (magazine), at 24 (tracing the origin of the phrases "drive-by" and "drive-through" delivery). The balance of this Article refers to such discharges as "drive-through deliveries." It is important to note the normative implications of labeling a postpartum discharge as "early" or "drive-through." By framing the issue in this fashion, opponents of the practice started with a built-in advantage. *See* Eugene Declercq & Diana Simmes, *The Politics of "Drive-Through Deliveries": Putting Early Postpartum Discharge on the Legislative Agenda*, MILBANK Q., June 1997, at 175, 184 ("The widespread adoption of the phrase '*early* discharge' was a victory in itself for advocates because it described the problem in a way that suggested mothers and babies might have been sent home prematurely."); Vobejda, *supra* note 1, at A17 ("Perhaps it is the expression itself, 'drive-by deliveries,' that propelled this issue so quickly from grass-roots grumbling to the congressional fast lane."). To even out the normative stakes, this Article intermittently refers to the alternative to a drive-through delivery as an "extended postpartum hospitalization."

19. *See* Declercq & Simmes, *supra* note 18, at 176–77.

20. *See id.*

21. *Id.* (discussing the Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. §§ 300gg-4, -51 (1996))).

created by hospitals' use of per-diem pricing; or the manner in which managed care organizations (MCOs) make coverage decisions.[22]

The campaign against drive-through deliveries does illustrate some problems familiar to students of regulation. The case for extended postpartum stays was based almost entirely on wrenching, but extraordinarily unrepresentative, horror stories[23] and overheated rhetoric.[24] The "reform" exploited social reluctance to make explicit cost-benefit tradeoffs in matters of public health and safety.[25] The health care providers who testified in favor of the proposed "consumer protection" neglected to mention that the issue was

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22 For a discussion of the various forms of managed care and the tools employed by MCOs, see *infra* notes 38–40 and accompanying text.

23. *See infra* notes 46–60 and accompanying text. On the perils of anecdote-driven legislation, see David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L. J. 797, 804–07 (1998) [hereinafter Hyman, *Lies*]. *See also* Hyman, *Consumer Protection, supra* note 3, at 453–54 ("In drafting consumer protections, there is little guarantee that the legislature will actually target the right problem because its selection is heavily influenced by bad anecdotes and perceived public appeal. Even if the legislature fortuitously picks a reasonable target today, there is no guarantee it will do so tomorrow.").

24. *See infra* notes 61–78 and accompanying text. Medical organizations were not shy about participating in and contributing to the rhetorical firestorm. For example, at the only hearing held by Congress on the issue of drive-through deliveries, the American Medical Association's (AMA) representative complained that

> the money that is saved from this does not got back into the plan like it does in the not-for-profit organizations, but goes to the stockholders. They are depriving mothers and babies of appropriate care and raising the amounts of money that their stockholders and their presidents and CEOs get.

Newborns' and Mothers' Health Protection Act: Hearings on S. 969 Before the Senate Committee on Labor and Human Resources, 104th Cong. 45 (1995) (Sup. Docs. No. y4.L11/4:S.HRG.104-327) [hereinafter *Newborns' and Mothers' Hearing*] (statement of Dr. Palma Formica, AMA Board of Trustees).

25. Public opinion polls have consistently demonstrated that most Americans believe everyone should have access to all necessary health care services, regardless of ability to pay. *See* Daniel Yankelovich, *The Debate That Wasn't: The Public and the Clinton Plan*, HEALTH AFF., Spring 1995, at 7, 12. A Harris poll found almost universal agreement (91%) with the idea that "everybody should have the right to get the best possible care—as good as the treatment a millionaire gets." *Id.*

Although these views are understandably honored in the breach, they empower advocacy groups to argue that public policy should proceed from the assumption that a human life is beyond price. Professor James Blumstein has accurately described such rhetoric as "symbolic blackmail." James F. Blumstein, *Financing Uncompensated Care: An Approach to the Issues*, 38 J. LEGAL EDUC. 511, 522 (1988). These tensions are resolved in predictable ways when the tradeoffs must actually be made. *See* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 26 (1978) ("Evasion, disguise, temporizing, [and] deception are all ways by which artfully chosen allocation methods can avoid the appearance of failing to reconcile values in conflict."); Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 7 (1975) ("A policy dialogue in which a taboo surrounds any concession to the reality of limited resources is bound to be rich in posturing and assertion ....").

merely the opening salvo in their campaign against managed care—and that their preferred remedy was a return to the model of professional dominance whose excesses led to managed care in the first place.[26]

Part I of this Article provides some background on insurance, managed care, and cost-quality and quality-quality tradeoffs. Part II reviews the state and federal legislation that emerged in 1995 and 1996 mandating coverage of a minimum postpartum hospital stay. Part III analyzes the case for such "consumer protection" laws and concludes that there is little or no evidence that such laws will provide any real benefit to consumers. Part IV explores the empirical literature on health care quality and argues that legislators have ignored the real problem (variable quality) and instead have embraced symbolic legislation addressing a non-existent problem. Part V evaluates "who won what" as a result of such legislation. Part VI offers a narrative perspective on the issue. A brief conclusion follows Part VI.

I. INSURANCE AND MANAGED CARE OVERVIEW

A. Fundamentals of Insurance Economics and Law

Insurance is a mechanism for shifting, spreading, and distributing risk.[27] Health insurance allows an individual to pre-pay some portion of his anticipated medical expenditures for the coming year and to spread the costs of some of the associated but more unpredictable health-related risks. The scope of the risks that are shifted and spread is dictated by a contract: the health insurance policy.

Health insurance policies are issued to groups and individuals. Group insurance lowers the administrative and marketing costs of insurance and decreases the significance of adverse selection. When group insurance is provided as a result of employment, it also qualifies for favorable tax treatment.[28] Coverage in both group and

26. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 15. Legislators could have figured this point out if they had been paying attention. The written submission of the AMA for the federal hearing on drive-through deliveries declared forthrightly that "managed care employees should not be permitted to interfere in the clinical decision-making of physicians." *Newborns' and Mothers' Hearing*, *supra* note 24, at 55. The AMA is usually more circumspect about its ultimate objectives. *See id.* at 56 ("The AMA is not anti-managed care.").

27. *See* KENNETH ABRAHAM, DISTRIBUTING RISK 1–2 (1986).

28. *See* I.R.C. § 106 (West 1996), *amended by* I.R.C. § 106(a) (West Supp. 1999) ("[G]ross income of an employee does not include employer-provided coverage under an accident or health plan."). The value of this subsidy has been estimated at $76.2 billion

individual markets is based on the aggregation of consumer preferences.

Most insured employees secure their insurance through their employers. Employer plans vary greatly in coverage and in the out-of-pocket costs charged to employees. Even across these diverse contractual settings, certain risks, such as cosmetic surgery, are never insured; others, such as fertility treatment and radial keratotomy, are voluntarily insured only if the policy is a "rich" one. Those risks which are not transferred are self-insured.

More generous coverage is more expensive. Copayments and deductibles help fine-tune the coverage (and deal with the problem of moral hazard) by allowing for a mix of self-insurance and third-party coverage. Not surprisingly, a policy with a substantial copayment and deductible is cheaper than one that pays for all medically necessary expenses. Similarly, a policy with generous hospitalization benefits is generally more expensive than one that encourages outpatient treatment, provides coverage at a limited number of inpatient facilities, or strictly limits length of hospital stays.

Willingness to purchase health insurance is heterogeneous and greatly affected by the premium.[29] As the premium increases, the policy becomes less affordable for people at the margin. Those who are selling the policy must decide whether better coverage is worth offering if it prices the policy out of a particular market. Those who would willingly have bought a more limited policy must self-insure (i.e., become one of the approximately 43 million uninsured Americans) once the cost of the minimum product exceeds their willingness to pay.

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per year in fiscal year 1999, making it the single largest tax expenditure. *See* National Health Policy Forum, *Retooling Tax Subsidies for Health Coverage: Old Ideas, New Politics*, 3 (visited Oct. 15, 1999) <http://www.nhpf.org/pdfs/8-728t(web).pdf>. Many commentators have criticized this statute for effectively tying health insurance to employment and doing so with a subsidy that is worth the most to those who need it the least. *See, e.g.*, Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 BYU L. REV. 1229 *passim*; David Kendall & Will Marshall, *Health Reform, Meet Tax Reform*, AM. PROSPECT, Spring 1995, at 74, 74. Although these criticisms are well taken, there are advantages to even this peculiar structure, including the dampening of adverse selection and the utilization of an agency relationship to offset the bounded rationality of any given individual. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 25.

29. *See* Hyman, *Consumer Protection*, *supra* note 3, at 437; *see also* David A. Hyman, *Professional Responsibility, Legal Malpractice, and the Eternal Triangle: Will Lawyers or Insurers Call the Shots?*, 4 CONN. INS. L.J. 353, 399 (1998) [hereinafter Hyman, *Professional Responsibility*] (noting that "consumer preferences are heterogeneous, but cost is an important issue for many people").

The demand for health care also varies in ways that are generally predictable along a number of parameters, including age, race, and sex. For example, individuals in their twenties and thirties require more sports medicine than those in their fifties; those in their fifties require more cardiac rehabilitation than those in their twenties; elderly men require urologists; younger women require obstetricians and family-planning services; children require pediatricians; African-Americans require more treatment for hypertension and renal failure than European-Americans; European-Americans require more treatment for malignant melanoma than African-Americans. Because insurance only shifts and spreads risk for which the policy provides coverage, the specification of such coverage necessarily implies a series of tradeoffs within the common pool, with significant distributional implications within and across identifiable groups. For example, coverage of routine mammograms for women in their forties may preclude coverage of bone marrow transplants for advanced breast cancer patients. Coverage of family-planning services may preclude coverage of more aggressive screening for sexually transmitted diseases. Coverage of aggressive screening for prostate cancer may result in more limited coverage of screening for uterine cancer. Legislative mandates can reallocate resources within the common pool, but new or enhanced services are covered at the expense of other services, increased premiums, or both. In short, you don't get something for nothing, even from an insurance company.

Health insurance coverage is also invariably limited to "medically necessary" expenses. Thus, hospitalization is a covered benefit only if the necessary services must be provided in a hospital. For obvious reasons, the secondary attributes of a hospitalization—including rest, recuperation, food, shelter, and education—are not sufficient free-standing reasons for hospitalization. Until recently, insurance companies simply accepted an individual physician's certification that hospitalization was necessary, but insurers have grown increasingly aggressive in specifying whether they will authorize coverage of a hospitalization and how long they will continue to authorize payment.[30]

In general, the regulation of health insurance has been left to the

30. *See* George Anders & Laurie McGinley, *Actuarial Firm Helps Decide Just How Long You Spend in Hospital*, WALL ST. J., June 15, 1998, at A1 ("A decade ago, most patients got whatever care their doctor recommended, subject only to insurance-company squabbles about cost. Now, hospitals and health plans are setting up detailed checklists ahead of time, telling doctors how to accelerate treatment of almost any serious illness.").

states.[31] Historically, the states took full advantage of this authority and aggressively regulated the terms of insurance contracts.[32] However, the Employee Retirement Income Security Act of 1974 (ERISA)[33] creates a large loophole in this structure because it effectively preempts state-level regulation of employer-provided health insurance without supplying substantive regulation of its own.[34] Thus, employment-based health insurance is effectively unregulated. When an employer purchases insurance from a state-regulated insurer (an "insured" plan), ERISA provides that the state can indirectly regulate the employee-benefit plan.[35] If, however, the employer furnishes its own insurance (a "self-funded" employee benefit plan), the plan effectively is not subject to any state regulation.[36] It does not overstate the case to note that ERISA effectively creates a health benefits free-fire zone, and with 50 million Americans in self-funded plans and another 100 million Americans in insured plans, a clear majority of the insured population find themselves in a regulatory no-man's-land.[37]

B. Managed Care Overview

When managed care comes up in conversation, most people think about HMOs. In reality, managed care encompasses a wide

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31. The McCarran-Ferguson Act specifies that the states have primary regulatory authority over insurance. *See* 15 U.S.C. §§ 1011–1015 (1994). However, Congress retains the right to legislate specifically in this area, and it has done so a number of times. *See, e.g.*, Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 100 Stat. 1936 (1996) (codified in scattered sections of 29 U.S.C.).

32. *See* ROBERT H. JERRY, UNDERSTANDING INSURANCE LAW 437–39 (1996).

33. *See* 29 U.S.C. §§ 1001–1191 (1994).

34. *See* Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986, 1986–87 (1996).

35. *See id.* at 1987.

36. The precise boundaries of ERISA preemption have always been controversial, but the issue has become particularly heated since the Supreme Court's opinion in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656–62 (1995) (declining to find preemption of New York's rate regulatory system, and employing logic suggesting that lower courts should be more cautious in finding ERISA preemption). Cases decided subsequent to the *Travelers* decision have come to inconsistent conclusions. *See, e.g.*, Prudential Ins. Co. v. National Park Med. Ctr., 154 F.3d 812, 815 (8th Cir. 1998) (holding that the Arkansas Patient Protection Act was preempted and noting "the precise scope of ERISA preemption of state law has left courts, including the Supreme Court, deeply troubled"); Washington Physicians Serv. Ass'n v. Gregoire, 147 F.3d 1039, 1042 (9th Cir. 1998) (rejecting the preemption of the Washington Alternative Provider Statute); Dukes v. United States Healthcare, Inc., 57 F.3d 350, 351–52 (3rd Cir. 1995) (holding that ERISA did not preempt state common law claims); Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 52–53 (D. Mass. 1997) (finding ERISA preemption of state common law claims).

37. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 9.

array of arrangements for the financing and delivery of health care services.[38] In sharp contrast to indemnity insurers, MCOs manage care and costs by methods such as requiring preauthorization for medical expenses, restricted access to specialists, restricted panels of providers, higher copayments (and sometimes denial of coverage) for out-of-network care, capitation, bonuses, practice guidelines, retrospective denials of coverage, "real-time" utilization review, restricted coverage of prescription drugs, and limitations on benefits.[39] The academic literature on the quality of care provided by MCOs is generally quite favorable.[40] In global terms, MCOs offer a

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38. *See* John M. Eisenberg, *Economics*, 273 JAMA 1670, 1670 (1995) ("[T]he wide variety of managed care organizations share mainly an attempt to control costs."). In managed care organizations, the

> financing and delivery of care can be integrated to a greater or lesser extent; the corporate structure can be non-profit or for-profit; providers can be employees of the managed care organization or independent contractors; providers can be selected and compensated and the risks shared in a wide variety of ways.

David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish for?*, 32 U. MICH. J.L. REFORM (forthcoming December 1999) (manuscript at 15, on file with the *North Carolina Law Review*).

39. *See* Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 NEW ENG. J. MED. 1678, 1681 (1995) (concluding that managed care plans use complex systems for selecting, paying, and monitoring physicians); Dahlia K. Remler et al., *What Do Managed Care Plans Do to Affect Care? Results from a Survey of Physicians*, 34 INQUIRY 196, 200 (1997) (presenting data on the impact of managed care techniques on physicians and determining that utilization review and discounted fees are the most prevalent practices).

40. *See* Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 NEW. ENG. J. MED. 1227, 1228 (1996) ("In general, the literature in this area . . . consistently shows that costs are lower in managed care systems, with quality equal to or better than that in fee-for-service care."); Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 716 (1994) (presenting generally favorable evidence on the quality of care provided by MCOs); Fred J. Hellinger, *The Effect of Managed Care on Quality*, 158 ARCHIVES OF INTERNAL MED. 833, 833 (1998) ("[M]anaged care has not decreased the overall effectiveness of care. However, evidence suggests that managed care may adversely affect the health of some vulnerable subpopulations."); Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1513–17 (1994) (collecting studies showing that the quality of care provided by HMOs is comparable to or better than that provided by fee-for-service plans); Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., Sept.–Oct. 1997, at 7 [hereinafter Miller & Luft, *Quality of Care*] (updating earlier research and finding mixed, but generally favorable, evidence on the quality of care provided by MCOs).

To be sure, some studies have found that the quality of care provided by MCOs is lower than in fee-for-service practice. Moreover, there is an overriding question as to whether studies from the early days of managed care, when homogeneous subscriber populations were served by non-profit MCOs, are applicable to the current environment in which neither of these characteristics exist. *See* Miller & Luft, *Quality of Care*, *supra*, at 13–18. However, the most negative conclusion one can reach is that "HMOs produce better, the same, and worse quality of care, depending on the particular organization and

more restricted choice of and access to providers and treatments in exchange for lower premiums, deductibles, and copayments than traditional indemnity insurance.

C. *Cost-Quality and Quality-Quality Tradeoffs in Health Insurance*

Health care services generally contribute to patient health, but not all services are equally beneficial. Fraud aside, considerable controversy exists about whether and how expenses that make a variable contribution to health should be constrained.[41] There is general agreement that it is appropriate for private insurance to provide coverage for services so long as marginal benefits exceed marginal costs.[42] There is equally general agreement that it is

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particular disease." *Id.* at 14.

41. *See generally* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS (1997) (reviewing the advantages and disadvantages of three alternative medical spending decision makers: patients, doctors at the bedside, and third parties such as government, insurers, or citizen groups); Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1451 (1994) (reviewing various mechanisms for implementing cost-containment in light of preference variability).

Despite this diversity of views, health policy scholars are essentially unanimous that cost-benefit tradeoffs are inevitable. *See, e.g.*, VICTOR R. FUCHS, WHO SHALL LIVE?: HEALTH, ECONOMICS, AND SOCIAL CHOICE 29 (1998) ("We must recognize that we can't have everything . . . ."); Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCIENCE 418, 419 (1990) (discussing methods for reducing costs); David M. Eddy, *Health System Reform: Will Controlling Costs Require Rationing Services?*, 272 JAMA 324, 327–28 (1994) (discussing the need to cut costs by reducing the "volume and intensity of health services"); Lester Carl Thurow, *Learning to Say "No,"* 311 NEW ENG. J. MED. 1569, 1569 (1984) ("Instead of stopping treatments when all benefits cease to exist, physicians must stop treatments when marginal benefits are equal to marginal costs.").

However, some physician-commentators do not understand that scarcity is not an artificial construct or a conspiracy against the less fortunate. *See, e.g.*, Marcia Angell, *Cost Containment and the Physician*, 254 JAMA 1203, 1207 (1985) ("In a country that is this year spending about $300 billion on defense and $25 billion on tobacco, and in which $500,000 is spent for a 30-second television advertisement during the Super Bowl, we should be prepared to argue for spending whatever is necessary for effective medical care.").

42. To be sure, there is a non-frivolous argument that matters are not so simple. Under normal circumstances, a rational individual would be willing to invest his resources in health care until marginal costs exceed marginal benefits. However, an individual might well choose to spend considerably less on health care if expenses in other areas resulted in a higher payoff. Given the choice between death by starvation tomorrow and death from a chronic disease at some time in the future, most people would conclude that it is rational to spend one's resources on food instead of medicine if one cannot afford both. Because the price of health insurance is a significant factor for many purchasers, tradeoffs within this zone are not at all unreasonable. Of course, such tradeoffs are not unique to health care. *See* David A. Hyman & Charles Silver, *And Such Small Portions: Limited Performance Agreements and the Cost/Quality/Access Trade-Off*, 11 GEO. J. LEGAL

appropriate to exclude coverage for services that provide no benefit. However, considerable controversy exists over the exclusion of services that provide a positive benefit when the benefit is less than the social cost ("cost-benefit-no-man's-land").[43] Indeed, the prevalence of third-party insurance encourages patients to demand such services, because from their perspective, the subsidized cost is less than the benefit.[44] Attempts to constrain coverage of services in the cost-benefit-no-man's-land invariably trigger complaints about the evils of rationing and profit-driven health care.

Dividing medical interventions into these categories is an obvious oversimplification. Ex ante, it is frequently difficult to decide into which zone a particular service will fall. Even if it is clear that a medical intervention is non-cost-worthy, accusations of rationing have a chilling effect on cost-containment efforts. Nevertheless, in recent years, MCOs have moved aggressively to deny coverage of services that they deem non-cost-worthy—and they seem to have classified extended postpartum stays in that category.[45]

ETHICS 959, 973–78 (1998) (noting the tradeoffs between the cost, quality, and availability of legal services).

43. *See* Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. 47, 51–54 (1994) (reviewing the realities of the cost-benefit-no-man's-land).

44. Professors Havighurst & Blumstein provide charts depicting the cost-benefit tradeoff from the individual and social perspectives. *See* Havighurst & Blumstein, *supra* note 25, at 18. Because an individual with insurance has an out-of-pocket cost much less than the true cost, the social cost-benefit-no-man's-land is far larger than the individual cost-benefit-no-man's-land. In the interest of simplicity, this Article focuses on the social cost. The growth of managed care arrangements has modified the dynamic somewhat because individuals now face fewer financial (but greater structural) barriers to the consumption of health care services—precisely the model suggested by Professor Kenneth Arrow to deal with the moral hazard problems that result from the existence of health insurance:

> [I]f individuals are free to spend as they will with the assurance that the insurance company will pay, the resulting resource allocation will certainly not be socially optimal. This makes perfectly reasonable the idea that an insurance company can improve the allocation of resources to all concerned by a policy which rations the amount of medical services it will support under the insurance policy.

Kenneth J. Arrow, *The Economics of Moral Hazard: Further Comment*, 58 AM. ECON. REV., 537, 538 (1968).

45. Because of the aggregation that is implicit in group coverage, MCOs are a far from perfect mechanism for encouraging the making of tailored cost-benefit tradeoffs, but they are still an improvement on unmixed indemnity coverage—and there are offsetting benefits associated with aggregated coverage at various price-points. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 25.

II. REGULATING POSTPARTUM LENGTHS OF STAY

A. *Making the Case Against Drive-Through Deliveries*

The case against drive-through deliveries was built with anecdotal reports of infants who died following rapid postpartum discharges. A typical example of the genre was the tragic case of Michelina Bauman.[46] Following a normal pregnancy and delivery, Michelina was discharged with her mother on May 17, 1995, at twenty-eight hours postpartum.[47] On her first night home, Michelina was fidgety and would not eat.[48] On May 18, the Baumans made a number of calls to their pediatrician, but reportedly were informed that the infant's behavior was not unusual.[49] After Michelina developed a rash, her parents called the pediatrician again, but reached the answering service.[50] The Baumans then contacted their MCO, which routinely sent a nurse to the home within forty-eight hours of discharge to assess the infant and mother.[51] After her parents described Michelina's symptoms, a nursing supervisor advised them to call the pediatrician again.[52] The pediatrician called back at 5:30 p.m., but Michelina Bauman had already died from an infection.[53]

The hospital claimed that the infection would have been detected—and the death possibly prevented—had the health plan

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46. The narrative in the text is drawn primarily from the oral and written testimony of Michelina's parents at a hearing before the Senate Committee on Labor & Human Resources. *See Newborns' and Mothers' Hearing*, *supra* note 24, at 79–80 (statements of Steve and Michelle Bauman). The same story is reflected in a host of other sources. *See, e.g.*, Sandra G. Boodman, *Discharged Too Soon?*, WASH. POST, June 27, 1995, at Health Insert 11; Terese Hudson, *Quick Fixes*, HOSPS. & HEALTH NETWORKS, Sept. 20, 1995, at 36, 36.

47. Depending on the source, Michelina was discharged at either 24 or 28 hours postpartum. *Compare* Hudson, *supra* note 46, at 36 (24 hours), *and* John Merline, *The Backlash Against Managed Care*, CONSUMERS' RES., Nov. 1996, at 15, 15 (24 hours), *with Newborns' and Mothers' Hearing*, *supra* note 24, at 19, 79 (28 hours), *and* Karen Riley, *Support Grows for Maternity Stay Law*, WASH. TIMES, Sept. 13, 1995, at B6 (28 hours).

48. *See Newborns' and Mothers' Hearing*, *supra* note 24, at 20, 80 (statement of Mrs. Bauman, statements of Mr. and Mrs. Bauman).

49. *See id.*

50. *See id.*

51. *See id.* Due to a mix-up, the MCO first learned of Michelina's birth when they were contacted by the parents. *See id.* The MCO typically sent a visiting nurse within 24 hours, but was contractually obligated to do so only within 48 hours. In a sadly ironic note, the MCO contacted Mr. Bauman's place of employment on May 19, 1995, to schedule the home visit—within the 48 hours of discharge promised by the health plan, but the day after Michelina died. *See id.*

52. *See id.*

53. *See id.* (statements of Mrs. Bauman).

been willing to pay for a stay of forty-eight hours.[54] The health plan responded that it was not responsible for the timing of the discharge and that there was no evidence that the timing had any impact on the outcome in any case.[55] The Baumans had no doubts where to lay the blame; they declared that Michelina's death certificate should have read "Death by System" and that HMO actually stands for "How Many Others?"[56] They subsequently filed suit against both the pediatrician and the health plan.[57] The case was featured in multiple national media reports, and the Baumans testified before Congress on the issue of postpartum stays.

Stories of this sort virtually ensured that MCOs could not defend

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54. *See id.* at 20, 26 (statements of Mrs. and Mr. Bauman); *CBS Evening News* (CBS television broadcast, July 25, 1995). *But see infra* note 56 (presenting the views of the chief of medical affairs at the treating hospital as to whether the infection would have been detected and death could have been prevented).

55. *See* Boodman, *supra* note 46, at 12; *CBS Evening News* (CBS television broadcast, July 25, 1995).

56. *See Newborns' and Mothers' Hearing, supra* note 24, at 19, 80 (statement of Mrs. Bauman). Despite the tragic outcome, the parents' assessment of its causes is far from self-evident. It is unclear whether the outcome in this particular case would have been any different, regardless of how long Michelina Bauman stayed in the hospital. The chief of medical affairs at the treating hospital was interviewed for a newspaper article and noted that

> [i]t is impossible . . . to say for sure whether an additional 24 hours in the hospital would have saved the baby's life; streptococcus B infections in newborns have a high mortality rate . . . . "Would the death have been prevented if this baby had been in the hospital? Maybe. Would the baby's illness have been caught somewhat earlier had she been in the hospital? Probably."

Boodman, *supra* note 46, at 12 (quoting Michael B. Grossman, Kennedy Memorial Hospital, Washington Township, New Jersey).

In like fashion, it is far from clear whether the tragic outcome was attributable to the actions of the pediatrician, the health plan, some combination of both, or neither—although Mrs. Bauman seemed particularly unhappy with the performance of the pediatrician. *See Newborns' and Mothers' Hearing, supra* note 24, at 21 (statement of Mrs. Bauman) ("The baby was given a clean bill of health by the pediatrician . . . . We did exactly what [the pediatrician] asked us to do, but not once [during the phone calls we made to her] did she tell us to bring the baby into the emergency room . . . . [Had she done so,] our baby would be alive today."). The hospital performed an internal review that found no wrongdoing in "the events surrounding the baby's discharge and the pediatrician's actions." Boodman, *supra* note 46, at 12.

Finally, the illness to which Michelina Bauman succumbed can strike any time in the first two weeks of life, so a postpartum stay of 48 hours has no necessary connection to the prevention of such tragedies. *See Newborns' and Mothers' Hearing, supra* note 24, at 41 (statement of Dr. Sharon Levine, Associate Medical Director, Permanente Medical Group, Inc.).

57. *See* Bauman v. United States Healthcare, Inc., 1 F. Supp. 2d 420, 421 (D.N.J. 1998), *aff'd in part, rev'd in part*, Nos. 98-5222, -5262, -5263, 1999 U.S. App. LEXIS 22464 (3d Cir. Sept. 16, 1999).

the merits of rapid postpartum discharges.[58] Empirical studies casting light on the issue were ignored, and the debate was driven by a handful of anecdotes.[59] The normative boundaries of the debate were framed by the pejorative use of "drive-through deliveries" and "drive-by deliveries" to describe the discharge practices.[60]

The net effect of this packaging of the issue was demonstrated when legislation prohibiting drive-through deliveries was considered by Congress. The *Congressional Record* is replete with condemnation of insurance companies' greed and MCOs' willingness to place the lives of women and infants at risk.[61] When the Newborns' and

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58. The managed care industry formed a self-styled Coalition for Optimal Maternity Care to advance their position that drive-through deliveries are safe. *See* Leslie Barker, *The Difference a Day Makes*, DALLAS MORNING NEWS, Oct. 2, 1996, at 1C, *available in* LEXIS, News Library, Dalnws File ("In debates before the bill passed, the Coalition for Optimal Maternity Care argued that no conclusive study supported the need for a specific length of stay for childbirth.").

59. *See* Laurie McGinley, *A Family Hails Bill Providing Maternity Stay*, WALL ST. J., Sept. 20, 1996, at B1 ("[T]he research was overshadowed by horrifying anecdotes."). As two other commentators noted:

> The issue has enormous potential to elicit an emotional response from the public, as occurred in the case of heavily reported testimony in New Jersey by parents whose baby's life might have been saved with more time in the hospital, or that of the Massachusetts mother whose early discharge might have contributed to her congestive heart failure .... In light of such powerful anecdotal testimony, presentation of national neonatal hospital readmission rates had little impact.

Declercq & Simmes, *supra* note 18, at 185.

To be sure, and as detailed *infra* at note 165, there were considerable difficulties with the empirical studies, including their size, non-randomized nature, and the nature of the endpoints that were studied. However, the debate never even reached these technical questions; simply stated, the anecdotal bad outcomes defined the agenda. *See* Debra E. Kuper, Comment, *Newborns' and Mothers' Health Protection Act: Putting the Brakes on Drive-Through Deliveries*, 80 MARQ. L. REV. 667, 673–75 (1997) (presenting various anecdotes); Suzanne Seaman, Comment, *Putting the Brakes on Drive-Through Deliveries*, 13 J. CONTEMP. HEALTH L. & POL'Y 497, 503–05, 510 (1997) (presenting several anecdotes and concluding that these stories spurred the legislation).

60. *See* Declercq & Simmes, *supra* note 18, at 184 ("The issue was defined largely by advocates in a way that served their interests: greedy insurers were risking the health of mothers and of our most vulnerable and innocent population, babies."); *see also supra* note 18 and accompanying text (describing the normative implications of using these terms).

61. *See, e.g.*, 142 CONG. REC. S10021 (daily ed. Sept. 6, 1996) (Sup. Docs. No. x1.1/A:142/121) (statement of Sen. Dorgan) ("Our country can no longer afford to let money, rather than the health needs of mothers and babies, be our paramount concern."); 142 CONG. REC. H6317 (daily ed. June 27, 1996) (Sup. Docs. No. x1.1/A:141/106) (statement of Rep. Miller) ("The health of the baby, not of insurance company portfolios, should be our No. 1 concern."); 142 CONG. REC. E767 (daily ed. May 10, 1996) (Sup. Docs. No. x1.1/A:142/65) (statement of Rep. Dingell) ("This bill responds to the concerns of pregnant women and ... physicians ... who have become increasingly concerned about the risks involved [with early postpartum discharge].... This is happening more and more frequently because insurance companies are deciding that early discharge is in [their] best

Mothers' Health Protection Act ("Newborns' Act") was considered on the floor of the Senate, Senators from across the political spectrum condemned drive-through deliveries as "unconscionable" (Senators DeWine and Helms),[62] "scary" (Senator Biden),[63] and "simply unacceptable" (Senator Snowe).[64] Individual Senators argued that it was "common sense" for an insurance policy to include the mandated coverage (Senator Bradley)[65] because physicians could not detect certain common medical problems within the first twenty-four hours of birth (Senators Bradley, Moseley-Braun, Kennedy, Snowe, Bryan, and Feinstein),[66] and, therefore, there were "clear health problem[s] with women who are discharged too early" (Senator Bradley).[67] The mandated coverage would "be beneficial to countless mothers and their newborn children because it [would] restore health care decisions to those best suited to make them—the mothers and their doctors" (Senator Helms)[68] and "increase[] the odds that the next generation gets off to a healthy start" (Senator Wyden).[69]

Senators Wellstone, DeWine, Boxer, Chaffee, and Helms recounted how their personal experiences, including discussions with

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interest [even when both the doctor and new mother believe that the longer stay is medically appropriate]."); 142 CONG. REC. S4640 (daily ed. May 2, 1996) (Sup. Docs. No. x1.1/A:142/59) (statement of Sen. Rockefeller) ("Many large insurers are refusing to pay for more than 24 hours of maternity care. I do not know where managed care is going to take this country. [I] am extremely worried about it, and I am even more worried about for-profit HMOs and managed care.").

62. 142 CONG. REC. S9908 (daily ed. Sept. 5, 1996) (Sup. Docs. No. x1.1/A:142/121) (statement of Sen. DeWine); *Id.* at S9910 (statement of Sen. Helms).

63. *Id.* at S9905 (statement of Sen. Biden).

64. *Id.* at S9913 (statement of Sen. Snowe).

65. *Id.* at S9904 (statement of Sen. Bradley). Senator Bradley repeated this characterization of the issue when he appeared on the ABC news program *Nightline*. *See* Declercq & Simmes, *supra* note 18, at 185. Governor Christine Todd Whitman similarly noted that the New Jersey statute mandating similar coverage was " 'common sense to give women a chance to recover and babies a chance to get a good head start.' " Jay Nordheimer, *New Mothers Gain 2nd Day of Care*, N.Y. TIMES, June 29, 1995, at B1 (quoting Governor Whitman).

Finally, President Clinton echoed this characterization when he signed the bill. *See* President's Remarks on Signing the Department of Veterans Affairs and Housing and Urban Development and Independent Agencies' Appropriations Act, 1997, 2 PUB. PAPERS 1676, 1677 (Sept. 26, 1996) ("This law is common sense and now it will be the law of the land.").

66. *See* 142 CONG. REC. S9914 (daily ed. Sept. 5, 1996) (Sup. Docs. No. x1.1/A:142/121) (statement of Sen. Feinstein); *id.* (statement of Sen. Bryan); *id.* at S9913 (statement of Sen. Snowe); *id.* at S9912 (statement of Sen. Kennedy); *id.* at S9911 (statement of Sen. Moseley-Braun); *id.* at S9904 (statement of Sen. Bradley).

67. *Id.* at S9904 (statement of Sen. Bradley).

68. *Id.* (statement of Sen. Helms).

69. *Id.* at S9909 (statement of Sen. Wyden).

their daughters and daughters-in-law, led them to vote for such legislation.[70] The issue also struck a chord with the public. Senator Bradley revealed that he had received 85,000 pieces of mail backing the Newborns' Act after an article appeared in *Good Housekeeping* magazine about the legislation—an observation that lost some of its persuasive force when Senator Bradley noted that he had gotten even more mail on the arcane subject of interest deferral.[71]

Similar rhetoric was reflected in other venues. Newspaper columnists condemned drive-through deliveries in outraged tones.[72] Two prominent New Jersey pediatricians branded drive-through deliveries " 'maternal abuse, child neglect, and physician harassment' " in the pages of the official journal of the American Academy of Pediatrics (AAP).[73] The American College of Obstetrics and Gynecology (ACOG) denounced rapid postpartum discharge as "an uncontrolled experiment" on the health and safety of American women and children and called for a moratorium on drive-through deliveries until their safety could be established.[74] A foreign medical

70. *See id.* at S9910 (statement of Sen. Helms); *id.* (statement of Sen. Chaffee); *id.* at S9908 (statement of Sen. Boxer); *id.* (statement of Sen. DeWine); *id.* at S9907 (statement of Sen. Wellstone).

71. *See id.* at S9904 (statement of Sen. Bradley) (referring to Jeanie Russell Kasindorf, *Home Too Soon; Premature Hospital Discharge of Newborn Infants*, GOOD HOUSEKEEPING, Oct. 1995, at 116 *passim*). Senator Biden similarly observed that the issue was called to his attention by someone who had read the same *Good Housekeeping* article. *See id.* at S9905 (statement of Sen. Biden).

72. *See, e.g.*, Robin Abcarian, *Is 48 Hours So Much to Ask?*, L.A. TIMES, May 15, 1996, at E1 ("The outraged have joined forces in an unprecedented and deeply satisfying attempt to force insurance companies and HMOs to pay for a woman to stay in the hospital for at least 48 hours after giving birth."); Boodman, *supra* note 46, at 11; Editorial, *Drive-Through Delivery*, WASH. TIMES, Feb. 14, 1996, at A16, *available in* LEXIS, News Library, Wtimes File; Ellen Goodman, *Lower Speed Limit on Highway to Drive-Thru Deliveries*, BOST. GLOBE, July 9, 1995, § 7, at 63; Betsy McCaughey, *Don't Send Babies Home So Soon*, WASH. TIMES, Oct. 24, 1995, at A23, *available in* LEXIS, News Library, Wtimes File.

73. Seymour Charles & Barry Prystowsky, *Early Discharge, in the End: Maternal Abuse, Child Neglect, and Physician Harassment*, 96 PEDIATRICS 746, 746 (1995).

74. Julie Rovner, *USA Divides over Early Discharge of Mothers*, 346 LANCET 171, 171 (1995) (" 'The routine imposition of a short and arbitrary time limit on hospital stay that does not take maternal and infant need into account could be equivalent to a large, uncontrolled, uninformed experiment that may potentially affect the health of American women and their babies ....' " (quoting the ACOG statement)); Sandra G. Boodman, *Congress Moves to Limit Early Discharges After Childbirth*, WASH. POST, July 4, 1995, at Health Insert 6 ("ACOG called the practice a 'large, uncontrolled, uninformed experiment' that may needlessly endanger newborns because it provides too little opportunity for doctors to observe or to test a baby or to teach parents how to adequately care for one.").

Although ACOG's statement might appear compelling, it is so hedged with qualifiers ("could be equivalent" and "may potentially affect") as to be meaningless.

journal even got into the act, calling the practice "one of the most egregious examples of the type of cost-cutting that misinforms corporate medicine."[75]

Hillary Rodham Clinton condemned the practice in her newspaper column, at a speech during the Democratic National Convention, and in an appearance on the *Oprah Winfrey Show*.[76] President Clinton announced his support for the legislation in a Mother's Day radio address.[77] Professor Arthur Miller addressed the

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More significantly, ACOG did not address the fact that relatively few medical practices have been validated by randomized controlled trials—including the existing patterns of postpartum care, which the Newborns' Act effectively enshrined as federal law. *See infra* notes 176, 261 and accompanying text. For example, fetal monitoring became a routine and well-accepted component of obstetrical practice without the benefit of such controlled trials. When large-scale studies of fetal monitoring were finally performed, it became clear that fetal monitoring created costs without benefits, despite the vehement views of many obstetricians to the contrary:

> More than 20 years and 11 randomized trials later, electronic fetal monitoring appears to have little documented benefit over intermittent auscultation with respect to perinatal mortality or long term neurologic outcome. Furthermore, probably in part because of the widespread use of fetal monitoring, the rate of Cesarean section has increased, with a resulting increase in maternal morbidity and costs but without apparent decrease in the incidence of cerebral palsy.

Karin B. Nelson et al., *Uncertain Value of Electronic Fetal Monitoring in Predicting Cerebral Palsy*, 334 NEW ENG. J. MED. 613, 613 (1996) (citations omitted).

The now routine use of ultrasound during pregnancy raises similar issues. Unlike fetal monitoring, routine ultrasound does not appear to result in any harm, but it does impose costs without medical benefit. *See* Bernard G. Ewigman et al., *Effect of Prenatal Ultrasound Screening on Perinatal Outcome*, 329 NEW ENG. J. MED. 821, 825 (1993) (finding no medical benefit from routine ultrasound screening of pregnant women). Predictably enough, "[e]minent obstetricians immediately denounced the report as clinically useless, however scientific its methodology, because it failed to place any value on the patients' peace of mind during pregnancy." Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 466 (1994).

In 1993, the cost attributable to this peace of mind was between $500 million and $1 billion. *See* Warren E. Leary, *Study Finds Waste in Ultrasound Use*, N.Y. TIMES, Sept. 16, 1993, at A17. Given the shellacking that they received in the campaign against drive-through deliveries, it is not all that surprising that MCOs have not moved against unnecessary prenatal ultrasounds. *See* Jon Van, *Ultrasounds Still Cloudy, Costly Issue*, CHI. TRIB., Dec. 2, 1997, § 1, at 1 ("Virtually every pregnant woman today expects to get at least one ultrasound image of her fetus . . . .").

75. Editorial, *Manipulated Care*, 348 LANCET 903, 903 (1996).

76. *See* Hillary Rodham Clinton, *Our Family, Like Your Family, Is Part of a Larger Community*, WASH. POST, Aug. 28, 1996, at A31; Hillary Rodham Clinton, *Safeguards Needed for Childbirth*, BUFF. NEWS, Oct. 1, 1995, at 11F; Kasindorf, *supra* note 71, at 116.

77. *See* Robert Pear, *Clinton Says Maternity Plans Need to Offer 2 Hospital Days*, N.Y. TIMES, May 12, 1996, at A27. President Clinton pulled out all the stops on the subject of drive-through deliveries:

> Tomorrow millions of Americans will honor our mothers with hugs and bouquets and visits for dinner. Others of us will simply offer up a silent prayer for the mother who still lives in our heart, but who has left this Earth. I miss my own

subject in one of his famous roundtables.[78] Despite this widespread enthusiasm for a legislative solution, the debate over drive-through deliveries never reached the merits. Instead, the issue was resolved on the basis of anecdotes, popular hostility, and "common sense."

B. State Legislative Initiatives

Twenty-nine states prohibited drive-through deliveries within eighteen months of the issue appearing on the policy agenda.[79] With limited variations, the state statutes followed two distinct models: mandatory specified coverage and mandatory standard-driven coverage. The mandatory specified coverage statutes required insurers to cover an inpatient hospitalization for a definite time period—typically forty-eight hours for a vaginal delivery and ninety-six hours for a Cesarean section.[80] The mandatory standard-driven coverage statutes required insurers to provide coverage of an inpatient hospitalization for the amount of time suggested by ACOG and AAP or to defer to the judgment of the attending physician.[81]

Because the statutes mandated coverage and not care, women

> mother very much, especially on Mother's Day. I can't give her roses tomorrow, but with your help we can honor all mothers by giving mothers-to-be something far more important—the assurance that when they bring a baby into this world, they will not be rushed out of the hospital until they and their health care provider decide it is medically safe for both mother and child.

Transcript of the President's Radio Address, 1 PUB. PAPERS 733, 733 (May 11, 1996).

78. *See Your Money & Your Life: America's Managed Care Revolution* (PBS television broadcast Sept. 6, 1995) (Arthur Miller, moderator), *transcript available at* <http://www.wnet.org/archive/mhc/Info/TV/Transcript.html>.

79. *See supra* notes 19–20 and accompanying text.

80. For example, New Jersey's statute specifies that insurers are required to cover "a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a Cesarean section for a mother and her newly born child in a health care facility." N.J. STAT. ANN. § 17:48-6l(a) (West 1996). Most of the other states have followed this strategy. *See* Elizabeth H. Thilo et al., *The History of Policy and Practice Related to the Perinatal Hospital Stay*, 25 CLINICS PERINATOLOGY 257, 262–63 (1998) (noting that Alaska, Arkansas, California, Connecticut, Delaware, Georgia, Idaho, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Virginia, West Virginia, and Wisconsin mandate coverage of a certain number of hours of postpartum hospitalization).

81. For example, Alabama's statute requires insurance plans to provide coverage that "shall be consistent with the most recent version of the '*Guidelines for Perinatal Care*' prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists." ALA. CODE §§ 27-48-1, -2 (LEXIS through 1998 Reg. Sess.). Arizona, Colorado, Florida, Indiana, Iowa, Maine, Maryland, New Hampshire, Tennessee, and Washington also followed this strategy. *See* Thilo et al., *supra* note 80, at 262–63.

were not required to deliver their children in hospitals, nor were they required to stay in the hospital until their coverage was used up. The states adopted varying strategies for addressing this issue. Most states left the decision to the attending physician, either with or without consultation with the mother.[82] Three states specified that the mothers was required to make the decision.[83] Most states prohibited MCOs from offering positive or negative inducements to the mother and physician to encourage early discharge.[84]

Some states authorized discharge in less than the specified time so long as there was post-discharge follow-up, but legislators quickly became unenthusiastic about such arrangements if they were employed too frequently. For example, when Maryland prohibited drive-through deliveries in 1995, it allowed a rapid postpartum discharge if there was a follow-up home visit. However, this provision was removed in 1996 because it was perceived as offering insurers a means of circumventing the statutory mandate favoring extended postpartum stays.[85]

The most interesting feature of the state statutes was their tendency to expressly exclude certain portions of the population from their protections. Of the twenty-nine states that initially enacted such

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82. *See* GENERAL ACCOUNTING OFFICE, GAO/HEHS-96-207, MATERNITY CARE: APPROPRIATE FOLLOW-UP SERVICES CRITICAL WITH SHORT HOSPITAL STAYS 18 (1996) (Sup. Docs. No. GA1.13:HEHS-96-207) [hereinafter GAO REPORT] ("In 11 states, early discharge is permitted only upon the recommendation of the attending physician and then only if the mother consents or is at least consulted. Seven other states provide for the decision to be made by the attending physician, usually based [on medical necessity or] the AAP/ACOG guidelines.").

83. *See id.* ("In Kentucky, New York, and New Jersey, the decision about when to go home rests solely with the mother.").

84. *See id.* ("Seventeen states that mandate minimum stays for new mothers or require that maternity care decisions be consistent with AAP/ACOG guidelines also provide some degree of [professional] protection to physicians making such decisions."). Missouri and Ohio also prohibit insurers from offering money or gifts to encourage mothers to leave the hospital. *See id.* at 18 n.32.

85. *See id.* at 18. As the General Accounting Office noted:

> Under the original Maryland law, the insurer could choose to cover less than a 48- to 96-hour stay if a newborn met the AAP/ACOG criteria for medical stability and at least one postpartum home visit (including newborn screening) was authorized. Because the home visit was much less expensive than another day of hospital care, many insurers chose early discharge. This was of such concern to Maryland legislators that the law was subsequently amended to provide that the decision regarding length of stay be made by the mother after conferring with her physician.

Id.; *see also* Declercq & Simmes, *supra* note 18, at 189 ("Early evidence suggested that the new law had no impact on postpartum lengths of stay in [Maryland], and the 1996 revision expanded and strengthened the provisions of the law.").

legislation, eighteen states excluded Medicaid beneficiaries.[86] Because Medicaid pays for approximately 40% of the births in the United States, with the percentage considerably higher in some states, the on-budget costs of such legislation obviously played a role in the decision to exclude the Medicaid population from the statutory ambit.[87] Indeed, California considered such legislation, but deferred action for one year after it determined that the costs associated with prohibiting drive-through deliveries for its Medicaid population were too high.[88] Similarly, nineteen states excluded state employees from their statutes' protection.[89] As with the Medicaid population, state governments would incur on-budget costs if they had to purchase coverage for extended postpartum stays for state employees. Thus, most state legislatures displayed concern for the plight of women and infants "victimized" by drive-through deliveries only as long as state governments did not have to foot the bill to fix the problem.

C. *Federal Legislative Initiatives*

It quickly became apparent that state-based regulation of drive-through deliveries was ineffective. As outlined previously, ERISA wholly preempts state regulatory authority over the 50 million

86. *See* GAO REPORT, *supra* note 82, at 21 ("Of the 29 states with maternity care requirements, 11 made them applicable to the state Medicaid program ...."); *see also* Declercq & Simmes, *supra* note 18, at 192 ("Only in eight out of the 23 states for which we have data on Medicaid coverage do the new laws clearly apply to women on Medicaid: Alabama, Georgia, Kentucky, Massachusetts, Missouri, Oklahoma, Tennessee, and Virginia.").

87. *See* Katherine Swartz, *Babies Are Coming: Don't Cap Medicaid*, 277 JAMA 421, 421 (1997) ("In 1994, there were 12 states in which Medicaid paid for 45% or more of all births. Nationally in that year, Medicaid paid for 39% of all births."). The federal government pays the lion's share of Medicaid expenses, but even with the federal funds, Medicaid remains a major expense for most states. *See* Richard Manski et al., *Medicaid, Managed Care, and America's Health Safety Net*, 25 J.L. MED. & ETHICS 30, 30 (1997) ("Expressed in terms of its percentage of state budgets, Medicaid doubled from 10 percent to 20 percent [between 1988 and 1993] to the point that it is currently the second largest budget item for most states.").

88. *See* David R. Olmos, *Bill to Extend HMOs' Birth Care Is Shelved*, L.A. TIMES, Aug. 8, 1996, at A3 (noting that the bill, which would have required coverage of minimum inpatient maternity stays, was delayed after a legislative analyst's report concluded that it would cost the state Medi-Cal program as much as $50 million in 1997). California ultimately passed such legislation in 1997. *See* CAL. HEALTH & SAFETY CODE § 1367.62 (West Supp. 1999). California was not the only state with short postpartum stays for Medicaid beneficiaries. *See* Stephanie L. Ferguson & Carolyn Long Engelhard, *Maternity Length of Stay and Public Policy: Issues and Implications*, 11 J. PEDIATRIC NURSING 392, 393 (1996) (discussing the "Home Tomorrow Program" administered by the Virginia Medicaid program).

89. *See* GAO REPORT, *supra* note 82, at 21 ("Of the 29 states with maternity care requirements, ... 10 [made them applicable] to state employees.").

Americans in self-funded employee benefit plans.[90] In some states, this preemption meant that the state's prohibition on drive-through deliveries had no impact on the majority of its employed population.[91] In addition, individuals who crossed state borders to work or to receive health care could find themselves without the protections that their state legislators had thought were appropriate. For example, an individual who worked in state *A* and received her health insurance from an insured employee benefit plan would have the scope of her maternity coverage dictated by the laws of state *A*, even if she lived in state *B* and delivered her baby in state *C*. Similarly, if an individual lived and worked in state *A* and delivered her baby in state *B*, the scope of her maternity coverage would again be dictated by state *A*. Short of imposing a mandate directly on hospitals to provide the specified care, states *B* and *C* simply could not affect postpartum lengths of stay for individuals who secured their insurance from another state.[92] As understanding of these "regulatory mismatches" expanded, it became clear that a comprehensive solution required congressional action.[93]

Several bills prohibiting drive-through deliveries were introduced in Congress in 1995, but Senate Bill 969 became the vehicle for consideration of the issue.[94] In August 1995, the Senate Labor and Human Relations Committee held its only hearing on the subject. Senators from both parties issued stern warnings about the hazards of

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90. *See supra* notes 33–37 and accompanying text.

91. *See, e.g.*, 142 CONG. REC. S9905 (daily ed. Sept. 5, 1996) (Sup. Docs. No. x1.1/A:142/121) (statement of Sen. Biden) ("The bottom line of this is that, in Delaware, only about 15 percent of the people with health insurance would be affected by a State law that my State is passing."); *see also id.* at S9907 (statement of Sen. Wellstone) ("In Minnesota I think it is about only 40 percent of the people . . . .").

92. Massachusetts finessed the ERISA problem by imposing the burden directly on in-state hospitals. *See* Kuper, *supra* note 59, at 686. Chicago considered a similar approach, which involved taking away the hospital's license and its right to secure water without charge if it did not keep postpartum women for the requisite number of hours. *See id.*

93. *See* STEPHEN BREYER, REGULATION AND ITS REFORM 191–96 (1982) (defining a "regulatory mismatch" as a poor fit between the tools available to a regulator and the problem being regulated).

94. The federal proposals included H.R. Con. Res. 79, 104th Cong. (1995) (Sup. Docs. No. Y1.4/9:H.Con.Res.104-79); H.R. 1936, 104th Cong. (1995) (Sup. Docs. No. Y1.4/7:H.R.104-1936); H.R. 1948, 104th Cong. (1995) (Sup. Docs. No. Y1.4/7:H.R.104-1948); H.R. 1950, 104th Cong. (1995) (Sup. Docs. No. Y1.4/7:H.R.104-1950); H.R. 1955, 104th Cong. (1995) (Sup. Docs. No. Y1.4/7:H.R.104-1955); H.R. 1970, 104th Cong. (1995) (Sup. Docs. No. Y1.4/7:H.R.104-1970); and S. 969, 104th Cong. (1995) (Sup. Docs. No. Y1.4/1:104). Senate Bill 969 was the focus of the hearing held by the Senate Committee on Labor and Human Resources. *See Newborns' and Mothers' Hearing, supra* note 24, at 4.

drive-through deliveries.[95] The witness list was stacked in favor of the legislation. Four witnesses provided heart-wrenching testimony about how their infants had died or nearly died as a result of a drive-through delivery.[96] Representatives of the AMA and ACOG denounced the way MCOs were interfering with physicians' ability to exercise their professional discretion and warned in dark terms about the hazards of drive-through deliveries.[97] A neonatologist from Dartmouth Medical Center reported the results of her study finding an elevated risk of readmission and visits to the emergency department if mother and infant were discharged within forty-eight hours of birth.[98] Representatives from two MCOs were left for last. They testified that their organizations had experienced considerable success and a high degree of patient satisfaction with short postpartum stays.[99] Additional statements supporting the legislation were filed with the Committee by the AAP,[100] the Chicago Department of Public Health,[101] a neonatologist in California,[102] and

95. *See Newborns' and Mothers' Hearing, supra* note 24, at 1–14, 51–52, 69–70 (statements of Senators Bradley, Frist, Kassebaum, Kennedy, Pell, and Wellstone).

96. *See id.* at 15–23, 77–80 (statements of Karen Davies, Virginia Leigh Fallon, Michelle Bauman, and Steve Bauman).

97. *See id.* at 32–36, 52–58 (statements of Dr. Michael T. Mennuti, Chair, ACOG, and Dr. Palma Formica, Board of Trustees, AMA).

98. *See id.* at 30–32, 80–81 (statements of Dr. Judith E. Frank, Dartmouth Medical School).

99. *See id.* at 36–39, 58–69 (statements of Dr. Richard Marshall, Chief of Pediatrics, Harvard Community Health Plan, and Dr. Sharon Levine, Associate Medical Director, Permanente Medical Group, Inc.). On the satisfaction level of managed care enrollees with rapid postpartum discharges, see *id.* at 66 (statement of Dr. Sharon Levine) (noting patient satisfaction rates with rapid postpartum discharges in excess of 90% in one MCO). Indeed, one of the MCO representatives noted that in Sacramento, 65% of patients were satisfied with their time of discharge, and 20% complained it did not occur early enough. *See id*; *see also* Mary Lord, *Check In, Deliver, Go Home*, U.S. NEWS & WORLD REP. Dec. 5, 1994, at 98, 99 ("[E]arly 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.").

Both MCO representatives emphasized that careful patient selection, education, and follow-up were critical, and that the decision to discharge should be a medical one. As one of the MCO representatives observed, arbitrary coverage restrictions of any sort were problematic, whether dictated by statute or by the insurer. *See Newborns' and Mothers' Hearing, supra* note 24, at 38–39 (statement of Dr. Sharon Levine).

100. *See Newborns' and Mothers' Hearing, supra* note 24, at 76–77 (statement of the AAP).

101. *See id.* at 70–71 (statement of the Chicago Department of Public Health).

102. *See id.* at 81–83 (statement of Dr. Augosto Sola). Dr. Sola reported his anecdotal experience that a number of infants were suffering brain damage or dying as a result of undiagnosed hyperbilirubinemia and asserted that such cases would have been diagnosed and appropriately treated if postpartum stays were longer. *See id.* Dr. Sola's results were published in abstract form. *See* Augusto Sola, Abstract, *Changes in Clinical Practice and*

the Association of Women's Health, Obstetric and Neonatal Nurses.[103] The American College of Nurse-Midwives filed a statement opposing the legislation.[104]

Although there was a substantial delay due to budgetary disputes between the 104th Congress and President Clinton, the Newborns' Act eventually passed Congress virtually unanimously and was signed by President Clinton on September 26, 1996.[105] The Newborns' Act incorporated elements from many of the state statutes, but encompassed all insurers in the United States, including self-funded employee benefit plans. The preliminary findings reflected Congress' considered judgment that:

> [T]he length of post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the ability and confidence of the mother and the father to care for their newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up health care . . . .[106]

Effective January 1, 1998, the Newborns' Act requires coverage of at least forty-eight hours of hospitalization following a normal vaginal delivery and ninety-six hours of hospitalization following a Cesarean section.[107] Earlier discharge is possible if the physician, in consultation with the mother, decides it is appropriate.[108] The Act prohibits offers of monetary payments, rebates, or additional services to mothers to encourage them to accept less than the minimum benefits. The Act also prohibits adjusting physicians' compensation

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Bilirubin Encephalopathy in "Healthy Term Newborns," 37 PEDIATRIC RES. 145A, 145A (1996).

Two other articles presented additional data on this point. *See* Audrey K. Brown & Lois Johnson, *Loss of Concern About Jaundice and the Reemergence of Kernicterus in Full-Term Infants in the Era of Managed Care, in* YEARBOOK OF NEONATAL AND PERINATAL MEDICINE xvii, xviii, xvix–xxvi (1996); Mhairi G. MacDonald, *Hidden Risks: Early Discharge and Bilirubin Toxicity Due to Glucose 6-Phosphate Dehydrogenase Deficiency*, 96 PEDIATRICS 734, 734–38 (1995).

103. *See Newborns' and Mothers' Hearing, supra* note 24, at 70–73, 76–77 (statement of the Association of Women's Health, Obstetric and Neonatal Nurses).

104. *See id.* at 72–73 (statement of the American College of Nurse-Midwives).

105. *See* Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. §§ 300gg-4, -51 (1996)).

106. *See id.* § 602.

107. *See* 29 U.S.C.A. § 1185. The same provision restricts the ability of insurers to require physicians to obtain authorization for any particular hospitalization, so long as it is less than the mandated coverage. *See id.*

108. *See id.*

to induce them to discharge patients more rapidly.[109] Thus, women who are discharged in less than forty-eight hours after a vaginal delivery or ninety-six hours after a Cesarean section cannot receive home nursing visits unless the visits duplicate the services they would have received in the hospital.[110]

Like many of the state statutes, the Newborns' Act excludes Medicaid recipients from its protections.[111] Although the bill that ultimately became the Newborns' Act originally encouraged the substitution of post-discharge care for postpartum hospitalization, the statute as enacted is silent on this issue.[112]

For those states that already had passed legislation, the Newborns' Act provided that state law would govern if it was at least as strict as the federal legislation.[113] During the fourteen month delay between the passage of the Newborns' Act and its implementation, a number of additional states enacted their own legislation.[114]

Reaction to the Newborns' Act and the corresponding state legislation has been overwhelmingly positive. Newspaper editorials and columnists have hailed the laws.[115] At least nine law review notes have supported these initiatives for restraining the worst impulses of

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109. *See id.* Although the Newborns' Act does not address the possibility of a disagreement between mother and physician, the plain language of the statute indicates that the physician has decision-making authority, so long as the mother is consulted. *See id.*

110. Rules for Group Health Plans and Health Insurance Issuers Under the Newborns' and Mothers' Health Protection Act of 1996, 63 Fed. Reg. 57,546, 57,554, 57,555 (1998) (interim rules) [hereinafter Newborns' Regulations].

111. Almost one year later, a provision in the Balanced Budget Act of 1997 applied the Newborns' Act to state Medicaid programs, but only if the state participates in a Medicaid managed care program. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4704, 111 Stat. 275, 498 (codified at 42 U.S.C.A. § 1396u-2(b)(8) (West Supp. 1999)).

112. Senate Bill 969 specified that:

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

S. 969, 104th Cong. (1995) (Sup. Docs. No. Y1.4/1:104:S.969).

113. *See* 29 U.S.C.A. § 1185.

114. *See* Newborns' Regulations, *supra* note 110, at 57,552 ("It should be noted that since the enactment of [the Newborns' Act], twelve additional States have enacted laws or regulations . . . .").

115. *See, e.g.*, Editorial, *A Step That Shouldn't Be Necessary*, HARTFORD COURANT, Oct. 3, 1996, at A18 ("What ought to have been common sense now has the force of federal law . . . ."); Cynthia Tucker, *The Unprofitability of Health Care*, S.F. CHRON., Dec. 9, 1995, at A20 ("The poster children for market forces gone awry are newborns and their moms, forced to leave the hospital, on average, in 24 hours—whether they are medically ready to go or not . . . .").

managed care and for helping to "put the brakes" on drive-through deliveries.[116] The general sentiment is that the Newborns' Act was a necessary step to protect consumers in the medical marketplace. Emboldened by their success, enthusiasts have pushed to extend similar protections to women who have undergone mastectomies.[117] Unfortunately, the real medical, economic, and policy issues raised by such legislation have been buried beneath the general enthusiasm about a true "motherhood and apple-pie" law. The balance of this Article addresses these issues.

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116. *See* Freeman L. Farrow, Note, *Drive-Through Deliveries: In Support of Federal Legislation to Mandate Insurer Coverage of Medically Sound Minimum Lengths of Postpartum Stays for Mothers and Newborns*, 29 U. MICH. J.L. REFORM 1039 (1996); Susan D. Hargus, Note, *Define Minimum In-Patient Care That Health Insurers Must Provide for a Mother and Newborn*, 13 GA. ST. U. L. REV. 201 (1996); Kuper, *supra* note 60; Christine A. McAteer, Note, *Health Care Mandates: The Delivery Debate*, 26 SETON HALL L. REV. 1691 (1996); Beth Mandel Rosenthal, Note, *Drive-Through Deliveries and the Newborns' and Mothers' Health Protection Act of 1996*, 28 RUTGERS L.J. 753 (1997); Seaman, *supra* note 60; Tracy Wilson Smirnoff, Note, *"Drive Through Deliveries": Indiscriminate Postpartum Early Discharge Practices Presently Necessitate Legislation Mandating Minimum In-Patient Hospital Stays*, 44 CLEV. ST. L. REV. 231 (1996). Two of the law review notes were considerably more critical than the others, but were still supportive of the legislation. *See* Note, *Health Care Law—"Drive-Through Delivery" Regulation—Massachusetts Requires Hospital Stays of Forty-Eight Hours for Newborns and Postpartum Mothers*, 109 HARV. L. REV. 2116 (1996); Kate E. Ryan, Note, *Mandating Coverage for Maternity Length of Stays: Certain Problems with the Good Idea*, 11 J.L. & HEALTH 271 (1996).

117. *See, e.g.*, President William Jefferson Clinton, 1997 State of the Union Address (Feb. 4, 1997), *reprinted in* N.Y. TIMES, Feb. 5, 1997, at A14 ("Just as we ended drive-through deliveries of babies last year, we must now end the dangerous and demeaning practice of forcing women home from the hospital only hours after a mastectomy."); Raymond Hernandez, *Accord in Albany Seeks Change in Policy on Mastectomy Care*, N.Y. TIMES, Jan. 17, 1997, at B1 (discussing a bill that would allow women the option to stay in the hospital as long as they and their doctors choose following a mastectomy).

Knowing a loser when they see it, MCOs have essentially capitulated. *See* Laura Johannes, *Managed-Care Group Softens View on Hospital Stays After Mastectomies*, WALL ST. J., Nov. 14, 1996, at B6 (reporting that an MCO trade organization adopted a policy urging its members not to deny hospital stays following mastectomies); Laura Johannes, *More HMOs Order Outpatient Mastectomies*, WALL ST. J., Nov. 6, 1996, at B1 (reporting that one MCO reversed its outpatient mastectomy policy "largely in recognition of the 'emotional issues' involved in the surgery. 'Some battles just aren't worth fighting ....'" (quoting Lee Newcomer, Chief Medical Officer of United Healthcare Corporation)).

Although Congress has been unable to pass legislation prohibiting such practices to date, *see* Judy Mann, *Breast Cancer Patients Deserve Better*, WASH. POST, May 15, 1998, at E3, legislative ingenuity continues apace; a proposed patients' bill of rights in Maryland provides for coverage of 48-hour minimum hospital stays for testicular cancer surgery and 24-hour stays for lymph node dissection and lumpectomies. *See* Timothy B. Wheeler, *Added Patient Rights Sought*, BALT. SUN, Jan. 23, 1999, at 1B.

III. DRIVE-THROUGH DELIVERIES: GOOD OR BAD?

The appropriate postpartum length of stay is an exceedingly complex issue, heavily influenced by both social and economic considerations. In recent years, there has been a fairly precipitous, broad-based decline in the rate and length of hospitalization for all conditions, including postpartum stays. The length of a postpartum hospitalization also varies significantly on a regional basis. The empirical scholarship on the appropriate postpartum length of stay does not support the conventional wisdom that there are significant perils associated with early discharge. Part III addresses each of these points in turn.

A. U.S. Hospitalization Trends

This century has witnessed a quick rise and an even more precipitous decline in inpatient treatment.[118] In the past, hospitals routinely admitted patients for rest, observation, and "leisurely workups."[119] Those days are long over. Now, many treatments are provided on an outpatient basis, and even post-surgical stays have been shortened to an extent undreamed of less than a decade ago.[120]

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118. Indeed, postpartum hospitalization itself is a comparatively recent development. In 1900, less than 5% of women delivered their children in a hospital. *See* Valerie M. Parisi & Bruce A. Meyer, *To Stay or Not to Stay? That Is the Question*, 333 NEW ENG. J. MED. 1635, 1635 (1995). By 1945, this figure had climbed to almost 80% of all deliveries. *See id.*

Outside the United States, the length of postpartum hospitalization varies tremendously. *See* John R. Britton et al., *Early Discharge of the Term Newborn: A Continued Dilemma*, 94 PEDIATRICS 291, 291 (1994) ("Recently, 1- to 3-day postnatal stays have also become more popular in other western countries such as the United Kingdom, Australia, and Scandinavia, where 6- to 10-day hospitalizations had been customary in the past."); Lord, *supra* note 99, at 99 (presenting data on ten countries, with length of stay ranging from 24 hours to two weeks); Thilo et al., *supra* note 80, at 265–68 (same). In the United Kingdom, a 24-hour stay has become "increasingly common, whether the mother wants it or not." Sarah Lyall, *Less Time in Hospitals for Mothers in Britain*, N.Y. TIMES, Dec. 3, 1995, at A21. However, the United Kingdom relies heavily on midwives to provide post-discharge support. *See id.*

119. As one commentator has noted:

> Physicians who received medical training during the early days of Medicare may recall when patients with newly diagnosed uncomplicated diabetes and hypertension were admitted for leisurely workups. Disputing the attending physician's decision to transfer a patient to the intensive care unit for "observation" may have succeeded only in incurring his or her wrath—the issue of cost was seemingly irrelevant at the time.

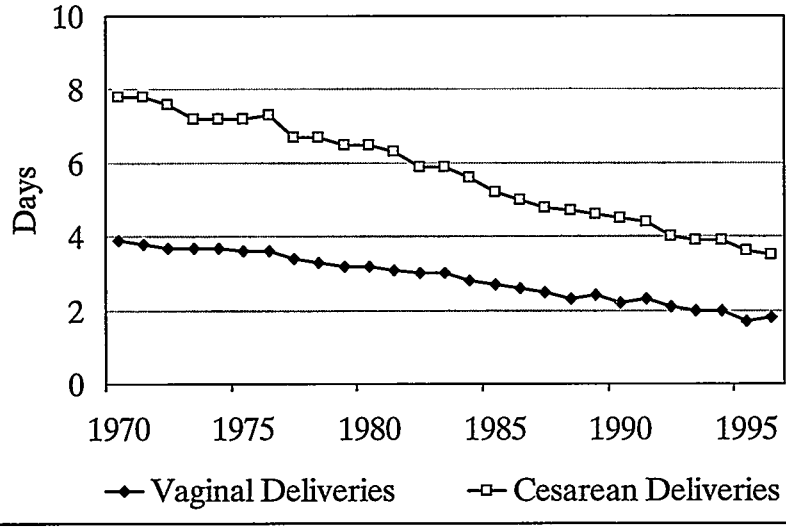
Jeanette M. Smith, *Effectively Costing out Options*, 276 JAMA 1180, 1180 (1996).

120. *See* Jan Ziegler, *Drive-Through Delivery: Bargain or Blunder?*, BUS. & HEALTH, Sept. 1995, at 19, 19 (noting that the trend to accelerate discharge has "cut across medical specialties. As little as two years ago ... the average heart patient undergoing by-pass surgery spent 14 to 16 days in the hospital. Now these same patients go home in five to

Changes in hospital reimbursement from cost-based per diem to prospective payment based on discharge diagnosis have accelerated the trend.[121] U.S. rates of hospitalization and average length of stay are now at all-time lows.[122]

Not surprisingly, these trends are reflected in postpartum lengths of stay. Figure 1 demonstrates that the average length of maternal postpartum hospitalization declined steadily from 1970 through 1996, and that the decline started well before managed care became a significant aspect of health care in the United States.[123]

FIGURE 1
LENGTH OF POSTPARTUM STAYS OVER TIME



seven days."). During the hearing on Senate Bill 969, Senator Frist echoed this point:

> In my own field of heart surgery, when I was doing routine coronary artery bypass surgery, 8 years ago, we would keep people in the hospital for 12 days. Because of pressures—the same sort of pressures that are applying here, mainly from managed care companies and insurers—that went to 10 days, 8 days, 7 days, and now is down to about 4 days."

Newborns' and Mothers' Hearing, supra note 24, at 9–10.

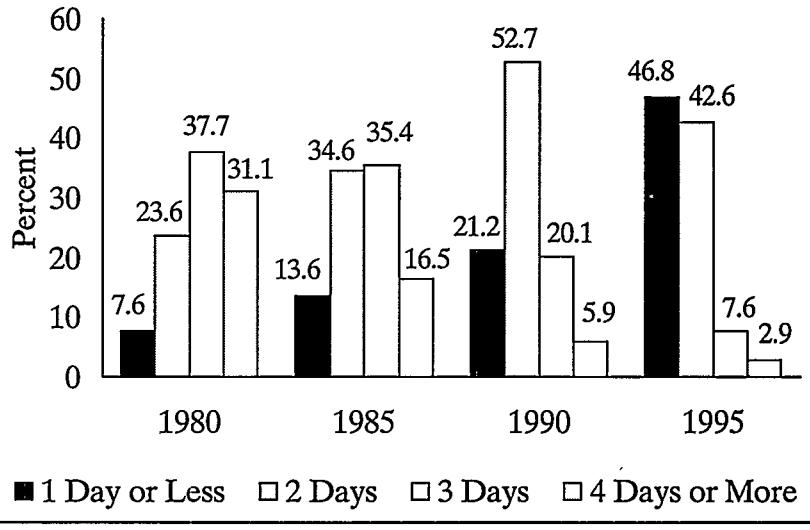
121. *See* David A. Hyman & Joel V. Williamson, *Fraud and Abuse: Regulatory Alternatives in a "Competitive" Health Care Era*, 19 LOY. U. CHI. L.J. 1133, 1139 n.41 (1988) (noting the impact of the prospective payment system on hospital length of stay).

122. *See* AMERICAN HOSP. ASS'N, HOSPITAL STATISTICS 2 (1998).

123. The chart was created using the data from Sally C. Curtin & Lola Jean Kozak, *Decline in U.S. Cesarean Delivery Rate Appears to Stall*, 25 BIRTH 259, 261 tbl.2 (1998). A similar chart presenting data from 1970 to 1992 is found in *Trends in Length of Stay for Hospital Deliveries—United States, 1970–1992*, 44 MORBIDITY & MORTALITY WKLY. REP. 335, 335 fig.1 (1995) [hereinafter *Trends*].

As this chart reflects, in 1970, the average length of stay after a vaginal delivery was 3.9 days, and the average length of stay after a Cesarean section was 7.8 days. By 1996, the average length of stay after a vaginal delivery had decreased to 1.8 days (a 57% decrease), and the average length of stay following a Cesarean section had decreased to 3.5 days (a 54% decrease). If one broadens the time-frame a bit, the decline is even more striking; postpartum length of stay ranged from ten to fourteen days in the 1940s and gradually dropped to five to seven days in the 1950s and 1960s.[124] Indeed, the definition of an "early discharge" has steadily dropped over the past several decades.[125]

FIGURE 2
LENGTHS OF STAY AFTER VAGINAL DELIVERY

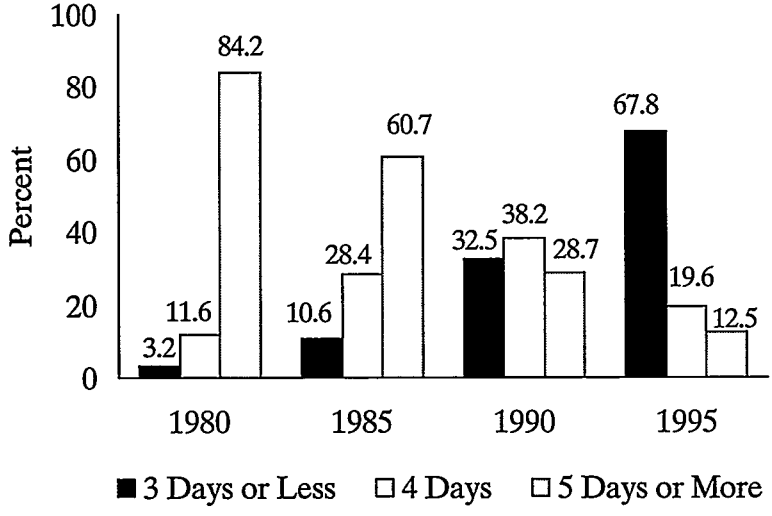


124. *See* Martha Shirk, *Snappy Birth Day*, ST. LOUIS POST DISPATCH, Oct. 9, 1994, at 1C ("Women in their 50s and 60s, who routinely spent a week in a hospital after giving birth to their children, are astonished by the idea of mothers going home the day after giving birth."); Lynn Steinberg, *Back Home with Baby*, SEATTLE POST-INTELLIGENCER, Oct. 24, 1994, at C1 (" 'In 1949, when I was born, moms were in the hospital for 10 days,' said Dr. Donald Shifrin, president of the Washington chapter of the American Academy of Pediatrics.").

125. *See, e.g.*, Britton et al., *supra* note 118, at 293 (noting that discharging in two to five days was considered a "drastic step" in 1959); Woody Kessel et al., *Early Discharge: In the End, It Is Judgment*, 96 PEDIATRICS 739, 739 (1995) ("There is no single standard definition for early discharge. In the United States it is currently defined as less than 48 hours for healthy newborns. In the past decade, it was defined as 2 to 4 days; and in the 1980s it was 5 to 7 days.").

If one looks at actual lengths of stay during a more compressed time period, it is remarkable how quickly one-day postpartum stays have become commonplace. Figure 2 indicates the distribution of maternal lengths of stay following a vaginal delivery in the United States in 1980, 1985, 1990, and 1995.[126] One-day stays accounted for only 7.6% of vaginal deliveries in 1980, but had almost tripled by 1990, increasing to 21.2%. In the next five years, one-day stays more than doubled again, to almost 47% of vaginal deliveries.

FIGURE 3
LENGTHS OF STAY AFTER CESAREAN DELIVERY



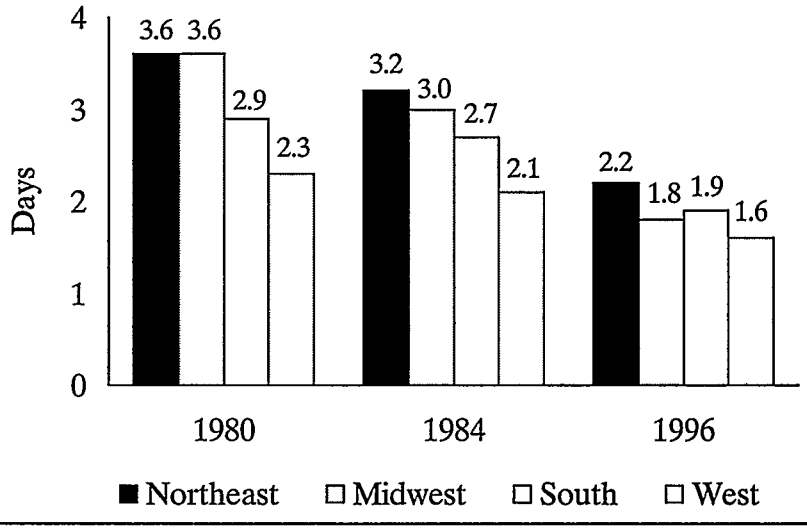
The distribution of lengths of stay following Cesarean sections during the same time period have a similar pattern.[127] Figure 3 demonstrates that almost 85% of women who had a Cesarean section stayed in the hospital for longer than five days in 1980, but the number had dropped to approximately 30% by 1990 and was less than 13% in 1995. Conversely, approximately 3% of women who had Cesarean sections in 1980 had three days or less of postpartum hospitalization, but the figure climbed to 32% by 1990 and to almost 70% in 1995. Individual states present a similar pattern. In Wisconsin, the percentage of discharges within forty-eight hours of a

126. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T. OF HEALTH AND HUMAN SERVS., PUB. NO. 99-1711, NATIONAL HOSPITAL DISCHARGE SURVEY: ANNUAL SUMMARY, 1996, at 38 tbl.32 (1999) (Sup. Docs. No. 20.6209/7:996) [hereinafter NCHS DISCHARGE SURVEY].

127. *See id.*

vaginal delivery increased from 18% of births in 1991 to 52% of births in 1994.[128] A similar pattern was observed in Ohio; the proportion of Medicaid infants discharged following a short stay (less than one day after vaginal delivery or two days following a Cesarean section) increased from 21% in 1991 to 59.8% in 1995.[129]

FIGURE 4
AVERAGE STAY AFTER VAGINAL DELIVERY BY REGION



These charts, which demonstrate widespread utilization of short postpartum stays, might lead one to believe that postpartum hospital stays are fairly uniform across the United States. Nothing could be further from the truth. As Figure 4 reflects, average maternal postpartum length of stay following a vaginal delivery has been substantially longer in the Northeast and substantially shorter in the West than in the rest of the nation for many years.[130]

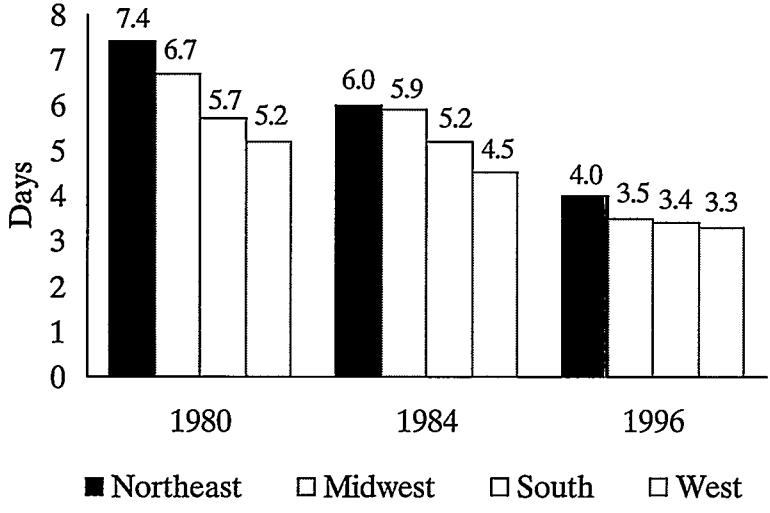
128. *See* M. Bruce Edmonson et al., *Hospital Readmission with Feeding-Related Problems After Early Postpartum Discharge of Normal Newborns*, 278 JAMA 299, 301 tbl.1 (1997); *see also* Anne M. Marbella et al., *Neonatal Hospital Lengths of Stay, Readmissions, and Charges*, 101 PEDIATRICS 32, 34 fig.2 (1998) (depicting the distribution of postpartum lengths of stay in Wisconsin from 1989 to 1994).

129. *See* Uma R. Kotagal et al., *Safety of Early Discharge for Medicaid Newborns*, 282 JAMA 1150, 1150 (1999). Because this study appeared while this article was in page proofs, it is not discussed in detail.

130. *See* NCHS DISCHARGE SURVEY, *supra* note 126, at 37 tbl.31; NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., PUB. NO. 86-1748, UTILIZATION OF SHORT-STAY HOSPITALS BY DIAGNOSIS-RELATED GROUPS: UNITED STATES, 1980–1984, at 33 (1986) (Sup. Docs. No. HE20.6209:13183) [hereinafter 1980–1984 NCHS STUDY]; NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND

As Figure 5 reflects, postpartum stays following Cesarean sections demonstrate a similar pattern.[131]

FIGURE 5
AVERAGE STAY AFTER CESAREAN DELIVERY BY REGION



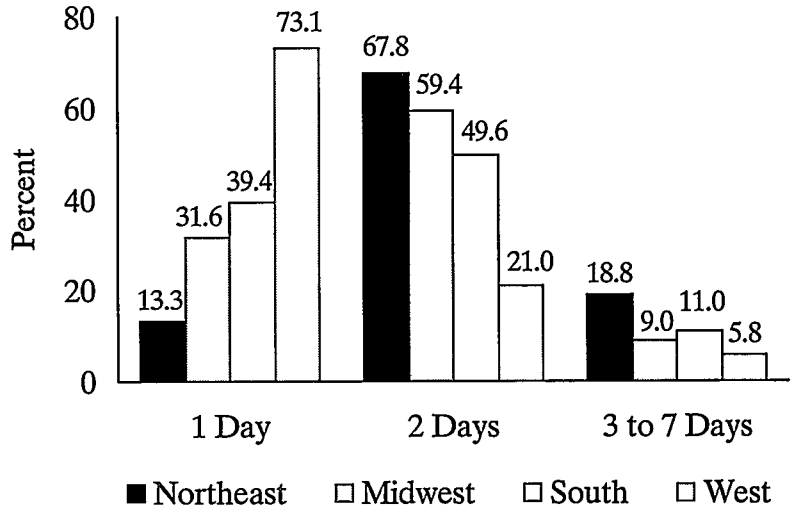
Similar patterns emerge if one focuses on the geographic distribution of actual lengths of postpartum stays. One unpublished study evaluated postpartum length of stay for approximately 1,137,000 newborns delivered vaginally in four regions of the country in 1993.[132] As Figure 6 demonstrates, the frequency of one day of postpartum hospitalization after a vaginal delivery ranged from a low of 13.3% of deliveries in the Northeast to 73.1% in the West.

HUMAN SERVS., PUB. NO. 83-1735, IN-PATIENT UTILIZATION OF SHORT-STAY HOSPITALS BY DIAGNOSIS: UNITED STATES, 1980, at 24 tbl.4 (1983) (Sup. Docs. No. HE20.6209:13174) [hereinafter 1980 NCHS STUDY].

131. *See* NCHS DISCHARGE SURVEY, *supra* note 126, at 37 tbl.31; 1980–1984 NCHS STUDY, *supra* note 130, at 33; 1980 NCHS STUDY, *supra* note 130, at 24 tbl.4.

132. *See* DAVE FOSTER & LINDA SCHNEIDER, HOSPITAL LENGTH OF STAY AND RE-ADMISSION RATES FOR NORMAL DELIVERIES AND NEWBORNS: RELATIONSHIP TO HOSPITAL, PATIENT, AND PAYER CHARACTERISTICS 8 (1995) (on file with the *North Carolina Law Review*).

FIGURE 6
DISTRIBUTION OF HOSPITAL STAYS AFTER VAGINAL DELIVERY



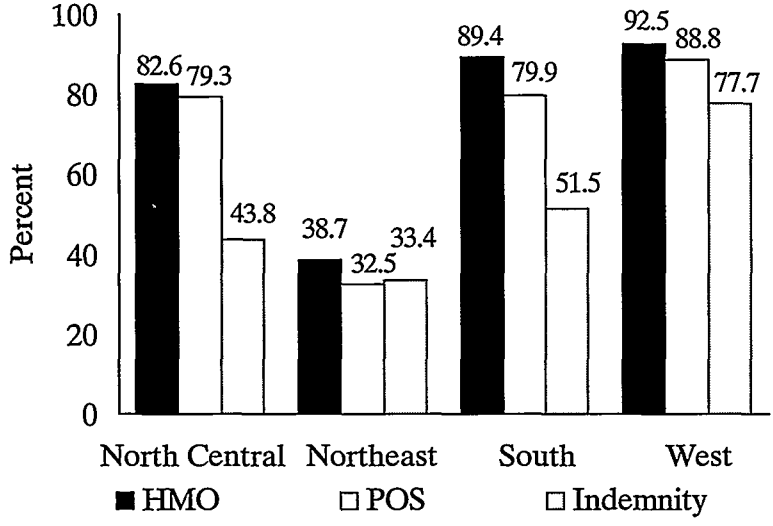
Newborns delivered by Cesarean sections had a similar, but less skewed distribution; 22.1% were discharged in two days or less in the West, 3.9% were discharged in two days or less in the Northeast.[133] Another study evaluated the frequency of one day of postpartum hospitalization in 14,000 women who delivered vaginally in 1994 in four regions of the country and found the percentage ranged from approximately 34% in the Northeastern United States to approximately 88% in the Western United States.[134] There is also significant variation within states; one study found that the frequency of early discharge in six regions of Ohio for Medicaid births varied from 37.3% to 82.9% in 1995.[135]

Of course, these regional variations might be explained by variations in insurance coverage. As noted previously, the conventional wisdom is that postpartum lengths-of-stay have dropped because MCOs are refusing to pay for such care. One study tested this claim by simultaneously evaluating the impact of location and insurance coverage on the percentage of one-day postpartum discharges.[136] Approximately one-third of the women were covered

133. *See id.* at 9.
134. *See* Julie A. Gazmararian & Jeffrey P. Koplan, *Length-of-Stay After Delivery: Managed Care Versus Fee-for-Service*, HEALTH AFF., Winter 1996, at 74, 76.
135. *See* Kotagal et al., *supra* note 129, at 1152, tbl. 2.
136. *See* Gazmararian & Koplan, *supra* note 134, at 74.

by an HMO,[137] another one-third were covered by a point of service plan (POS),[138] and the final one-third were covered by an indemnity plan.[139] The distribution of enrollees varied in different parts of the country; HMO enrollees dominated in the West, and POS enrollees dominated in the Northeast.[140] As Figure 7 reflects, local practice norms have a major impact on postpartum length of stay—and at least in the West and Northeast, they overwhelm the impact of one's insurance coverage.[141]

FIGURE 7
ONE DAY POSTPARTUM STAYS BY REGION AND INSURANCE TYPE



Similar results have been obtained in other studies. In New Jersey, the average inpatient length of stay for vaginal delivery in 1995 and 1996 fell within a narrow band, regardless of whether the mother was covered by New Jersey Blue Cross, Medicaid, an HMO,

137. An HMO typically provides coverage for care received from a network of authorized providers, but, except for emergencies when no authorized provider is available, does not cover care received from an out-of-network provider. *See id.* at 75.

138. Unlike an HMO enrollee, a POS enrollee has coverage for care received within the network of authorized providers, but also has the option of receiving care from an out-of-network provider and obtaining some level of coverage for such care. *See id.*

139. In a standard indemnity insurance model, enrollees can see any provider they choose and receive coverage in accordance with the terms of their insurance policy. *See id.*

140. *See id.* at 76.

141. *See id.*

self-pay, or commercial (indemnity) insurance.[142] In Minnesota, an analysis of 180,000 deliveries from 1990 to 1994 indicated that the percentage of one-day postpartum hospitalizations for normal newborns with indemnity coverage "generally tracked" that of newborns with managed care coverage.[143]

These sizeable regional variations in postpartum hospitalization patterns, which are primarily attributable to local practice norms, undercut the model of maternity care embraced by the state statutes and the Newborns' Act.[144] Several commentators have observed that in California, one-day stays after a vaginal delivery are the virtual rule and stays of twelve hours or less are common.[145] Illinois is an intermediate case; in 1995-1996, 56% of women with vaginal deliveries were discharged after one day, and 72% of women who had Cesarean sections were discharged in less than four days.[146] Conversely, in New Jersey and Massachusetts, one-day stays are very much the exception. In 1993, only 7% of newborns in New Jersey

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142. *See* State of N.J., Dept. of Health & Senior Services, *In-Patient Average Length of Stay (Days) by Primary Payer* (visited Oct. 14, 1999) <http://www.state.nj.us/health/hcsa/95payl.htm>.

143. GAO REPORT, *supra* note 82, at 4–5.

144. Such regional variation is by no means unique to postpartum care:

> Health services researchers have long been aware of large variations in the use of medical care among communities and regions ... in health care markets, geography is destiny: the care one receives depends in large part on the supply of resources available in the place where one lives—and on the practice patterns of local physicians.

Dartmouth Atlas of Health Care in the United States, Ctr. for Evaluative Clinical Sciences, *Geographic Variations in Health Care* (visited Aug. 19, 1999) <http://www.dartmouth.edu/~atlas/intro.html>; *see also* John Wennberg & Alan Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCIENCE 1102, 1107 (1973) (describing wide variations in practice patterns throughout the United States).

145. *See Newborns' and Mothers' Hearing*, *supra* note 24, at 48 (statement by Dr. Sharon Levine, Associate Medical Director, Permanente Medical Group, Inc.) (presenting testimony that in the Kaiser health plan in Northern California, 40% of postpartum women went home in less than 24 hours and the average length of postpartum hospitalization was 40 hours, while in Southern California, the average length of stay was 21–24 hours); Paula Braveman et al., *Early Discharge of Newborns and Mothers: A Critical Review of the Literature*, 96 PEDIATRICS 716, 716 (1995) (noting that in the western United States, "stays of 12 to 24 hours or less after uncomplicated vaginal birth and 48 to 72 hours after uncomplicated Cesarean delivery [were] standard"); Maribeth Inturrisi & Lael Lambert, *Length of Stay for Uncomplicated Vaginal Birth: A Perinatal Continuous Quality Improvement Project*, 12 J. PERINATAL & NEONATAL NURSING 11, 12 (1998) ("In California, most women went home within 24 hours."); Ziegler, *supra* note 120, at 19 ("Stays of 12 to 24 hours or less following an uncomplicated vaginal birth and 48 to 72 hours following an uncomplicated C[esarean] section are now standard, particularly in the western United States.").

146. *See* Kristiana Raube & Katie Merrell, *Maternal Minimum-Stay Legislation: Cost and Policy Implications*, 89 AM. J. PUB. HEALTH 922, 922 (1999).

and 10% of newborns in Massachusetts were discharged within a day of birth.[147] These studies confirm that as of 1995, abbreviated postpartum stays had become routine in most, but by no means all, of the United States.[148]

States that had the highest percentage of short postpartum stays were slow to adopt legislation restricting such practices, while states that had the lowest percentage of short postpartum stays were quickest to adopt such legislation.[149] This pattern is peculiar; from a relative-risk perspective, one would have expected that states that had the highest percentage of drive-through deliveries would face the highest risk from such practices and, thus, would be most enthusiastic about such legislation—unless, of course, the legislation was the result of lobbying by providers seeking to maintain their preferred practice patterns in states with relatively low numbers of rapid postpartum discharges.[150] At least in New Jersey, this is exactly what happened.[151]

Some of the trend toward short postpartum stays is probably attributable to the general shortening in hospital lengths-of-stay for all conditions.[152] Of course, larger social issues are at play as well:

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147. *See* Rachel M. Schwartz & Russell Kellogg, *Findings of the Robert Wood Johnson Foundation Study: One Day Hospitalizations for Mothers and Infants: Readmission Risk, in* 10 NAT'L PERINATAL INFO. CTR. SPECIAL RES. REP. 1, ¶12 (Oct. 1997), *available at* <http://www.npic.org/NL_X2/newsletter_X2.html>.

148. *See* Laura N. Sinai et al., *Phenylketonuria Screening: Effect of Early Newborn Discharge*, 96 PEDIATRICS 605, 605 (1995) (reporting survey results indicating that overall, 24% of full-term newborns were discharged by 24 hours of life, but the percentage of newborns discharged within one day of birth ranged from zero to 100% depending on the hospital).

149. *See* Declercq & Simmes, *supra* note 18, at 192 ("It is therefore in the western region of the country, where postpartum lengths of stay are currently shortest, that legislative actions to lengthen stays are least successful."). Other authors have also noted this pattern:

> Interestingly, some of the states that recently have enacted legislation mandating hospital stays of 48 hours after normal delivery are in the Northeast (New Jersey, Massachusetts, and New York), where lengths-of-stay are the longest and do not vary by plan type and where managed care penetration is lower than it is in other parts of the country.

Gazmararian & Koplan, *supra* note 134, at 79.

150. *Cf.* Declercq & Simmes, *supra* note 18, at 192 ("This distinction may reflect wider acceptance of [rapid postpartum discharges in the western United States] or the desire of states in the East and the Midwest to prevent further growth of the systems already adopted in the South and the West.").

151. *See* Charles & Prystowsky, *supra* note 73, at 746 ("In New Jersey, physicians were not consulted by home [sic] maintenance organizations (HMOs) before early discharge began. There was only the assurance that early discharge had gone well in California.... [When things did not work out from physicians' perspective,] we had no recourse but to seek appropriate legislation.").

152. *See supra* notes 118–22 and accompanying text; *see also* Charlotte Catz et al., *Summary of Workshop: Early Discharge and Neonatal Hyperbilirubinemia*, 96

pressure to "demedicalize" birth has clearly played a role.[153] By common consensus, however, the dominant factor in the shortening of postpartum stays to their current levels was the determination by payors (insurers and MCOs) that such stays were not medically necessary and their efforts to discourage extended stays through various means, including outright denial of coverage.[154] Prior to the enactment of the Newborns' Act, most MCOs and insurers appear to have been providing automatic coverage of at least twenty-four hours of postpartum hospitalization for a normal vaginal delivery and seventy-two hours of hospitalization for a Cesarean section.[155] A number of prominent MCOs had embraced shorter stays,[156] and one

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PEDIATRICS 743, 743 (1995) ("Cost containment strategies such as managed care have resulted in a continued trend toward shorter lengths of stay for all hospitalizations in all age groups. As a part of this trend, early discharge of neonates has also become common.").

153. *See* GAO REPORT, *supra* note 82, at 5–6 ("Since the 1970s, many maternity patients have requested shorter hospital stays because of a growing interest in less medical intervention for childbirth."). The trend is a marked change from 1960, when:

> [E]ssentially all births in the United States were planned to take place in hospitals.... In the 1970s, however, this pattern of care shifted. Some women wanted to give birth at home, or, if home birth was not possible (or was deemed unsafe), to leave the hospital and return home as quickly as possible after giving birth.

Parisi & Meyer, *supra* note 118, at 1635.

154. *See, e.g.*, Britton et al., *supra* note 118, at 291 ("[E]conomic considerations often limit the choice of families and their physicians. Third party payers usually fund only the shortest possible in-patient stays, thus constituting a driving force behind the trend to earlier discharge."); MacDonald, *supra* note 102, at 734 ("[A]s they fund progressively shorter hospital stays, managed care and health insurance companies constitute a major driving force toward earlier postpartum discharge."); Parisi & Meyer, *supra* note 118, at 1636–37 ("Although the early discharge programs of the 1970s were developed in response to demand from consumers, the reckless trend toward decreased insurance coverage for maternity stays, in some cases resulting in stays as short as eight hours, appears to be based solely on considerations of costs.").

One HMO followed an increasingly prescriptive approach to shortening postpartum stays:

> First the HMO tried offering women who agreed to go home within one day a certificate good for four hours of free housekeeping services, plus the normal home nursing visits. This deal doubled the number of voluntary one-day discharges, but the HMO remained dissatisfied. "It wasn't up to our expectations," said the spokesman. "Now it's a mandatory one-day coverage."

MICHAEL MILLENSON, DEMANDING MEDICAL EXCELLENCE 305 (1998).

155. *See* Joyce Smith & Julius A. Karash, *New Mothers Get an Extra Day—Free*, KANSAS CITY STAR, Jan. 10, 1996, at B1 ("It's now common for insurers to limit the stay to 24 hours after a vaginal delivery and 72 hours after a Caesarean delivery, unless there are complications.").

156. *See* David R. Olmos, *Early Release Policy at HMOs Draws Fire*, L.A. TIMES, June 16, 1995, at D1 (noting Cigna Healthcare of Southern California's policy of discharging mothers and newborns within 12 to 24 hours for normal deliveries and within 48 hours after Cesarean sections, and noting a similar discharge policy at the Los Angeles County-

MCO had floated the idea of a standard postpartum stay of eight hours.[157] Because MCOs and insurers refused to pay for extended postpartum stays, hospitals and doctors came under considerable economic pressure to discharge patients when their coverage ran out.[158] MCOs argued that they were willing to provide coverage if an extended postpartum stay was medically necessary, but suggested that few women and infants actually have a medical reason to stay in the hospital beyond twenty-four hours.[159]

The stage was set for the confrontation outlined in Part II. Unfortunately, the extensive medical literature on the subject of the appropriate length of a postpartum stay was almost entirely ignored or was used as sound-bites in the free-for-all that erupted over drive-through deliveries. Parts III.C to III.F systematically evaluate the benefits and costs of extended postpartum stays.

B. Postpartum Stays: How Long Is Long Enough—and for What?

Historically, postpartum stays have served a number of distinct purposes, including recuperation, monitoring, and education of the mother as well as monitoring and metabolic screening of the newborn infant. During the debate over the Newborns' Act, critics charged that the probability of a post-discharge problem, such as infection, jaundice, dehydration, or undetected metabolic deficiencies was inversely proportional to the length of the postpartum hospitalization and cited a number of anecdotal cases and a few empirical studies to

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University of Southern California Medical Center, which mainly serves indigent patients). At one Kaiser hospital, "a 12-hour stay is now standard for uncomplicated vaginal deliveries." Shirk, *supra* note 124, at 1C.

157. *See* Olmos, *supra* note 156, at D1. Representatives of Kaiser took the position that the program was intended to begin the process of evaluating postpartum women for discharge within eight hours of delivery, but not necessarily to discharge them at that point. *See id.*; *Newborns' and Mothers' Hearing*, *supra* note 24, at 47–48 (statement of Dr. Sharon Levine, Associate Medical Director, Permanente Medical Group, Inc.). At the hearings on Senate Bill 969, Senator Bradley's attempts to cross-examine Dr. Levine on this issue were less than successful because Dr. Levine described the practice at Kaiser hospitals in Northern California, and Senator Bradley attempted to discredit her testimony using data from Kaiser hospitals in Southern California. *See Newborns' and Mothers' Hearing*, *supra* note 24, at 48 (statement of Sen. Bill Bradley). Nevertheless, at another Kaiser hospital, the nurse-manager for prenatal services estimated that "by 2000, it'll be six hours." Shirk, *supra* note 124, at 1C.

158. *See, e.g.*, Farrow, *supra* note 116, at 1040–41 (noting the various ways that economic pressure was brought to bear on doctors); Boodman, *supra* note 46, at 12 (same); *CBS This Morning* (CBS television broadcast, June 8, 1995), *available in* 1995 WL 3219519 (broadcasting an interview with Dr. Nancy Dickey, AMA, complaining of increasing pressure from MCOs to discharge patients quickly).

159. *See* Shirk, *supra* note 124, at 1C.

support their claims.[160] Supporters of abbreviated postpartum stays had their own empirical studies indicating that rapid postpartum discharge was safe and beneficial, but also argued that there were hazards associated with extended hospitalization, that length of stay was no indicator of the quality of services received, and that alternatives to hospitalization were better for both women and infants.[161] This section systematically evaluates the empirical evidence with regard to these issues.

The backdrop for the dispute over drive-through deliveries was provided by guidelines issued jointly by ACOG and AAP in 1992 to specify recommended postpartum treatment.[162] The guidelines recommended a postpartum stay of forty-eight hours after a normal vaginal delivery and ninety-six hours after a Cesarean section unless a lengthy list of conditions were satisfied. With regard to vaginal deliveries, the guidelines coyly noted that "it is unlikely that the fulfillment of these criteria and conditions can be accomplished in less than 48 hours."[163] Although physicians in most parts of the United States were discharging postpartum women and newborn infants well

160. *See* Britton et al., *supra* note 118, at 291 ("Opponents . . . argue that an element of risk may be involved because detection of significant illness may be either missed or delayed outside of the hospital."); Catz et al., *supra* note 152, at 743. Reported risks include hyperbilirubinemia,

> potential adverse effects on newborn screening, poor preparation for breast-feeding, inadequate surveillance of mothers and neonates for health problems in the postpartum/neonatal period, reduced opportunities for parent training in 'at risk' populations, disruptions of immunization practices, and shifting of economic burdens to families and non hospital-based providers.

Catz et al., *supra* note 152, at 743.

161. *See* Braveman et al., *supra* note 145, at 720 ("Early discharge might be beneficial if in-hospital practices are unsupportive of breast feeding."); Britton et al., *supra* note 118, at 291, 294 ("Proponents of early discharge claim that it is safe and may be advantageous from both a medical and psychosocial standpoint.... [T]he superiority of a longer hospitalization in facilitating improved outcomes has not been established, and arguments that continued hospitalization poses increased risk are equally tenable.").

162. *See* AMERICAN ACADEMY OF PEDIATRICS/AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 105–08 (1992)[hereinafter GUIDELINES FOR PERINATAL CARE]. AAP issued supplemental guidelines for newborn discharge in 1995. *See* Committee on Fetus and Newborn, American Academy of Pediatrics, *Hospital Stay for Healthy Term Newborns*, 96 PEDIATRICS 788, 788–89 (1995).

AAP and ACOG began jointly issuing these guidelines in 1983 to provide guidance to providers and policy-makers. The 1983 guidelines did not address delivery by Cesarean section. Recommendations for postpartum length of stay following a Cesarean section were added in 1988. The most recent version of the guidelines appeared in 1997 and is generally consistent with the 1992 guidelines on the issue of postpartum length of stay. The evolution of these guidelines is described in Thilo et al., *supra* note 80, at 259–60.

163. GUIDELINES FOR PERINATAL CARE, *supra* note 162, at 105–08.

in advance of this recommended period,[164] the guidelines provided a ready source of authority for those arguing that drive-through deliveries were inappropriate.

As it happens, the safety of rapid postpartum discharge has been studied extensively over several decades. Many of the studies suffer from obvious flaws or are difficult to compare with one another because of differences in the definition of "rapid postpartum discharge" and because of disparities in the nature of the post-discharge services that were offered.[165] However, no study has demonstrated *any* statistically significant increase in infant or maternal mortality after a rapid postpartum discharge.[166] One recent study of neonatal mortality demonstrated that of the infants who died in the neonatal period, 90% "were symptomatic in the first 8 hours of life, 93% in the first 12 hours, and 99% by 18 hours of life."[167] Thus, an extended postpartum stay is unlikely to make an appreciable difference in the detection and treatment of such problems.[168]

Absent evidence of increased mortality, studies of the safety of rapid postpartum discharge have focused on the frequency of hospital readmission. Unfortunately, readmission is a problematic endpoint. To be sure, hospital readmission is objective, moderately frequent (at least compared to maternal or infant mortality), readily verifiable through medical record review, and usually indicative of a significant problem. On the other hand, not all readmissions are preventable, regardless of the initial length of stay,[169] and if there is a diversity of

164. *See supra* Figures 4 and 5 and accompanying text.

165. The flaws with the studies include their small sample size, the almost universal absence of randomization, and the frequent lack of controls. *See* Braveman et al., *supra* note 145, at 720 ("In practice, however, interpretation of 'early discharge' seems to differ across institutions; recommended screening criteria are inconsistently interpreted or applied; and routine postdischarge follow-up varies widely."); Catz et al., *supra* note 152, at 743 ("Available studies are compromised by inadequate sample size, inconsistent risk factors, variable outcomes measures, differing interventions, and a general lack of appropriate comparison groups ... there are not even uniform and universally-accepted definitions of numerous key terms including 'early discharge.' ").

166. *See* Susan A. Beebe et al., *Neonatal Mortality and Length of Newborn Hospital Stay*, 98 PEDIATRICS 231, 234 (1995) ("We could not demonstrate a significant association between neonatal mortality and length of newborn hospital stay."); Britton et al., *supra* note 118, at 292 ("Among published studies of infants discharged early, mortality rates are low and not significantly different from those of accompanying controls or the general population of infants from which the study groups were drawn.").

167. Beebe et al., *supra* note 166, at 234.

168. *See id.* ("Although we cannot conclude that no infant would benefit from a longer hospital observation time, certainly the majority of infants who die in the neonatal period have signs or symptoms present within 18 hours of birth.").

169. *See* Edmonson et al., *supra* note 128, at 299 (noting that the readmission rate "may not be a suitable outcome measure [because] many neonatal readmissions occur for such

opinion about the necessity of hospitalization for treating certain medical conditions, readmission rates could give a quite distorted impression.[170] Unless the study is designed carefully, it may miss some readmissions (detection bias), and without randomization, it is quite difficult to know whether the results are actually attributable to the early discharge (selection bias).[171] Because readmission is rare, a large study is required to detect a significant difference in readmission rates.[172] Thus, readmission is both overinclusive and underinclusive as an endpoint for assessing the safety of rapid postpartum discharge.[173]

In 1994, the Department of Health and Human Services Maternal and Child Health Bureau (MCHB) reviewed all of the available studies on postpartum discharge. MCHB concluded that there was no evidence indicating that rapid postpartum discharges were unsafe, but there was also no evidence indicating that they were safe.[174] Another group of scholars came to essentially the same conclusion after conducting their own comprehensive review of scientific literature on the issue.[175] Strikingly, both reviews

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nonpreventable conditions as community acquired infections").

170. *See id.* ("Analysis of jaundice-related readmissions is particularly plagued by selection and detection biases and a lack of consensus about the definition, detection, and treatment of jaundice in most newborns."); *see also* Britton et al., *supra* note 118, at 294 (noting the possibility "that a patient re-admitted at one center might [have been treated] as an outpatient at another").

171. For example, if infants kept longer than 48 hours are significantly sicker than those discharged earlier, the observation that readmission rates are identical does not necessarily mean that the risk of readmission is identical. The significance of an abbreviated postpartum hospitalization on readmission rates is also likely to be sensitive to the period of time over which the probability of readmission is evaluated.

172. *See* Braveman et al., *supra* note 145, at 721. For example:

> At a rehospitalization rate of two percent among the group with the best outcome, at least 14,000 patients would be needed in each of two groups to detect a 25% increase in rehospitalizations related to early discharge, an effect that would have considerable medical and economic implications; more than 4000 in each group would be needed to detect a 50% increase.

Id.

173. Stated differently, the fact that an individual was readmitted does not necessarily indicate that a longer postpartum hospitalization was appropriate, and the fact that an individual was not readmitted does not necessarily indicate that a drive-through delivery was appropriate.

174. *See* Kessel et al., *supra* note 125, at 741 ("Failing to prove that shorter hospital stays are unsafe (especially in the face of numerous methodological flaws) is not the same as proving they are safe.").

175. *See* Braveman et al., *supra* note 145, at 724 ("The currently available literature provides little scientific evidence to guide discharge planning for most apparently well newborns and their mothers . . . [but] there is no evidence to support the general safety or advisability of early discharge in the absence of stringent selection criteria and postdischarge nurse home visits.").

determined that there was also no clear evidence demonstrating "the safety, efficacy, and effectiveness of the hospital and posthospital practices that were previously standard" before early discharges became common.[176]

A study outlined in testimony before Congress and published in abstract form evaluated the probabilities of readmission and of emergency department (ED) visits for approximately 15,000 births in New Hampshire in 1993.[177] The 24% of infants who were discharged within forty-eight hours of birth were more likely to be readmitted (1.61%) and seen in the ED (2.04%) than those discharged after a longer period of time (1.09% and 1.17%, respectively).[178] The most frequent causes for readmission were jaundice (47%), infection (23%), and gastrointestinal problems (8.8%). The study did not separately evaluate Cesarean sections and vaginal deliveries, which complicates the analysis somewhat.[179] Although this study was the source of the widely circulated "sound-bite" that drive-through deliveries caused a 50% increase in the likelihood of readmission and a 70% increase in the likelihood of a visit to the ED, the absolute number of readmissions and ED visits was quite small.[180]

Another unpublished study encompassing approximately 29,000 maternal discharges and 155,000 infant discharges in 1993 found that the incidence of readmission for both mothers and newborns was unrelated to initial length of stay, with the exception of infants who were delivered by a Cesarean section and were discharged within

176. *Id.*; *see also* Kessel et al., *supra* note 125, at 741 ("There are no objective scientific data to determine the appropriate length of stay now or in the past.").

177. *See Newborns' and Mothers' Hearing*, *supra* note 24, at 30–32, 80–81 (statements of Dr. Judith E. Frank, Department of Pediatrics, Dartmouth Medical School). The abstract was published as Judith Frank et al., *The Risk of Readmission and ER Visits in Newborns with Early Discharge: A Population Based Study*, 37 PEDIATRIC RES. 255A (1995). The final paper is Judith Frank et al., *Neonatal Hospitalization and Emergency Room Visits Associated with Early Discharge: A Population Based Study* (1996) (unpublished study, on file with the *North Carolina Law Review*) [hereinafter *New Hampshire Study*].

178. If one expresses these figures in terms of increased risk, there was a 50% increased risk of readmission and a 70% increased risk of being seen in the ED. *See Newborns' and Mothers' Hearing*, *supra* note 24, at 30–31 (statement of Dr. Judith E. Frank).

179. Nevertheless, given the figures on the regional distribution of postpartum hospitalization following a Cesarean section, it seems unlikely that many women who delivered by Cesarean section were discharged within 48 hours in New Hampshire. *See supra* figure 5 and accompanying text.

180. , *See Newborns' and Mothers' Hearing*, *supra* note 24, at 31 (statement of Dr. Judith E. Frank).

twenty-four hours.[181] The overall readmission rate for mothers was 0.4%, and for newborns was 1.7%.[182] The readmission rate was 1.7% for infants with a one-day postpartum stay, 1.9% for a two-day postpartum stay, and 2.0% for a three-day stay.[183]

Another study found that 2.2% of newborns and 0.45% of women were readmitted within the first month of the newborn's life, but the readmission rate did not vary by length of stay, type of coverage, region of the country, or age of the mother.[184] The primary cause for newborn readmission was jaundice, which typically occurred within the first three days of discharge.[185] Infections were the second most common cause of readmission, but they typically occurred fifteen to twenty-eight days after discharge.[186] The authors concisely observed that "because the majority of newborn and maternal readmissions occurred more than three days after delivery, an additional day in the hospital after delivery probably would not avert most newborn and maternal readmissions."[187]

Another researcher evaluated the frequency of readmission in approximately 19,000 births in California.[188] One interesting wrinkle in this study was that the data allowed the author to determine the actual number of hours postpartum at which mother and infant were discharged. A majority of the women were discharged within twenty-four hours, and some were discharged as early as eight hours after giving birth. The probability of readmission was unrelated to the length of stay, even for exceedingly short postpartum

181. *See* FOSTER & SCHNEIDER, *supra* note 132, at 11. Less than 1% of mothers who delivered by Cesarean section were discharged after a one-day stay. Even with this elevated risk of readmission, it was cheaper to discharge all infants, and readmit the few infants who required inpatient services. *See id.* at 6.

One weakness of the empirical literature in this area is that a significant number of the studies are unpublished. Publication is one of the traditional benchmarks for assessing the evidentiary reliability of a study. *See* Daubert v. Merrill Dow Pharm. Corp., 509 U.S. 579, 594 (1993) (noting that "publication (or lack thereof) in a peer-reviewed journal [is a] relevant, though not dispositive, consideration in assessing the scientific validity" of a study).

182. *See* FOSTER & SCHNEIDER, *supra* note 132, at 4.

183. *See id.*

184. *See* Gazmararian & Koplan, *supra* note 134, at 76–77.

185. *See id.* at 77.

186. *See id.* at 77–78.

187. *Id.* at 79.

188. *See* Peter I. Juhn, *Newborn Length of Stay and Hospital Readmission: Does Early Discharge Lead to Adverse Outcomes?*, *in* HEALTH SERVICES RESEARCH: IMPLICATIONS FOR POLICY, HEALTH CARE DELIVERY, AND CLINICAL PRACTICE, PROCEEDINGS OF THE ASSOCIATION FOR HEALTH SERVICES RESEARCH 13TH ANNUAL MEETING 53 (1996).

hospitalizations.[189] Infants discharged before twenty-four hours had a readmission rate of 2.7%, while those discharged twenty-four to forty-eight hours after birth had a readmission rate of 3.3%.[190]

Another unpublished study of approximately 110,000 normal newborn births by the National Perinatal Information Center found that the risk of readmission increased as the length of the postpartum hospitalization decreased.[191] Although actual rates of rehospitalization were low, the authors calculated that a one-day stay increased the risk of rehospitalization by 25% to 50% relative to a longer stay.[192]

A retrospective study examined the impact of home nursing visits after early discharge and determined that such services were associated with a twofold decrease in the number of acute care visits within fourteen days of discharge.[193] However, the study was too small to determine whether the decrease was statistically significant. The authors speculated that the home nursing visits allowed for earlier recognition and prevention of problems that otherwise would necessitate an acute visit. The authors also recounted anecdotal evidence that providers "stated that they generally discharged babies even earlier than previously once routine home visiting was instituted, because of the virtually assured follow-up."[194]

As noted earlier, the GAO issued a report on postpartum stays in September 1996.[195] The GAO had been asked to identify the risks attributable to abbreviated postpartum stays, examine whether health plans were taking action to ensure quality postpartum care, and determine what actions the states were taking to ensure patient protection.[196] The GAO summarized the available research on the safety of rapid postpartum discharge as follows:

> [R]esearch on the safety of short postpartum stays is inconclusive. More specifically, there are mixed results on the association between newborn length of stay and rehospitalization, one indicator of adverse outcomes.... [T]here is no conclusive evidence that discharging women

189. *See id.*
190. *See id.*
191. *See* Schwartz & Kellogg, *supra* note 147, ¶ 14.
192. *See id.*
193. *See* Paula Braveman et al., *Health Service Use Among Low-Risk Newborns After Early Discharge with and Without Nurse Home Visiting*, 9 J. AM. BD. FAMILY PRACTITIONERS 254, 256–57 (1996).
194. *Id.* at 258.
195. *See* GAO REPORT, *supra* note 82, at 1.
196. *See id.*

> and their babies less than 48 hours after childbirth has or does not have adverse effects on the health and well-being of mothers and newborns.[197]

Much of the text of the report focused on the importance of ensuring a full range of maternity services, rather than the length of the postpartum hospital stay. The report expressly noted that "most of the experts we contacted agree that the debate over postpartum hospitalization needs to focus on overall quality of maternity care rather than the length of stay."[198] The focus of the GAO's conclusions was nicely captured by the title of the report: "Appropriate Follow-up Services Critical With Short Hospital Stays."[199]

The July 23–30, 1997, issue of the *Journal of the American Medical Association* contained the two most exhaustive studies of the issue performed to date, as well as a commentary by several authors of earlier articles on the subject. The first study evaluated the risk of rehospitalization after a discharge less than thirty hours postpartum following a normal vaginal delivery in Washington from 1991 to 1994.[200] The authors noted that "the vast majority of newborns discharged home from the hospital remained healthy [but approximately] 2% . . . of all newborns developed subsequent medical problems severe enough to warrant rehospitalization within the first thirty days of life."[201] Newborns discharged at less than thirty hours were more likely to be readmitted, with the risk highest in the first week following discharge.[202] Infants born to first-time mothers also had an increased risk of admission within the first month postpartum.[203] The authors estimated that eight of every 100 rehospitalizations within the first week of life "may be attributable to early discharge or may be preventable if the risk of early discharge was eliminated."[204]

The second study examined rehospitalizations for feeding-related problems within twenty-eight days of normal vaginal deliveries in Wisconsin from 1991 to 1994.[205] The authors focused on the risk of

197. *Id.* at 1–2, 6.
198. *Id.* at 3.
199. *Id.*
200. *See* Lenna L. Liu et al., *The Safety of Newborn Early Discharge: The Washington State Experience*, 278 JAMA 293, 296–98 (1997).
201. *Id.* at 296.
202. *See id.*
203. *See id.*
204. *Id.*
205. *See* Edmonson et al., *supra* note 128, at 299.

readmissions for feeding-related problems in an attempt to address the overinclusiveness and underinclusiveness of global readmission rates[206] and because they believed that "feeding-related readmissions could be considered sentinel events that more specifically reflect the impact of early postpartum discharge on preventive newborn care."[207] As in the other studies, the rate of readmission was modest. During the study period, early discharges increased threefold, but feeding-related readmissions remained stable.[208] The likelihood of a feeding-related readmission was enhanced if the infant was breast-fed, firstborn, preterm, or born to mothers who were poorly educated, unmarried, or on Medicaid.[209] Once these other factors were controlled for, "early postpartum discharge had little or no independent effect on the risk of feeding-related hospital readmission."[210] The authors observed that the majority of feeding-related readmissions occurred during the first week of life and speculated that "the timing of routine clinic-based or home-based postpartum follow-up visits may prove to be more crucial than the timing of hospital discharge."[211] The authors also noted that "[u]nfortunately, [the Newborns' Act] fails to address either the funding or the timing of postdischarge medical attention."[212]

The commentary accompanying the two studies evaluated their strengths and weaknesses.[213] The commentary noted that although a definitive answer would require a large prospective randomized study, "it is reasonable to conclude that discharging apparently well newborns from the hospital before approximately the third day of life, at least in the absence of documented substitute services at an alternate site, is likely to result in moderately but not dramatically increased risks of hospital readmissions."[214] However, "the difference

206. *See id.*
207. *Id.*
208. *See id.* at 302.
209. *See id.*
210. *Id.*
211. *Id.* at 303.
212. *Id.*
213. *See* Paula Braveman et al., *Early Discharge and Evidence-Based Practice: Good Science and Good Judgment*, 278 JAMA 334, 334 (1997).
214. *Id.* at 335. Since the publication of this commentary, two small studies, one large study, a literature review, and a special issue of *Clinics in Perinatology* have appeared. Their results have generally confirmed these conclusions. *See* Elizabeth J. Bragg et al., *The Effect of Early Discharge After Vaginal Delivery on Neonatal Readmission Rates*, 89 OBSTETRICS & GYNECOLOGY 930, 931, 932 tbl.2 (1997) (noting that the adoption of a structured early discharge program, including a home visit by a nurse, had no statistically significant effect on the rate of readmission, despite the fact that median length of stay dropped from 49 hours to 30 hours; approximately 1% of newborns required readmission;

between a postpartum stay of 24 hours and a stay of 48 hours is unlikely to be a critical determinant of newborn or maternal health outcomes."[215]

As these studies reflect, a modest percentage of postpartum women and newborn infants will be readmitted, and a small percentage of postpartum women and newborns will die, regardless of the length of their initial hospitalization—a fact that makes clear the perils of an anecdote-driven approach to the issue.[216] Even if rapid postpartum discharge increases the number of readmissions, the "number needed to treat" helps place the readmission sound bite in context.[217] In order to prevent one incremental readmission (which will last on average 2.5 days), we would have to provide extended postpartum hospitalization for at least 232 well newborns, and perhaps as many as 866.[218]

The major preventable causes of readmission are jaundice, infection, and dehydration.[219] The available empirical evidence suggests that the risk of readmission for jaundice is the same if the infant is discharged at any time earlier than seventy-two hours.[220] The

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and approximately 65% of readmissions were attributable to infection or jaundice, regardless of length of stay); Kenneth E. Grullon & David A. Grimes, *The Safety of Early Postpartum Discharge: A Review and Critique*, 90 OBSTETRICS & GYNECOLOGY 860, 860 (1997) (concluding that early postpartum discharge appears to be safe for carefully selected consenting patients, but current data do not support or condemn generalized use of such practices); Kotagal et al., *supra* note 129, at 1150 (finding that rapid postpartum discharge had no effect on readmission rates in the Ohio Medicaid population from 1991 to 1995); Susan F. Meikle et al., *Rehospitalizations and Outpatient Contacts of Mothers and Neonates After Hospital Discharge After Vaginal Delivery*, 179 AM. J. OBSTETRICS & GYNECOLOGY 166, 169–70 (1998) (finding no effect of postpartum length of stay on infant readmissions, but finding a higher rate of maternal readmission associated with a longer initial hospital stay); 25 CLINICS PERINATOLOGY, 257, 257–527 (1998) (devoting an entire issue to "[e]arly [p]erinatal [h]ospital [d]ischarge . . . [i]ssues and [c]oncerns").

215. Braveman et al., *supra* note 213, at 335; *see also* M. Bruce Edmonson et al., *Early Discharge of Newborns*, 278 JAMA 2066, 2067 (1997) ("[R]outine discharge at 48 hours or longer following an uncomplicated nursery stay may be an economically inefficient way to reduce the risk of neonatal readmission.").

An article in *Newsweek* communicated these results to the public in damning terms: "Congress may have shot the wrong target. . . . [E]arly discharge is not a major danger. As the new studies make clear, inexperience is the major cause of preventable health problems. Keeping babies in the hospital for several days is one way to combat that problem, but not a very efficient one." Cowley & Springen, *supra* note 1, at 65.

216. *See supra* notes 46–57 and accompanying text.

217. Edmonson et al., *supra* note 215, at 2067.

218. *See* Alvah R. Cass & Robert J. Volk, *Early Discharge of Newborns*, 278 JAMA 2064, 2064–65 (1997); Edmonson et al., *supra* note 215, at 2067.

219. *See* Gazmararian & Koplan, *supra* note 134, at 77–78.

220. *See* M. Jeffrey Maisels & Elizabeth Kring, *Length of Stay, Jaundice, and Hospital Readmission*, 101 PEDIATRICS 995, 996–97 (1998).

[A]lthough the American Academy of Pediatrics recommends closer follow-up

risk of infection is actually increased by a lengthier stay in the hospital,[221] and the risk of dehydration is not really addressed by postpartum stays of forty-eight hours.[222] Thus, mandated coverage of postpartum hospitalization of the specified lengths has little or no nexus with the detection and prevention of problems likely to result in a bad outcome.[223] Moreover, it is a singularly inefficient way of addressing the problem of maternal inexperience.[224]

> for infants discharged <48 hours, we found no increase in risk of readmission to hospital for those infants whose length of stay was <48 hours compared with ≥48 hours to <72 hours.... It seems that discharge at any time <72 hours significantly increases the risk for readmission with hyperbilirubinemia when compared with discharge after 72 hours.

Id. at 996; *see also* Paula A. Braveman, *Short Hospital Stays for Mothers and Newborns*, 42 J. FAMILY PRACTICE 523, 523–24 (1996) ("Neonatal jaundice often does not peak until the 3rd day of life, and bilirubin levels prior to that time are not always good predictors of the peak level."); Braveman et al., *supra* note 145, at 720 ("Jaundice usually peaks at around 3 days after delivery, and several neonatal cardiac and gastrointestinal problems do not manifest until the second or third day of life."); Errol I. Soskolne et al., *The Effect of Early Discharge and Other Factors on Readmission Rates of Newborns*, 150 ARCHIVES PEDIATRIC ADOLESCENT MED. 373, 376 (1996) (finding significantly lower risk of readmission for newborns discharged 72 hours postpartum, but no effect from discharge at 24, 36, or 48 hours postpartum).

221. *See* GAO REPORT, *supra* note 82, at 11 ("Studies show that the chances of a newborn infection increase the longer the newborn remains in the hospital."); Britton et al., *supra* note 118, at 294 (noting that medical problems such as infections, which appear long after a discharge, "commonly arise de novo and are often unrelated to events of the immediate newborn period"); Lord, *supra* note 99, at 99 ("[T]he faster mother and child check out, the less likely they are to pick up hospital germs."). In addition, the bacteria to which mother and infant are exposed in the hospital are much more likely to be drug-resistant than bacteria in the community.

222. *See* Braveman et al., *supra* note 145, at 720 ("Breast milk may not have come in by the second or third postpartum day, and newborns may feed inconsistently before that time."); Boodman, *supra* note 46, at 12 (" '[D]ehydration never happens until after two to five days.' " (quoting Dr. Augusto Sola)).

223. *See* GAO REPORT, *supra* note 82, at 23 ("Extending hospital stays to 48 hours may provide for more medical surveillance, but it does not include the period when many neonatal problems usually occur—at 3 days of age."); Braveman et al., *supra* note 213, at 335 ("If the goal of postpartum/postnatal services is optimal maternal and child health, ... then it can be argued based on current physiologic knowledge that hospital discharge should be considered 'early' when it occurs before 3 or 4 days after delivery, not only before 2 days."); Declercq & Simmes, *supra* note 18, at 180 ("Ironically, keeping a mother and baby in the hospital for a second day increases the likelihood of discovering jaundice but still misses a critical period for identification of the problem."); Maisels & Kring, *supra* note 220, at 996 ("These findings ... suggest that undue emphasis has been placed on the 48-hour time period."); William B. Pittard & Kitty M. Geddes, *Newborn Hospitalization: A Closer Look*, 112 PEDIATRICS 257, 257 (1988) ("Only four of the 52 readmission diagnoses among infants discharged moderately early could potentially have been identified (not prevented) before discharge with an extended newborn hospitalization.").

224. Because of this simple fact, medical commentators who have examined the empirical literature have pointed out that the widespread enthusiasm for additional days of postpartum hospitalization is ultimately unhelpful. *See, e.g.*, Kessel et al., *supra* note

An additional argument made against drive-through deliveries is that short hospital stays do not provide sufficient time for instruction on breast-feeding. The actual impact of rapid postpartum discharge on breast-feeding is unclear.[225] The available studies have small sample sizes and come to inconsistent conclusions. One small randomized study found that early discharge was associated with an increased likelihood of breast-feeding in the days immediately following discharge, no observable differences in breast-feeding success at fourteen days postpartum, and a non-statistically significant increased likelihood of breast-feeding at six months after.[226] A retrospective non-randomized study found that early postpartum discharge had no impact on breast-feeding prevalence at twenty days postpartum,[227] but another prospective case surveillance study found that women who were discharged early were more likely to discontinue breast-feeding during the first two weeks of life.[228] Another small study found no difference in breast-feeding rates between women discharged at twenty-four hours or less and those discharged later when there was support for breast-feeding in the hospital and after discharge.[229] Still another study found no correlation between the length of hospitalization and the rate of

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125, at 740 ("Discharge of infants and mothers when they are ready is the correct approach; a focus solely on the timing of discharge is inappropriate."); Edmonson et al., *supra* note 215, at 2067 ("Routine discharge at 48 hours or longer following an uncomplicated nursery stay may be an economically inefficient way to reduce the risk of neonatal readmission.").

225. As one commentator has observed:

> Although longer hospital stays afford more time to provide breast-feeding instruction and establish successful lactation, conclusive data are lacking to support the notion that early discharge has an adverse effect on breast-feeding duration. Other factors, including prior breast-feeding knowledge, hospital practices, family support, and follow-up services, may be more important than time of discharge.

Marianne R. Neifert, *The Optimization of Breast-Feeding in the Perinatal Period*, 25 CLINICS PERINATOLOGY 303, 304 (1998).

226. *See* U. Waldenstrom et al., *Early and Late Discharge After Hospital Birth: Breastfeeding*, 76 ACTA PEDIATRICA SCANDINAVICA 737, 729–30 (1987).

227. *See* J. Bernier et al., *Early Postpartum Discharge and Breastfeeding, abstracted in* 149 ARCHIVES PEDIATRIC ADOLESCENT MED. P78, P78 (1995).

228. *See* A. Gadomski et al., *Outcomes of Early Hospital Discharge, abstracted in* 149 ARCHIVES PEDIATRIC ADOLESCENT MED. P99, P99 (1995). The authors did not identify any adverse impact of early postpartum discharge on morbidity or health care utilization. *See id.*

229. *See* Martha J. Miller et al., *Success in Breast Feeding by Early Discharge Mothers Is Associated with Intensive Support*, 41 PEDIATRIC RES. 205A, 205A (1996). The support included an in-hospital lactation consultant, a home nursing visit, and a home phone call from a lactation consultant. *See id.*

breast feeding at three months postpartum.[230] Of course, the more general issue of whether hospitals actually provide a supportive environment for breast-feeding is not addressed by the Newborns' Act.[231]

Another argument made against drive-through deliveries is that they undermine the nation's system of screening for genetically inherited metabolic diseases.[232] Reality is more complex. Every state requires metabolic screening for a variety of genetic diseases, including phenylketonuria ("PKU"), before an infant is discharged from the hospital.[233] This strategy made perfect sense when infants stayed for longer periods of time, but the incidence of false-negative tests for PKU increases when the testing is performed less than twenty-four hours after the infant has eaten for the first time.[234] Of course, it does not follow that the only solution is an extended postpartum stay. Some states have mandated rescreening of all newborns within two weeks of birth.[235] In states that have not

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230. *See* Julie A. Gazmararian et al., *Maternity Experiences in a Managed Care Organization*, HEALTH AFF., May/June 1997, at 198, 204.

231. Indeed, in one of the studies, women complained that the presence of other mothers and hospital routines disrupted their ability to initiate breast-feeding. *See* Waldenstrom et al., *supra* note 226, at 731. In another study, the authors were unable to demonstrate any effect of "hospital supportiveness of mothers with short lengths of stay" on the prevalence of breast-feeding. Bernier et al., *supra* note 227, at P78; *see also* Lord, *supra* note 99, at 99 ("Breast-feeding tends to go more smoothly at home than on a busy maternity ward.").

232. *See* Charles & Prystowsky, *supra* note 73, at 746 ("HMOs have destroyed the integrity of the National Newborn Screening Program for Genetic Disease, a veritable triumph in preventive medicine.").

233. *See* Sinai et al., *supra* note 148, at 607.

234. *See* Kessel et al., *supra* note 125, at 740 ("[T]he earlier a phenylketonuria specimen is taken, the higher the false-negative rate."); Sinai, *supra* note 148, at 607. ("Early newborn discharge puts infants at risk for delayed or even missed diagnosis of PKU because of decreased sensitivity of screening .... Screening performed at 12 hours would miss 30% of infants with PKU and screening between 12 and 24 hours of age would miss 10%.").

Of course, it is not at all clear that this problem can be solved by letting physicians make individualized decisions as to the time of discharge, unless the "individualized" decision is that every infant will stay for the requisite number of hours specified in the Newborns' Act. Nevertheless, if the PKU test is inaccurate when blood samples are taken too early, what is the justification for drawing blood to perform an inaccurate test?

235. *See* Sinai et al., *supra* note 148, at 606. *But see* NAT'L HEALTH POLICY FORUM, GEORGE WASHINGTON UNIV., ISSUE BRIEF NO. 683, POSTPARTUM STAY: A NO-WIN FOR MANAGED CARE? 6–7 (1996). The National Health Policy Forum questioned the value of rescreening because in 1987, " 'only 2 cases of PKU [were] detected of 536,689 infants screened by a second test in 13 states,' and 'no cases of PKU [were detected] for 618,075 infants screened a second time in 1988.' " *Id.* (quoting the Council of Regional Networks for Genetic Services). It therefore cost approximately $7 million to catch a single case of PKU through rescreening—raising serious questions about the cost-

mandated rescreening, some pediatricians have been slow to make the necessary adjustments to ensure that newborns are appropriately tested.[236] This problem certainly should be addressed, but the Newborns' Act is a peculiar and costly way to do so.[237] It is also worth noting that pre-discharge PKU testing was mandated in the first place because careful economic analysis demonstrated it was cost-effective to do such screenings when infants were already going to be hospitalized during the time period in which the test could be performed accurately. The cost-benefit analysis is likely to look quite different if infants must stay in the hospital an extra day for the test to be valid. It is exceedingly unlikely that allowing physicians to make individualized discharge decisions will do anything whatsoever about this problem.[238]

The more general issue raised by the interaction of drive-through deliveries and genetic screening for metabolic diseases is whether pediatric and obstetric practice patterns have adjusted to deal with the realities of rapid postpartum discharges. The traditional model of pediatric care required a physical examination within eighteen hours of birth and again less than twenty-four hours before discharge.[239] A regular well-baby visit was then scheduled within fourteen days of discharge.[240] Similarly, the traditional model of obstetric care required follow-up within four to six weeks of discharge.[241] These guidelines made sense in a world in which women and infants stayed

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effectiveness of this policy.

236. *See* Sinai et al., *supra* note 148, at 608.

> Many institutions and practitioners never rescreen, whereas some rescreen all infants regardless of their individual risk. Still others perform repeated screens on a select high-risk population of newborns.
>
> The data show that awareness of the necessity for repeated screens is not universal, and specific knowledge of the AAP recommendations on this matter is poor.

Id.

237. It is noteworthy that an article on the subject focused on solving the problem by educating physicians, rescreening, or changing the cut-off for a negative test. *See id.* at 608. Conspicuous by their omission were any mention of the benefits of mandating insurance coverage of an additional day in the hospital or of allowing physicians the discretion to decide when infants were ready to be discharged.

238. Of course, if physicians exercised their discretion by keeping everyone in the hospital for the full time period specified in the Newborns' Act, the problem could be solved; however, that was not supposed to be the point of the Newborns' Act. *See* 142 CONG. REC. 9903 (Sept. 5, 1996) (Sup. Docs. No. x1.1:104/2nSess./v.142/pt.16) (statement of Sen. Bradley) (rejecting the claim that the Newborns' Act will require women to stay in the hospital for the full period for which coverage is mandated).

239. *See supra* notes 162–63 and accompanying text.

240. *See id.*

241. *See id.*

in the hospital for five days postpartum, but ACOG and AAP believed they were insufficient in a world of rapid postpartum discharges.[242] Although ACOG and AAP have adopted new guidelines, it appears that many pediatricians and obstetricians have been slow to change their scheduling of follow-up visits to compensate for the short length of hospitalization. In one recently published study,

> [O]nly a minority (39%) of the obstetricians surveyed routinely performed extra follow-up visits for women discharged early after vaginal delivery. On the other hand, 68 percent performed extra follow-up after post-Cesarean early discharge, perhaps because of the increased risk status of these mothers. Furthermore, although the current guidelines recommend follow-up within 48 hours of discharge, only one-half of the obstetricians surveyed advised follow-up at this time.[243]

Obstetricians also appear to be making early discharge decisions based almost entirely on medical criteria, even though the sponsors of the Newborns' Act presumed that physicians would consider family, environmental, and social risk factors—and the clear position of AAP and ACOG is that such elements need to be considered.[244] Although these problems should be addressed, it is both peculiar and costly to do so by mandating coverage of an extended postpartum hospitalization. Indeed, the failure of the involved professionals to adjust their practices to changed circumstances suggests that leaving the issue to their sole discretion may cause more problems than it solves.[245]

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242. *See id.*

243. John R. Britton, *Postpartum Early Hospital Discharge and Follow-Up Practices in Canada and the United States*, 25 BIRTH 161, 167 (1998); *see also* Brown & Johnson, *supra* note 102, at xviii (noting that in 42 infants with kernicterus, "only one infant had been given an appointment for early follow-up, and that appointment was not kept"); M. Jeffrey Maisels & Elizabeth Kring, *Early Discharge from the Newborn Nursery—Effect on Scheduling of Follow-Up Visits by Pediatricians*, 100 PEDIATRICS 72, 72 (1997) ("Although follow-up practices have changed in response to shorter newborn hospital stays, a significant proportion of pediatricians are not following the American Academy of Pediatrics guidelines for the follow-up of short-stay infants.").

244. *See* Britton, *supra* note 243, at 167 ("Although current AAP/ACOG guidelines advise that 'family, environmental, and social risk factors' be assessed before making early discharge decisions, many obstetricians appear to be unlikely to perform such an assessment."). As noted previously, these factors were frequently offered to explain why individualized discharge decisions were necessary and were prominently featured in the findings accompanying the Newborns' Act. *See supra* note 106 and accompanying text.

245. When obstetricians had sole discretion as to whether a Cesarean section was necessary, they performed far too many of them, causing the Public Health Service to

An equally important issue, which also is not addressed by the Newborns' Act, is whether the substantive content of an extended postpartum hospitalization accomplishes its intended purpose.[246] Opponents of early discharge insist that extended stays allow for more extensive educational efforts, but have offered no evidence to show that such efforts actually occur. Anecdotal reports suggest that postpartum education currently leaves much to be desired, but it is not clear that abbreviated postpartum hospitalizations are responsible.[247] Little effort has been made to look inside the black box of the hospital maternity ward. In one study, postpartum stays were lengthened because obstetricians had a monopoly on the performance of circumcisions, and mothers and infants were simply

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embrace a goal of decreasing their incidence from 25% to 15% of all deliveries by the year 2000. This target will almost certainly not be met. *See* Curtin & Kozak, *supra* note 123, at 261 ("The decline in the Cesarean birth rate appears to have stalled at around 21 to 22 births per 100 deliveries during the period 1994 to 1996.").

Interestingly, a program that set objective criteria for the most common indications for a Cesarean section, coupled with retrospective case review and a stringent requirement for a second opinion, resulted in a substantial decrease in Cesarean section rates at a single hospital without adverse consequences for mothers and infants. *See* Steven A. Myers & Norbert Gleicher, *A Successful Program to Lower Cesarean-Section Rates*, 319 NEW ENG. J. MED. 1511, 1511 (1988). These simple rule-based strategies worked better than the unconstrained discretion of the affected professionals.

To be sure, the failure of unconstrained discretion to generate optimal results is by no means unique to obstetricians. Physicians and legislators may believe that care that is specially tailored to individual patients is medically superior, but more than 40 years of empirical research has documented that in many cases, clinical judgment rarely outperforms simple prediction rules. *See* David Hadorn, *Response to Callahan*, *in* BASIC BENEFITS AND CLINICAL GUIDELINES 45, 48–49 (David Hadorn, ed., 1992). ("[S]imple clinical prediction rules have proven superior to physician judgment in the diagnosis of acute abdominal pain, acute myocardial infarction, streptococcal tonsillitis, pneumonia, intracellular vs. extracellular causes of jaundice, presence of ankle fracture, survival after diagnosis of Hodgkin's disease or coronary artery disease, and many other settings." (citations omitted)).

246. *See* Declercq & Simmes, *supra* note 18, at 195 ("There was little discussion in these debates about the actual content of the postpartum care to be provided during those mandated longer hospital stays."). AAP has suggested that one of the benefits of an extended postpartum stay is the ability to evaluate mothers and to identify "inexperienced, inept, or other potentially harmful behavior." GAO REPORT, *supra* note 82, at 9. However, as noted previously the empirical evidence does not suggest that many physicians consider these elements in making discharge decisions. *See supra* note 244 and accompanying text.

247. *See* Gil L. Solomon, *Length of the Hospital Stay for Mothers and Newborns*, 334 NEW ENG. J. MED. 1134, 1134 (1996) ("In the hospitals where I am an attending physician, postpartum education usually consists of minimal guidance about breastfeeding, a handout about common postpartum problems (usually prepared by the physician), and a short talk before discharge. I would not categorize these measures as intensive education.").

waiting for their obstetrician to be available.[248] The Newborns' Act simply takes on faith that good things will happen if more women spend more time in the hospital postpartum, even though proponents of extended postpartum stays have presented no evidence to support that belief.[249]

One final question is whether drive-through deliveries might be ill-advised in certain patient populations. Some commentators have suggested that drive-through deliveries are particularly perilous when they involve women who are poor or minorities.[250] In one study of rapid postpartum discharge in a low-income population, the risk of a missed post-discharge appointment was approximately 10%, and hospital readmission rates were elevated.[251] However, other studies suggest the contrary. Two small, randomized controlled trials of rapid postpartum discharge in a Medicaid population indicated that rapid postpartum discharge is not associated with any increased risk of adverse outcomes,[252] and at least one study found that African-American women actually had longer postpartum stays than

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248. *See* Inturrisi & Lambert, *supra* note 145, at 11. When responsibility for performing circumcisions was transferred to pediatricians, postpartum hospitalizations were shortened dramatically, with no impact on newborn health. *See id.*

249. To be sure, similar questions should be raised about the substantive content of post-discharge services. *See* Susan A. Egerter et al., *Follow-Up of Newborns and Their Mothers After Early Hospital Discharge*, 25 CLINICS PERINATOLOGY 471, 479 (1998) (explaining that "research to date provides little useful information to guide follow-up practices under current conditions"). In its report, the GAO noted that many health plans provide a home visit by a nurse within 48 to 72 hours after discharge. GAO REPORT, *supra* note 82, at 10. However, not all health plans have the necessary infrastructure to deliver these services, and some managed care arrangements place the obligation to arrange such services on the mother. *See id.* at 10–11.

250. *See* Catz et al., *supra* note 152, at 744 ("Early discharge plans may have their greatest impact on socioeconomically and educationally disadvantaged populations, precisely those whose ability to compensate for increased costs and responsibilities is most uncertain.").

251. *See* Britton et al., *supra* note 118, at 293–94.

> In a study of low-income mothers discharged with their infants 24 to 36 hours postpartum, 10% failed to return for a follow-up visit within 48 hours, even though they had signed a contract agreeing to do so. This population had been carefully screened for medical risk factors, yet still had a high rate of hospital re-admission. Possibly, similar low-income groups who are less carefully screened might be at even greater risk for unidentified medical or social problems.

Id. The study in question is Paul D. Conrad et al., *Safety of Newborn Discharge in Less Than 36 Hours in an Indigent Population*, 143 AM. J. DISEASES CHILDHOOD 98 (1989).

252. *See* Cynthia Brumfield et al., *72-Hour Discharge After Cesarean Delivery: Results in a Selected Medicaid Population*, 7 J. MATERNAL FETAL MEDICINE 72, 73–74 (1998); Cynthia Brumfield et al., *24-Hour Mother-Infant Discharge with a Follow-Up Home Health Visit: Results in a Selected Medicaid Population*, 88 OBSTETRICS & GYNECOLOGY 544, 544 (1996).

European-American women already.[253] Another study found that rapid postpartum discharges had no adverse effects on a population that was made up mostly of Medicaid recipients.[254] A large retrospective study of Ohio Medicaid births came to the same conclusion.[255] Finally, if drive-through deliveries are actually more hazardous for disadvantaged populations, it is truly extraordinary that Medicaid beneficiaries were excluded from the Newborns' Act and from the laws passed by a clear majority of the states that have legislated in this area.[256]

In light of the empirical research outlined in this section, it should come as no surprise that a report on postpartum hospitalization practices, prepared pursuant to a requirement in the Newborns' Act, offers no real praise for the coverage provisions specified by the Act.[257] The report does assert that the Newborns' Act is an "important achievement," but it provides no evidence to indicate why this conclusion is correct. Indeed, the report implicitly criticizes the Newborns' Act for its focus on the number of hours of postpartum hospital care, instead of the "needs of the mother and newborn and . . . the content and quality of the care they receive."[258] The first recommendation of the report is to "broaden the focus of concern beyond the issue of length of stay to the multiple important factors affecting maternal and infant health," and the third recommendation is to "ensure the delivery of health care needed after leaving the hospital, regardless of length of stay."[259] Likewise, the report implicitly criticizes the manner in which the campaign against drive-through deliveries was waged by observing that "the goal of postnatal and postpartum services should be to achieve optimal newborn and maternal health in the short- and long-term, and not only to prevent rare occurrences such as hospital readmission or catastrophic events leading to death."[260]

As this discussion demonstrates, there is no real evidence

253. *See* FOSTER & SCHNEIDER, *supra* note 132, at 3 ("[B]lack women and babies were less likely to be discharged within the first 24 hours and were substantially more likely to have a three-to-seven day stay than other patients.").

254. *See* Bragg et al., *supra* note 214, at 932.

255. *See* Kotagal et al., note 129, at 1150 (finding that the mean length of stay declined by 27%, but rehospitalization rates within 7 and 14 days of discharge decreased by 20%).

256. *See supra* notes 86, 111 and accompanying text.

257. *See* SECRETARY'S ADVISORY COMM. ON INFANT MORTALITY, DEP'T OF HEALTH AND HUMAN SERVS., PRELIMINARY REPORT FOR NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 2–5 (1998).

258. *Id.* at 24.

259. *Id.* at 26–27.

260. *Id.*

supporting the pattern of postpartum care that the Newborns' Act has enshrined as federal law.[261] Past practices have more to do with the existence of insurance coverage and provider preferences than with any real medical risks—with the result that patient preferences have been largely ignored in the framing of guidelines for postpartum care.[262] Part III.C turns to this issue.

C. *What Do Postpartum Women Want?*

Although physicians and health services researchers have focused on the risk of readmission to assess the desirability of rapid postpartum discharge, it does not follow that the readmission risk is all that we should be concerned about—especially in light of the fact that the readmission rate is simultaneously underinclusive and overinclusive.[263] Indeed, by focusing on readmission rates, the empirical studies have effectively missed, or at least unduly discounted, many of the concerns that have been voiced about drive-through deliveries. These concerns include the desire for a modest postpartum period of rest and recuperation, sufficient time to provide education about nursing and infant care, and maternal comfort about one's ability to care for the newborn infant after discharge. These factors are much more difficult to assess than the rate of maternal and infant readmission, but deficiencies in these areas can affect many more postpartum women and infants than readmission. The legislative focus on horror stories and the medical profession's focus on large scale studies of readmission risk has obscured a more basic set of questions: What do postpartum woman actually think about the care they receive? Do postpartum women value forty-eight hours in the hospital? Do they believe they are getting enough rest and recuperation in forty-eight hours? Would they be satisfied with less, or do they want more? What kind of education do they actually receive during the time they spend in the hospital? In short, what do

261. *See* Braveman et al., *supra* note 145, at 724 ("[T]here is no clear evidence for the safety, efficacy, and effectiveness of the hospital and posthospital practices that were previously standard."); Catz et al., *supra* note 152, at 743 ("It was agreed that there is an inadequate science base to determine the safety and appropriateness of discharge strategies both old and new."); Kessel et al., *supra* note 125, at 741 ("There are no objective scientific data to determine the appropriate length of stay now or in the past."); Parisi & Meyer, *supra* note 118, at 1637 ("Admittedly, the ideal postpartum hospital stay has not been determined, even in low-risk cases.").

262. *See* Catz et al., *supra* note 152, at 743 ("While early discharge protocols have been driven principally by financial imperatives arising out of managed care or other cost containment programs, both provider preferences and the availability of insurance coverage probably encouraged longer stays in the past.").

263. *See supra* notes 169–73 and accompanying text.

postpartum women want?[264]

Unfortunately, there have been few studies of postpartum women's preferences and attitudes.[265] The largest and most recent study involved a telephone survey of approximately 5200 women who had given birth during a four-month period in 1995.[266] Approximately 60% of the study population were discharged in less than twenty-four hours, 35% were discharged between twenty-four and forty-eight hours, and 5% were discharged in more than forty-eight hours.[267] Table 1 describes the survey respondents' answers when asked whether their postpartum stay was too short, too long, or about right.[268]

TABLE 1
ASSESSMENT OF ACTUAL POSTPARTUM STAY
(% RESPONDING)

	Actual Length of Stay (Hours)		
Stay Was:	<24	25-48	>48
Too Short	63.9%	47.8%	24.5%
About Right	33.4%	49.1%	69.2%
Too Long	2.7%	3.1%	6.3%

A substantial majority of women who were discharged in less than twenty-four hours and a near majority of women who were discharged in less than forty-eight hours believed their postpartum stay was too short.[269] The reasons cited for wanting to stay longer included: needing more rest (94%); not feeling well (64%); needing more information on infant care (36%) and self-care (28%); lack of adequate support at home (27%); lack of comfort in caring for the infant (24%); believing the infant was sick (16%); and simply wanting

264. *See* Diony Young, *First Class Delivery: The Importance of Asking Women What They Think About Their Maternity Care*, 25 BIRTH 71, 71 (1998) (bemoaning the lack of data on what women think about their maternity care, but noting that not all women want the same thing).

265. The available data tend to be customer satisfaction surveys, which are problematic for a variety of reasons, including selection bias.

266. *See* Gazmararian et al., *supra* note 230, at 199.

267. *See id.* at 199.

268. *See id.* at 203 exhibit 3.

269. Because data were collected in 1996, when public concern about drive-through deliveries was at its height, one cannot exclude the possibility that women's assessments of the length of their postpartum hospitalization was affected by public debate on the issue.

more time in the hospital (15%).[270] Table 2 illustrates the new mothers answers' when asked to specify their optimal stay, and given a choice of less than twenty-four hours, twenty-four to forty-eight hours, or greater than forty-eight hours.[271]

TABLE 2
ASSESSMENT OF OPTIMAL POSTPARTUM STAY
(% RESPONDING)

Optimal Stay Would Be:	Actual Length of Stay (Hours)		
	<24	25-48	>48
<24 Hours	37.6%	7.6%	12.4%
25-48 Hours	47.9%	56.8%	23.9%
>48 Hours	14.5%	35.6%	63.7%

These figures indicate a clear lack of enthusiasm among postpartum women for drive-through deliveries. The market's failure to respond to this unhappiness significantly strengthens the argument for a regulatory response, but if one probes behind these figures, the picture becomes considerably more complicated.[272]

Because one of the major purposes for an extended postpartum stay is parental education, the study investigated whether women believed they had received adequate information prior to discharge on such matters as bodily and emotional changes, breast- and bottle-feedings, infant bathing and care, screening tests, immunizations, umbilical cord care, sleep cycles, signs of illness, and follow-up appointments. Remarkably, there was absolutely no connection between length of stay and whether the women believed they had received adequate information; approximately 60% of women were dissatisfied with the amount of information they received, regardless of their length of stay.[273]

270. *See* Gazmararian et al., *supra* note 230, at 202–03.

271. *See id.* at 203 exhibit 3.

272. It is important to note that other surveys have come to considerably more positive results. *See supra* note 99 and accompanying text (reporting a high degree of satisfaction with rapid postpartum discharge among managed care enrollees).

273. *See* Gazmararian et al., *supra* note 230, at 200. There may be a coding issue lurking in this study. The authors coded as "inadequate information" a response expressing dissatisfaction with the information received on any of eight subjects. Because the study employed a binary coding system, it did not indicate the degree to which women were particularly satisfied or dissatisfied with the information they received or whether

The authors also asked whether women would be willing to go home in less than twenty-four hours after a future delivery and whether they would be more willing to do so if they received a variety of post-discharge services, such as access to a twenty-four hour hotline, a follow-up phone call or home visit by a health care professional, and housekeeping services.[274] Table 3 reflects the cumulative preference distribution of the women who were surveyed.[275]

TABLE 3
CUMULATIVE WILLINGNESS TO BE DISCHARGED WITHIN 24 HOURS
(% RESPONDING)

Actual Stay (Hours)	Not Willing	Willing, if Receive Number of Services:				
		0	1	2	3	4
<24	4.8%	42.5%	48.8%	60.1%	79.5%	95.2%
24-48	9.5%	24.2%	31.5%	45.9%	69.4%	90.5%
>48	9.0%	25.2%	32.9%	40.2%	65.8%	91.0%

Interestingly, a sizeable percentage of women were willing to go home whether or not they received any services, although willingness to leave without services was significantly affected by how quickly the woman had been discharged on the prior admission.[276] More importantly, an overwhelming majority of women were willing to be discharged within twenty-four hours, so long as they received some level of post-discharge support. Women who were simply unwilling to go home early were disproportionately married, college-educated, with multiple children, more than thirty-five years old, and lived in the Northeast or North Central regions—hardly the demographic group one would be most concerned about from a relative risk perspective.[277]

length of stay affected the number of subjects on which they reported receiving inadequate information.

274. *See id.* at 203.

275. *See id.* at 203 exhibit 3.

276. *See id.* at 203.

277. *See id.* at 200–01.

D. How Much "Safety" and at What Cost?

The critical questions to ask about the Newborns' Act are how much safety are we really purchasing and is that safety worth the cost?[278] Life is full of tradeoffs. Money spent on extended postpartum stays is money that is not available to be spent on other services that might benefit more infants and mothers—or on other health services that might benefit more people or save more quality-adjusted life years.[279] More globally, money spent on health insurance premiums is unavailable for other social goals, including education, police, roads, and the like.[280]

These questions take on greater significance because of the way in which the campaign against drive-through deliveries was waged. The prohibition on drive-through deliveries was driven by a few high-profile anecdotes offered by physicians and trumpeted by the news media.[281] The self-interested nature of the proposed reform attracted little or no attention, but physicians gained an invaluable legislative precedent—that insurers and MCOs should not dictate the manner or means of medical treatments.[282] The benefit of this precedent to

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278. The issue was nicely framed during the hearings on Senate Bill 969 in an exchange between Senator Bradley and a representative of an HMO:

> Sen. Bradley: [T]he issue is are we better off—is the mother better off—with an additional 24 hours.
>
> Dr. Levine: And how much better off, and how many mothers.
>
> Sen. Bradley: Yes. Those are all relevant questions.

Newborns' and Mothers' Hearing, supra note 24, at 47; *see also* Nduka U. Udom & Charles L. Betley, *Effects of Maternity-Stay Legislation on 'Drive-Through Deliveries,'* HEALTH AFF., Sept.-Oct. 1998, at 208, 215 ("[T]he issue in evaluating the effects of maternity-stay legislation is whether the increased costs are worthwhile.").

279. To be sure, there is good evidence that the costs of such legislation are largely borne by those who receive the mandated benefits. *See* Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622, 639 (1994).

280. *See, e.g.*, David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 49 (1996) ("Moreover, the public has a host of welfare needs, including better housing, education, and environmental protection, but has a limited purse. If we are to have any money left to pay for these other goods, we must place greater limits on spending for health care services.").

281. The physicians thus acted as "availability entrepreneurs." Timur Kuran & Cass Sunstein, *Availability Cascades and Risk Regulation*, 51 STAN. L. REV. 683, 687–88 (1999) (describing the role of "availability entrepreneurs" in skewing the regulatory agenda).

282. To be sure, obstetricians did not gain financially from the mandated coverage, because their fees were not tied to the length of a hospitalization. Pediatricians may or may not have gained, depending on whether they were able to bill for the "extra" visit necessitated by a rapid postpartum discharge. Both groups gained indirectly because it was easier and more convenient for them to deliver the services they deem medically necessary while mothers and infants are in the hospital. To assess the impact of such matters on the degree to which a professional organization supported or opposed the

physicians, who felt increasingly beleaguered by managed care, was incalculable.[283]

Although the campaign against drive-through deliveries was led by physicians, it was framed for the public as an uprising of concerned mothers.[284] The fixation on anecdotes of a few bad outcomes and the bipartisan enthusiasm for "motherhood" ensured that the full scope and significance of the issue of rapid postpartum discharge and the implicit tradeoffs that would result from its prohibition would be ignored or deemed immaterial.[285] Yet, only by systematically assessing the benefits and costs of such regulatory actions can we avoid misdirected regulatory efforts and prevent the adoption of policies that create costs without commensurate benefits.[286]

Newborns' Act, see *infra* notes 288–91 and accompanying text.

283. *See* Declercq & Simmes, *supra* note 18, at 197 (noting that laws "set some important precedents that may have a much more profound impact on health policy than is currently imagined ... [including the signaling of] a growing legislative interest in limiting insurers' control over clinical decision making").

284. *Compare* 142 CONG. REC. S9912 (daily ed. Sept. 5, 1996) (statement of Sen. Mikulski) ("This whole movement around providing care for 48 hours or 96 hours or whatever is medically appropriate came from mothers themselves."), *with* Charles & Prystowsky, *supra* note 73, at 747 ("We [physicians] had no recourse but to seek appropriate legislation."), Declercq & Simmes, *supra* note 18, at 186, 188–89 (noting that physicians approached state and federal legislators to seek such legislation), *and* Karen E. Kun & Edward Muir, *Drive By Deliveries: Legislating Practice*, 112 PUB. HEALTH REP. 277, 280 (1997) ("[A]dvocacy by parents, individual physicians, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists was influential in the decision of legislators to introduce legislation.").

285. As two commentators ruefully observed, "[A] reliance on personal experience is hardly a new factor in legislative decision making, but in an era where so many conscious efforts have been made to improve decision making by increasing the information resources of legislators, it is disappointing to see systematic research exerting so little influence." Declercq & Simmes, *supra* note 18, at 196 (citation omitted).

Because of their anecdotal focus, legislators were effectively engaging in "selective attention." Cass R. Sunstein, *Which Risks First?*, 1997 U CHI. LEGAL F. 101, 104 ("Too often government focuses on pieces or sides of a problem, failing to see that what is at work is a complex whole.... The problem of selective attention is aggravated by the role of the media, which quite generally focuses on sensationalistic pieces of problems ...."). The campaign against drive-through deliveries exemplifies this problem. As one commentator has noted:

> Public debate and the corresponding legislation have focused almost exclusively on concerns about length of stay and have given inadequate attention to the broader issues about what kinds of home-, office-, and hospital-based services and what kinds of connections among these different services are needed for both mother and child in the early days following birth.

Braveman, *supra* note 220, at 524. The net result was that the tradeoffs implicit in the Newborns' Act and state statutes were ignored. *Cf.* Cass R. Sunstein, *Health-Health Tradeoffs*, 63 U. CHI. L. REV. 1533, 1535, 1554–55 (1996) (arguing that health-health tradeoffs usually are ignored).

286. Opponents of drive-through deliveries typically claim that the expenses are

Despite enthusiastic public and congressional support for the Newborns' Act, there is little or no evidence on the benefit side of the ledger for postpartum stays of the specified length. The empirical studies conflict to some extent on relative risk, but if there is any medical benefit from extended postpartum hospitalization, it is quite small. Although some commentators have argued that extended postpartum hospitalization provides important social benefits, the evidence does not appear to support that claim either. Post-discharge home visits or appointments to be seen by a health care provider within two days of discharge can accomplish the objectives purportedly served by an extended postpartum stay—and may even be an improvement on such a stay if rapid discharge lowers the risk of an infection. If the goal of an extended postpartum stay is simply to ensure adequate time for bonding and rest, those purposes could be accomplished by providing women with a voucher for an overnight stay at a luxury hotel.[287]

Thus, the primary support for extended postpartum stays is little more than the collective clinical judgment of some (but by no means all) members of the medical profession and our collective "common sense" about what postpartum women need. Such judgments may well be better than nothing, but they have been wrong before—sometimes spectacularly so.[288] In addition, the widespread regional

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justified or that the nation should "err on the side of safety." *See Newborns' and Mothers' Hearing, supra* note 24, at 10 (statement of Sen. Bradley) ("[W]here do we err—do we err on the side of $900 less in costs, or do we err on the side of the health and safety of the mother and newborn? I think that we should come down for the safety of the mother and the newborn."); Parisi & Meyer, *supra* note 118, at 1637 ("The additional costs absorbed by the hospital seemed trivial in comparison with concerns about the potential medical consequences of the shorter stays covered by insurers.").

Obviously, such statements fall well below the standard of a formal cost-benefit analysis. Furthermore, those advocating that we should "err on the side of safety" would have more credibility if they were actually footing the bill. *See supra* notes 86–89 and accompanying text.

287. Some hospitals have effectively done precisely that by building or contracting for luxurious step-down facilities. *See* George J. Annas, *Women and Children First*, 333 NEW ENG. J. MED. 1647, 1650 (1995) (noting that Tampa General Hospital in Florida offers maternity patients 48 hours of post-discharge care in a hotel-like unit at no additional cost); Andrée Brooks, *Recovering, with All the Amenities*, N.Y. TIMES, Feb. 23, 1999, at F7 (describing the growth of medical hotels and post-operative recovery centers).

288. Consider for a moment what everyone (including doctors) "knows"—that walking helps shorten labor. Wrong. *See* Steven L. Bloom, *Lack of Effect of Walking on Labor and Delivery*, 339 NEW ENG. J. MED. 76, 76 (1998). Little harm probably resulted from this advice, but one cannot say the same for all medical fads. *See* Duncan Neuhauser, *Medical Technology Assessment as Social Responsibility*, 36 CASE W. RES. L. REV. 878, 878 (1986) (citing numerous examples of harm resulting from failure to conduct adequate assessments of medical and surgical interventions); *see also supra* note 74 (recounting the

variation in postpartum practice patterns suggests that the (at least partially self-interested) assessment of the involved professionals concerning the appropriate length of a postpartum stay should be evaluated with a jaundiced eye.[289] It is no accident that early discharge laws were supported by physicians and nursing groups who provided hospital-based services and opposed by nursing groups who provided home care services.[290] As one set of commentators dryly noted:

> For those (physicians and nurses) associated with hospital-based care, an extra day of hospitalization is a perfectly sensible policy, while those involved in home care see it as a waste of limited resources. As is often the case in health policy issues, self-interest and concern with patients' well-being were likely entangled.[291]

The cost side of the ledger is significantly more concrete, even after one nets out the costs of incremental readmissions and post-discharge visits. Childbirth is the most common reason for hospitalization in the United States; approximately 4 million children are born each year in this country.[292] Most discussions of the economic implications of rapid postpartum discharges begin and end by multiplying 4 million births by an average figure for inpatient hospitalization of $1000 per day to arrive at the understandable conclusion that $4 billion per incremental day of hospitalization is a powerful incentive to accelerate postpartum discharge.[293] Matters are not quite so simple.

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history of routine *in utero* monitoring).

289. As I have explained elsewhere, one should "be cautious about generating a normative baseline for the cost/quality mix of professional services based solely or even largely on the assessment of the affected professionals. Given their track record, professional pronouncements on the appropriate and/or necessary level of quality should be viewed with a jaundiced eye." Hyman, *Professional Responsibility*, *supra* note 29, at 399.

290. *See* Declercq & Simmes, *supra* note 18, at 187 (noting that nursing groups "took positions on this legislation according to whether or not they provided hospital or home care services").

291. *Id.*

292. *See Trends*, *supra* note 125, at 335.

293. The $4 billion figure was circulated widely and generally is attributed to Robert Torricelli, currently the junior Senator from New Jersey. *See Newborns' and Mothers' Hearing*, *supra* note 24, at 56 (statement of Dr. Palma E. Formica, AMA Board of Trustees); *Congress Takes on Insurers over Hospital Birth Stay*, OMAHA WORLD-HERALD, Sept. 13, 1995, at 1, *available in* 1995 WL 4087548; Editorial, *Ensure Care for Newborns: Mom's Entitled to at Least 2 Days in Hospital*, BUFF. NEWS, Oct. 17, 1995, at 2B, *available in* 1995 WL 5508117; *Legislators Rush to Get Minimum Hospital Stays for Mothers, Newborns*, SUN-SENTINEL (Ft. Lauderdale, Fla.), July 17, 1995, at 3A, *available in* 1995 WL 8821411.

To begin, both mother and infant must be hospitalized, so the cost might be as high as $8 billion per year. Of course, not all mothers want to stay in the hospital for forty-eight or ninety-six hours, regardless of their legal and contractual entitlement to do so, and some women have a medical reason to remain in the hospital longer than forty-eight or ninety-six hours.[294] Thus, the universe of potential beneficiaries predictably will be less than the total number of births. It also seems likely there will be considerable regional variation in the number of women who will take advantage of such coverage, depending on local physician practice norms and whether post-discharge follow-up services are available.[295]

The only way that MCOs incur expenses at the specified rate ($1000 per incremental day) is if hospitals price their delivery-related services per diem.[296] More generally, the price of $1000 per day is based on nationwide average hospital *charges.* The actual *cost* (let alone marginal cost) of providing an extra day of care is likely to be considerably less than $1000.[297] In many markets, managed care organizations probably have the bargaining power to drive per diem charges closer to cost.[298]

On the other hand, if hospitals actually were willing to charge marginal cost for each incremental day of hospitalization, it is unclear

294. If women voluntarily leave the hospital in less than 48 or 96 hours or if the MCO/insurer would have voluntarily covered a stay of at least 48 or 96 hours, no incremental costs are incurred as a result of postpartum stay legislation.

295. *See* Tom Philp, *New Moms Face Short Stay in Hospitals Despite Law,* SACRAMENTO BEE, Oct. 17, 1996, at A1, *available in* LEXIS, News Library, Scmnto-Bee file (reporting that California-based providers do not expect to change their practice of discharging women in 12 to 24 hours, despite passage of the Newborns' Act). *But see* Tim Bonfield, *Law May Give Birth to New Difficulties: 48-Hour Stay for Births Begins Today,* CINCINNATI ENQUIRER, Oct. 17, 1996, at B1, *available in* 1996 WL 2264659 (noting a physician's statement that "if you discharge at 36 or 24 hours and something less than positive happens, it could be considered a violation of a standard of care").

296. If hospitals priced their services on a different basis, such as a fixed rate for vaginal delivery regardless of length of stay or a high charge for the first 24 hours of admission and variable cost thereafter, MCOs would become indifferent as to the length of a postpartum hospitalization.

297. As Professor Uwe Reinhardt has questioned, "[How] can $1,000 be the real cost of keeping a healthy mother and her baby an extra day . . . ? Aside from some food, a change of linen and a bit of tender loving care, what extra items would that $1,000 cover?" Uwe Reinhardt, *When Trenton Plays Obstetrician,* N.Y. TIMES, July 9, 1995, § 13, at 15 (N.J. edition).

298. *See* David R. Olmos, *Maternity Rules Raise Questions on Care, Cost,* L.A. TIMES, Sept. 24, 1996, at A1 ("Hospital officials are concerned that insurers will use their marketplace clout to push the cost burden down to them .... Insurance companies can still leverage the oversupply in the market and say, 'We'll pay you $600 a day for a two-day stay.' " (quoting Jim Lott, spokesman for the Health Care Association of Southern California)).

why MCOs and insurers would be quite so keen on rapid postpartum discharge.[299] Regardless, mandating coverage of a second postpartum day actually makes it more likely that hospitals can insist on being paid more than marginal cost, because MCOs no longer have the option of simply refusing to purchase such care.[300]

Modeling the impact of these elements is a difficult task. Although the Congressional Budget Office (CBO) never scored the Newborns' Act, it did score Senate Bill 969, which was the vehicle in the Senate for consideration of the issue.[301] The CBO estimated that Senate Bill 969 would affect 900,000 births[302] and would impose costs on the private sector attributable to an additional 400,000 inpatient days (at $400 per day) and 200,000 home visits (at $100 per visit), for a total of $180 million per year.[303] In addition, the CBO estimated that the law would require the Medicaid program to pay for an additional 80,000 inpatient days (at $300 per day) and 80,000 home health visits (at $75 per visit) for a total of $30 million per year.[304]

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299. *See generally* Reinhardt, *supra* note 297, at 15 ("[T]he insurance companies in New Jersey and elsewhere are obsessed with reducing the length of hospital stays. New Jersey hospitals charge these companies about $1,000 for an extra day, at a time when hospitals are rich in empty beds. That could understandably lead to an obsession.").

300. *See* Uwe Reinhardt, *"Efficiency and Civility in Managed Care" or "How Much Jello Can a Mother Eat?,"* 56 MED. CARE RES. & REV. 47, 53 (1999) ("For the hospitals, this government intervention represents, of course, an official license to foist on the health insurance industry additional, essentially discretionary hospital days at a high per diem charge, that is, at very high profit margins."). If multiple hospitals are competing to contract with the MCO, this effect will be less significant.

301. The CBO's analysis is included in S. REP. NO. 104-326, at 11–17 (1995) (Sup. Docs. No. Y1.1/5:104-326).

302. Specifically, the CBO estimated that there were 4 million births annually in the United States, of which approximately 33% were paid for by Medicaid. Of the 2.7 million non-Medicaid births, 500,000 were to uninsured mothers. Of the remaining 2.2 million births, about 20% already were covered by state laws requiring extended postpartum stays. Of the remaining 1.75 million births, approximately 50% stayed less than the required amount of time. The CBO report estimated that approximately two-thirds of this group of 900,000 women who had stayed less than the required time would need either an additional day in the hospital or a post-discharge visit and that the ratio would be two-thirds hospitalization and one-third post-discharge visit. *See id.*

303. *See* S. REP. NO. 104-326, at 16.

304. *See id.* at 13. It is unclear why the CBO determined that Senate Bill 969 would require 80,000 additional inpatient days and 80,000 post-discharge visits because Senate Bill 969 does not apply to state Medicaid programs. The CBO was unable to clarify this point, but given the disparity in projected utilization in the private market and Medicaid, I presume that the CBO was attempting to account for the spill-over effects of Senate Bill 969 on obstetrical practice patterns, regardless of the specifics of the coverage mandate. The CBO also was unable to explain why they estimated that Medicaid deliveries would require an equal distribution of extra days in the hospital and post-discharge visits, while their estimate in the private market was two-thirds hospitalization and one-third post-discharge visit.

The costs attributable to federal employee benefits accounted for an additional $7 million.[305] State and local governments would also incur additional costs of approximately $3 million per year.[306] Thus, the total cost of Senate Bill 969 was estimated at approximately $220 million per year.[307]

An updated estimate was released in October 1998, when the Departments of Treasury, Labor, and Health and Human Services jointly issued regulations implementing the Newborns' Act. Because the Act did not encourage the substitution of post-discharge visits for hospitalization to the same degree as Senate Bill 969,[308] the regulations noted that it was possible that "those who would have chosen a follow-up visit under Senate Bill 969 will elect[] to remain in the hospital for an additional day . . . ."[309] However, the regulations noted that it was also possible that "mothers and physicians [would] determine that some of the follow-up care is unnecessary," even though discharge preceded the mandated forty-eight hours of coverage.[310] In addition, since the enactment of the Newborns' Act, an additional twelve states had enacted prohibitions on drive-through deliveries, thereby reducing the costs directly attributable to the federal legislation.[311] The regulations accordingly widened the range of cost projections for the Newborns' Act to between $130 million and $200 million per year.[312]

These estimates are subject to a number of important caveats. First, because both the CBO and regulations were scoring only the

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305. *See id.* at 14.

306. *See id.* at 11–17.

307. If one expresses the costs in terms of percentages, the CBO estimated that Senate Bill 969 would cause an increase in health insurance premiums of approximately 0.06%, which would cause employers and employees to reduce coverage or drop benefits for other services, with the net result that employer contributions for health insurance would increase by 0.02%. *See* S. REP. NO. 104-326, at 12. Because most of this increase would be passed through to employees in the form of lower wages, federal income and payroll tax revenues were projected to drop as well, by about $26 million per year. *See id.*

308. As noted previously, the original version of Senate Bill 969 required the insurer to cover postpartum hospitalization of 48 or 96 hours unless post-discharge services were provided and both the mother and attending provider agreed that discharge was appropriate. The Newborns' Act is silent on the issue of post-discharge services and simply leaves the issue of discharge up to the attending provider in consultation with the mother. Presumably, Congress assumed that the attending provider and mother would consider the availability of post-discharge services in deciding whether discharge was appropriate.

309. Newborns' Regulations, *supra* note 110, at 57,552.

310. *Id.*

311. *See id.*

312. *See id.*

independent effect of the Newborns' Act, they excluded from consideration the costs attributable to such mandates in the states that had passed legislation. Similarly, the CBO did not consider the impact of the Newborns' Act on the cost of care provided to the uninsured. From a social perspective, all of these costs are real and must be considered part of the cost of the campaign against drive-through deliveries, even if they are not solely attributable to the Newborns' Act. Second, despite the aura of certainty fostered by the use of specific figures for the number of inpatient days and outpatient visits, the figures are little more than educated guesswork. The determination that 400,000 incremental inpatient days and 200,000 post-discharge visits would be required for 900,000 insured deliveries and 80,000 inpatient days and post-discharge visits would be required for the 1.3 million Medicaid deliveries is plausible, but there was no back-up for these figures and far higher figures are not unreasonable. The foundation for determining the nominal cost for incremental days of hospitalization ($300–$400) and post-discharge visits ($75–$100) was equally unclear.[313] In addition, hospitals have shown little interest in charging marginal cost for incremental days of postpartum hospitalization—just as they have shown no interest in charging marginal cost for treatment in the emergency department.[314]

A number of studies have examined the cost of mandating coverage of an extended postpartum hospitalization in a systematic way.[315] Because each of these studies employed different data sets, involved distinct populations, and considered different aspects of the cost equation, they are offered as independent perspectives on the

313. A number of commentators have estimated the marginal cost of an additional day of hospitalization. These estimates are generally consistent with the CBO's and have ranged from $100 to $300 per day. *See* Annas, *supra* note 287, at 1650 (estimating that the marginal cost of an incremental day is "probably closer to $100 than $1,000, at least if the hospital has excess maternity-bed capacity"); Thomas Maier, *2-Day Maternity Stays Promised*, NEWSDAY, June 22, 1995, at 6, *available in* LEXIS, News Library, Newsday (New York, NY) file (estimating the marginal cost of $300 for an extra day at the University Medical Center in Stony Brook, New York).

314. *See* Hyman, *Consumer Protection*, *supra* note 3, at 433 n.82.

> From an economic perspective, it makes sense to use marginal cost instead of charges to score the true cost of inappropriate ED usage—but only if hospitals are actually prepared to charge marginal cost, and there is no excess capacity in the system. There is considerable evidence to indicate that neither of these preconditions are satisfied, although these points are not widely appreciated.

Id.

315. Other studies have evaluated the costs of particular short-stay protocols and of desired post-discharge services. *See, e.g.*, Julie A. Gazmararian & Jeffrey P. Koplan, *Economic Aspects of the Perinatal Hospital Stay*, 25 CLINICS PERINATOLOGY 483, 486–94 (1998) (summarizing various studies).

cost of mandating extended postpartum stays. My own computation of the cost of the Newborns' Act and similar initiatives is based on an integration of the conclusions of each of the individual studies and is presented at the end of this section.

The most exhaustive study was conducted by the staff of the hospital rate-setting commission for the state of Maryland.[316] The study demonstrated that Maryland's statute mandating coverage of extended postpartum hospitalizations had increased length of stay following a vaginal delivery from 1.45 days to 1.99 days (an increase of 37.6%) and increased length of stay following a Cesarean section from 2.99 days to 3.5 days (a 17.2% increase).[317] Charges went up by $250 for a vaginal delivery (a 10% increase) and $225 for a Cesarean delivery (a 6.3% increase).[318] Although these figures are based only on the cost of maternal hospitalization, they confirm that the incremental cost for an additional day of hospitalization is well below the average per diem charge. However, the universal increase in the length of stay to forty-eight hours following a vaginal delivery and the sizeable increase in length of stay following a Cesarean section suggests that the CBO was too optimistic in its assumption that more than half of postpartum women would be willing to be discharged before their coverage was exhausted. From a social-cost perspective, the legislation increased the amount spent on inpatient maternity care in Maryland by $5.5 million, exclusive of any incremental costs associated with post-discharge visits and newborn hospitalization.[319]

Another study assessed the costs of hospitalization associated with such legislation based on data from Illinois during 1995 and 1996.[320] The study used hazard rate estimates to arrive at marginal mean hospital charges of $990 for the second day following a vaginal delivery and $1922 for the fourth day following a Cesarean section.[321] As noted previously, in Illinois, 56% of women with vaginal deliveries were discharged after one day, and 72% of women with uncomplicated Cesarean deliveries were discharged in less than four

316. *See* Udom & Betley, *supra* note 278, at 208.

317. *See id.* at 210–11.

318. *See id.* at 214–15. In Maryland, charges are equivalent to costs because of the state's rate-setting system.

319. *See id.* at 208.

320. *See* Raube & Merrell, *supra* note 146, at 922. Thus, the study omitted the cost of physician, outpatient, and home-based services.

321. *See id.* at 923. For newborns, the figure was $497 for the second day of hospitalization. Because longer stays are associated with sicker infants, the cost for the fourth day of hospitalization was significantly higher ($1591). *See id.*

days.[322] Based on varying assumptions about the number of avoided readmissions and the percentage of women who would take advantage of a lengthier postpartum stay, the authors arrived at figures ranging as high as $200 million or 20% of the cost of all birth-related admissions and readmissions.[323]

Another study evaluated adjusted average charges based on varying lengths of stay during 1993.[324] The authors determined that for the second day of newborn hospitalization after a vaginal delivery, hospitals charged approximately $300 per day.[325] Comparable figures were incurred for maternal hospitalization.[326]

Another study that was discussed during the congressional hearing on Senate Bill 969 evaluated the avoided charges associated with early discharge in New Hampshire in 1993.[327] The study employed a per diem rate of approximately $2075 per day for the cost of hospitalizing mother and infant for an additional day.[328] Of approximately 15,000 births in New Hampshire in 1993, 3600 mothers and infants were discharged in less than forty-eight hours. The study determined that these discharges lowered hospitalization costs by nearly $7.5 million. The charges associated with readmission and treatment in the ED totaled $183,000 for infants discharged in less than forty-eight hours. The study concluded that early discharge saved nearly $7.3 million on the treatment of the infants in question.[329]

New Jersey's Department of Health and Senior Services conducted a study evaluating the impact of a prohibition on drive-through deliveries enacted in 1995.[330] New Jersey's electronic birth certificate data allowed the authors to determine precisely how many hours postpartum an infant had spent in the hospital.[331] The authors evaluated results from four hospitals, which represented approximately 8% of the births in New Jersey.[332] After the law was

322. *See supra* note 146 and accompanying text.
323. *See* Raube & Merrell, *supra* note 146, at 922.
324. *See* FOSTER & SCHNEIDER, *supra* note 132, at 2.
325. *See id.* at 10.
326. *See id.*
327. *See New Hampshire Study*, *supra* note 177, at 2.
328. *See id.* The figure was obtained from the New Hampshire Hospital Association and represented the average per diem charge in the state. *See id.*
329. *See id.* The study considered total ED and readmission charges, but not incremental charges attributable to early discharge.
330. *See* V. Dato et al., *Average Postpartum Length of Stay for Uncomplicated Deliveries—New Jersey, 1995*, 45 MORBIDITY & MORTALITY WKLY. REP. 700, 700 (1996).
331. *See id.*
332. *See id.*

enacted, average length of stay after a vaginal delivery increased from 1.4 to 1.8 days, and average length of stay for a Cesarean delivery increased from 2.8 days to 3.3 days.[333] This study suggests that many postpartum women (at least in the northeastern parts of the United States) will remain in the hospital for almost as long as they have coverage.

Another study by a health plan in Connecticut evaluated the consequences of legislation prohibiting rapid postpartum discharges.[334] Average postpartum length of stay after a vaginal delivery increased from 1.62 days to 2.12 days, and the percentage of women staying in the hospital for twenty-four hours or less dropped from 33.2% to 6.5%.[335] Before the legislation was enacted, the health plan had a program that allowed mothers discharged less than thirty hours postpartum to receive nursing visits, nanny care, and extra pediatric office visits.[336] The average cost of this program was well below the cost of an incremental day of hospitalization. The authors estimated "the savings at approximately $1000 per mother, as compared with a 2-day hospitalization for eligible mothers who chose not to participate in the program."[337]

Finally, a study at a single public hospital in Indianapolis assessed the impact of shortened postpartum hospitalizations on the cost per vaginal delivery for a population made up overwhelmingly of Medicaid patients.[338] The introduction of Medicaid managed care in Indiana brought about a 22% decrease in average postpartum hospital length of stay, from 2.68 to 2.13 days. However, costs declined by much less—12%—or about $280 per delivery.[339]

Considering all of this information, it is still difficult to arrive at a hard figure for the true financial cost associated with mandating coverage of extended postpartum hospitalizations. The oft-discussed $1000 per day estimate is far too high if one is considering the marginal cost of incremental days of postpartum maternal

333. *See id.* at 701.

334. *See* Joseph V. Cook Jr. et al., Letter to the Editor, *Early Discharge of Newborns*, 278 JAMA 2065, 2065 (1997).

335. *See id.*

336. *See id.* The authors determined that of 77 mothers, 1 did not use any nursing visits, 5 used one visit, 70 used two visits, and 1 used three visits. Twenty-five mothers did not use any nanny care, 2 used an average of eight hours, and 50 used sixteen hours. *See id.*

337. *Id.*

338. *See* Ming Tai-Seale et al., *Drive-Through Delivery: Where Are the "Savings"?*, 56 MED. CARE RES. REV. 30 *passim* (1999).

339. *See id.* at 39–40.

hospitalization, but one must include the costs attributable to both mothers and infants, weigh whether hospitals will charge only marginal cost when MCOs are forced to purchase the requisite number of days of postpartum hospitalization, and net out the costs of incremental post-discharge services, emergency department visits, and readmissions. In like fashion, one must consider how many women will choose to stay in the hospital until their postpartum coverage is exhausted and weigh the impact of regional variation in practice patterns. Some of these difficulties offset one another, while others are cumulative.

Rather than provide a specific figure for the total costs attributable to the legislation that resulted from the campaign against drive-through deliveries, I offer an upper and lower bound, which I readily admit is subject to considerable uncertainty. I estimate that the combined marginal cost for hospitalizing mother and newborn for an extra day, less the cost of post-discharge visits, and incremental readmissions and emergency department visits is no lower than $300 and no higher than $600. The number of women and infants who will take advantage of these provisions is particularly difficult to quantify, especially in light of the variations in regional practice patterns and the basic question of how dynamic those practice patterns actually are.[340] However, absent the Newborns' Act and similar state legislation, it seems likely that, over time, an overwhelming majority of the deliveries in the United States would have postpartum lengths of stay shorter than those specified in these statutes. The data suggest that most women will choose to take advantage of this coverage, although regional variation in practice patterns is likely to have an offsetting impact. Overall, I estimate that postpartum

340. The data presented in Part III suggest that practice patterns can be quite dynamic, but there are reports indicating resistance to the changing of local norms in response to the Newborns' Act, at least in California. *See* Philp, *supra* note 295, at A1. However, since the start of the campaign against drive-through deliveries in 1995, the length of a postpartum hospitalization has reversed a multi-decade decline and actually increased. *See supra* Figure 1. The average length of stay was 2.1 days in 1995 and 2.4 days in 1997. *See* Ctr. for Disease Control and Prevention, Nat'l Ctr. for Health Statistics, *Longer Hospital Stays for Childbirth* (last modified June 4, 1999) <http://www.cdc.gov/nchswww/products/pubs/pubd/hesats/hospbirth.htm>. The National Center of Health Statistics report is quite clear on the magnitude of the change:

> The number of women hospitalized for 1 day or less for childbirth dropped from 1.4 million (37%) in 1995 to 951,000 (25%) in 1997. Stays of 2–3 days increased from 2.0 million (54%) to 2.5 million (64%) during this period. Those with vaginal deliveries accounted for almost the entire decrease in stays of 1 day or less and increase in stays of 2–3 days. Women with Cesarean deliveries had an increased number of 4-day stays.

Id.

hospitalizations will be lengthened for approximately 75% of those who give birth, or 3 million deliveries. Combining these two elements, I estimate that extended postpartum stays have a social cost somewhere between $900 million and $1.8 billion every year.[341]

This figure is consistent with the results obtained from generalizing the results of single states. Maryland experienced a cost increase of $5.5 million (for approximately 23,000 deliveries) when it mandated coverage of extended postpartum hospitalizations.[342] If the same cost distribution holds for all 4 million births in the United States, the cost would be $956.5 million per year.[343] This study did not consider the cost of infant hospitalization, rehospitalization, or emergency department visits, nor did it include the offsetting cost of post-discharge services.[344] At the same time, and as previously noted, in Maryland charges more closely approximate actual costs (but not marginal costs).

In New Hampshire, there were 3600 rapid postpartum discharges out of 15,000 deliveries.[345] The avoided cost was $7.2 million. If the same cost distribution is assumed for all 4 million births in the United States, the estimated savings would be $1.9 million per year.[346] The study is flawed by its use of charges instead of costs and the extremely low percentage of drive-through deliveries in New Hampshire compared to the rest of the country. It does, however, include the costs associated with maternal and infant hospitalization, as well as the costs for post-discharge emergency department visits and readmissions (the last of which are overstated, because the study employed the costs attributable to all emergency visits and readmissions and not just incremental visits or readmissions attributable to the rapid postpartum discharge).

Using the midpoint of the range in the Illinois study, one arrives at a figure of approximately $1.3 billion.[347] Although this study

341. The calculation is: $300 per extra day x 3 million incremental days of hospitalization = $900 million; $600 per extra day x 3 million incremental days of hospitalization = $1.8 billion.

342. *See* Udom & Betley, *supra* note 278, at 208.

343. If it costs $5.5 million for 23,000 births, how much would it cost for 4 million births? The calculation is: $5.5 million ÷ 23,000 births = $293.13 per birth. $293.13 x 4 million births = $956.52 million in total cost.

344. *See* Udom & Betley, *supra* note 278, at 209–210, 214–15 (noting the limitations of the study).

345. *See supra* notes 327–29 and accompanying text.

346. Again, if it cost $7.2 million for 15,000 deliveries, how much does it cost for 4 million deliveries? The calculation is $7.2 million ÷ 15,000 births= $480 per birth. $480 × 4 million births = $1,920,000 in total costs.

347. *See* Raube & Merrell, *supra* note 146, at 923.

includes the charges associated with incremental maternal and infant admissions and readmissions, it excludes the cost of all post-discharge services, including post-discharge ED visits, and is based on charges, not costs. Finally, researchers from Prudential Health Systems estimated that the mandated coverage of extended postpartum stays would increase costs by $900 million to $2.2 billion per year.[348]

If one expresses this estimate of $900 million to $1.8 billion as a percentage of the total cost of health care in the United States, it turns out to be a relatively modest .12% to .24%.[349] As a percentage of the amount currently spent on postpartum hospitalizations, it is a substantially greater amount.[350] All such strategies, which involve presenting the cost of extended postpartum hospitalization as a percentage of some other (far greater) number, are deeply deceptive; the real issue is what are we buying for our $1 to $2 billion per year—and the answer appears to be not much.[351] Indeed, if the cost is so modest, it is rather striking that a majority of the states and the federal government were willing to mandate coverage for everyone except the 40% of births in the United States to mothers on Medicaid[352]—and a majority of the states passing legislation behaved the same with regard to state employees.[353]

From a distributional perspective, a prohibition on drive-through deliveries effectively compels the insurer to transfer resources from the common (insured) pool to those who take advantage of the extended postpartum hospitalization. In Maryland, those individuals were white women, between the ages of nineteen and thirty-five, with

348. *See* Gazmararian & Koplan, *supra* note 315, at 496.

349. If the costs of Medicare and Medicaid for the elderly and disabled, are excluded, the percentage increases to a range of .18% to .35%.

350. *See* Olmos, *supra* note 298, at A1 (noting the estimate of a Watson Wyatt Worldwide benefits consultant that extending maternity stays for normal vaginal deliveries from 24 to 48 hours would increase hospital bills by 18%); Udom & Betley, *supra* note 278, at 211 (finding that the statute resulted in a 10% increase in charges for vaginal deliveries and a 6.27% increase in charges for Cesarean deliveries).

351. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 32 (outlining difficulties with expressing the costs of consumer protection in dollars per month).

352. To be sure, Congress subsequently included Medicaid beneficiaries within the protections of the Newborns' Act—but only beneficiaries who were enrolled in a Medicaid managed care plan. *See supra* note 111 and accompanying text. Because most of the states now have this portion of the Medicaid population in a managed care program, the Balanced Budget Act effectively extended the protections of the Newborns' Act to the Medicaid population. However, because states share the cost of the Medicaid program with the federal government, Congress was being virtuous in part at the states' expense, even though the majority of states had already indicated their unwillingness to incur such expenses. *See supra* notes 86–89 and accompanying text.

353. *See supra* note 89 and accompanying text.

private health insurance, who delivered in rural and suburban hospitals.[354] As noted previously, similar results were obtained in another study: women who insisted on forty-eight hours of hospitalization were more likely to be married, college educated, with multiple children, and more than thirty-five years old.[355] It is very hard to make the case that such women are particularly in need of a governmental mandate to protect their interests—or that they face significant risks as a result of drive-through deliveries.

It is, of course, a different question whether the drive to shorten postpartum stays is the best way for MCOs to decrease the nation's health bill. The inevitable adaptive responses by health care providers will have to be addressed,[356] and preventing premature births may offer more "bang for the buck" than encouraging rapid postpartum discharge.[357] Some blame for the mess should be directed at hospitals, who caused much of the problem by pricing their services on a per diem basis even though incremental costs are relatively modest after the first day of postpartum hospitalization.[358] The

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354. *See* Udom & Betley, *supra* note 278, at 215.

355. *See* Gazmararian et al., *supra* note 230, at 203–04.

356. *See* Marbella et al., *supra* note 128, at 34 (noting that the proportion of full-term Wisconsin newborns who were classified as sick doubled in the year that early discharge policies were implemented). The authors suggested the trend was caused by one of two possibilities:

> [E]ither physicians are responding to these [early discharge] policies by classifying more newborns as sick in order to justify having the newborn stay in the hospital for extra time beyond what is allowed by the new discharge policies, or . . . hospitals are classifying these newborns as sick to get the reimbursement from the insurance carriers.

Id. at 34–35.

357. *See id.* at 35. Because premature births account for 6.3% of total births but 48.8% of total hospital delivery charges, Professor Marbella and her colleagues suggest that "[e]fforts to reduce premature births in managed care populations may have a greater impact on controlling medical costs than efforts to discharge full-term deliveries earlier." *Id.* at 34–35.

358. As Professor Uwe Reinhardt has observed:

> Because the incremental costs per in-patient day during the convalescent phase of a hospital stay tend to be relatively low, flat per diems are a truly perverse form of pricing. One seeks to recover with the highest allocation of hospital overhead from precisely those inpatient days that are more discretionary from a clinical perspective and, therefore, are more dispensable from the perspective of a highly price-sensitive payer, such as an HMO. One need not have a doctorate in economics to predict the untoward behavior that this perverse pricing scheme will trigger. In the end, the extraordinarily high price charged for a discretionary patient day will drive even church-going HMO executives to kick new mothers and their babies out of the hospital, because that will save their own HMO $1,000–$1,500 and because, these executives seem to believe, it also will save the nation $1,000–$1,500. Unfortunately, it saves society much less.

Uwe E. Reinhardt, *Spending More Through 'Cost Control:' Our Obsessive Quest to Gut*

standards employed by MCOs in formulating their determinations as to what constitutes medically necessary care may also require further consideration.[359] Yet none of these points detract from the reality that the campaign against drive-through deliveries was fundamentally misguided.

E. What Is the Regulatory Cost?

To this point, the analysis has focused on the financial costs associated with legislating postpartum length of stay. It is also worth noting the regulatory costs associated with such legislation. Legislative and regulatory time and attention are in short supply. It is hard to make the case that a prohibition on drive-through deliveries was the best use of these scarce resources, particularly in light of the absence of empirical evidence indicating there is any benefit from such coverage. Worse still, the whole campaign was a distraction from the far more pressing need to address problems with the overall quality of medical care provided in the United States. The adoption of the "doctor-knows-best" model implicit in the Newborns' Act makes it considerably less likely we will be able to address these quality problems or that we will do so in a meaningful way. As outlined in part IV, these problems developed and flourished because treatment decisions were left almost entirely to the clinical judgment of individual physicians—and the profound irony of the Newborns' Act is that it seeks to return us to those glorious days of yore. The net result of the Newborns' Act is thus the worst of all worlds—a non-solution which misses the real problem and simultaneously makes it less likely the real problem will ever be addressed.

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the Hospital, HEALTH AFF., Summer 1995, at 145, 149.

359. Not surprisingly, MCOs have a predictable incentive to place the burden of proving what constitutes necessary care on those resisting cost-containment—exemplified by the succinct subtitle of an article authored by one managed care executive: "In God we trust, all others bring data." Charles M. Cutler, *Research Needs for Managed Care*, HEALTH AFF., Fall 1996, at 93, 93. Physicians are less than enthusiastic about this approach to clinical practice. *See, e.g.*, Braveman et al., *supra* note 213, at 336 ("We need to reflect on where the burden of proof should be when definitive studies have not been conducted and cannot be conducted quickly if at all, but good judgment based on available knowledge tells us that a service is needed."); Kessel et al., *supra* note 125, at 741 ("The burden of proof should be based on 'first do no harm.' . . . Failing to prove that shorter hospital stays are unsafe (especially in the face of numerous methodological flaws) is not the same as proving they are safe. The latter is what is necessary.").

Of course, the coverage market will quickly look radically different depending on which of these views is adopted. If our goal is to attain "optimal" outcomes, the coverage will be richer and more expensive than it will be if our goal is to cover only cost-justified interventions. *See supra* notes 41–45 and accompanying text.

IV. REGULATING MANAGED CARE: QUALITY OR SYMBOLISM?

The campaign against drive-through deliveries played out an increasingly familiar script. A few horror stories are offered to indicate the problem. Provider groups complain bitterly that MCOs are interfering with their clinical judgment. Blanket claims are made about the declining quality of care delivered by MCOs. Politicians and self-styled consumer advocates emerge to insist that those in managed care should receive the highest quality of care available. One would be hard pressed to conclude that there were any quality problems with American medicine before the arrival of managed care or that the elimination of managed care would not solve everything that is wrong with the quality of American medicine.

In reality, there are longstanding and severe quality problems with American health care that developed and flourished well before managed care appeared on the scene. Although it did not attract much attention, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry recently issued a final report titled *Quality First: Better Health Care for All Americans*.[360] The report notes that American health care is dogged by persistent quality problems relating to overutilization of certain services, underutilization of other services, unexplained variations in service utilization, and errors in health care practice.[361] The report further observed that quality of care is not related to the institutional arrangements through which care is delivered: "Both the best and the worst health care our system has to offer can be found in managed care plans, as it can in traditional fee-for-service (or indemnity) arrangements."[362] As one prominent commentator titled his article in the *Journal of the American Medical Association*, "Managed Care Is Not the Problem, Quality Is."[363]

The extent to which there are fundamental problems with the quality of health care that are attributable to the discretion accorded individual providers is actually quite extraordinary. "Millions of people do not receive care they need and suffer needless

360. *See* PRESIDENT'S COMM'N ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUS., QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS (1998) (Sup. Docs. No. HE 20.6502:Q2/2), *available at* <http://www.hcqualitycommission.gov/final> [hereinafter QUALITY FIRST].

361. *See id.* at 21; *see also* Mark R. Chassin et al., *The Urgent Need to Improve Health Care Quality*, 280 JAMA 1000, 1001 (1998) (noting that "quality problems are serious and extensive").

362. QUALITY FIRST, *supra* note 360, at 21 (citations omitted).

363. Robert H. Brook, *Managed Care Is Not the Problem, Quality Is*, 278 JAMA 1612, 1612 (1997).

complications that add to health care costs and reduce productivity."[364] Almost 20,000 people die every year from heart attacks because they did not receive effective interventions after an earlier heart attack.[365] Millions of Americans also "receive health care services that are unnecessary, increase costs, and often endanger their health."[366] Medical error rates are also unacceptably high and include "missed diagnoses, errors in the interpretation of laboratory or imaging studies, medication administration or prescribing errors, surgical errors, and errors in the care furnished by doctors, nurses, and other health care professionals."[367] Approximately 80,000 deaths per year are attributable to infections acquired in the hospital, and many of these infections are caused by pathogens transmitted by health care workers who have not washed their hands between patients, but compliance with recommended hand-washing practices is quite low.[368] If one were trying to design a healthcare system in which the very training of physicians maximized variability in quality without reference to cost, one would be hard pressed to do a better job than has been accomplished in the United States.[369]

When one considers the Newborns' Act against this backdrop, it suddenly becomes less of a "mom-and-apple-pie" piece of legislation.

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364. QUALITY FIRST, *supra* note 360, at 22.

365. *See id.* Predictably enough, the failure to treat these patients appropriately after a prior heart attack has a distinct regional overlay. Although aspirin was prescribed at hospital discharge for approximately 78% of patients judged ideal for that therapy, prescription rates in individual regions ranged from approximately 52% to 96%. *See* Gerald T. O'Connor et al., *Geographic Variation in the Treatment of Acute Myocardial Infarction: The Cooperative Cardiovascular Project*, 281 JAMA 627, 630–31 (1999). More extreme distributional patterns were observed for two other drugs, Beta blockers and ACE inhibiting agents. Beta blockers were prescribed to approximately 50% of patients judged ideal for this treatment, but prescription rates in individual regions ranged from 0% to 92.7%. *See id.* at 631. ACE inhibiting agents were prescribed to approximately 60% of patients judged ideal for this treatment, but prescription rates in individual regions ranged from 6.7% to 100%. *See id.*

366. QUALITY FIRST, *supra* note 360, at 22.

367. *Id.* at 23.

368. *See* John M. Boyce, Editorial, *It Is Time for Action: Improving Hand Hygiene in Hospitals*, 130 ANNALS INTERNAL MED. 153, 153 (1999).

369. As one prominent commentator has noted:

> [F]rom the beginning when we educate medical students, we segregate out those medical students who are good from those who are poor. We select the students who are good to receive their residency training in those institutions with the best supervision by the most sophisticated physicians. We send less good students to those institutions that provide lower levels of supervision. The above policies do not reflect a concern over reducing future variations in practice. Then we wonder 10 years later why there is so much variation in quality of care as a function of an individual physician or an individual hospital.

Brook, *supra* note 363, at 1613.

Bluntly stated, if there are quality problems with American medicine that are attributable to the unconstrained discretion of physicians, why on earth would one try to solve these problems by mandating the coverage of more hours of such care? Wouldn't it make more sense to directly address the quality of care that is provided, whether within the hospital or without? To be sure, Congress is under no obligation to tackle problems in any particular order, but there are reasons to wonder about a reform strategy that ignores the overwhelming evidence of quality-based problems with most of American medicine and focuses instead on an area in which the evidence for quality-based problems is hardly colorable. Moreover, by embracing a "reform" based on the sanctity of physician discretion, the Newborns' Act makes it much more difficult to address the quality-based problems with American medicine, which, in fact, often *are* attributable to the unconstrained discretion accorded physicians.

Unfortunately, the Newborns' Act is not an aberration. The backlash against managed care may have been sold to the public as a response to concerns about quality, but the legislation that has emerged has more to do with provider lobbying, "gut instincts, negative anecdotes, and popular appeal" than with quality.[370] Indeed, the unfortunate reality is that quality has been used as a stalking horse by provider groups who are disguising less public spirited objectives.[371] For obvious reasons, health care providers prefer a return to the days of unconstrained discretion and professional dominance. Sweeping assertions that managed care has destroyed the quality of American medicine dovetail nicely with that objective.[372]

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370. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 4 (quoting Hyman, *Consumer Protection*, *supra* note 3, at 425–26).

371. *See id.*

372. Such conduct is hardly unique to the medical profession. For example, the staffing of railroad trains is dictated by "crew consist" agreements between the railroad and the unions. *See* Douglas M. McCabe, *Current Strategic Issues in Transportation Labor-Management Relations and Human-Resources Management: The Crew Consist Issue Revisited*, 55 TRANSP. PRAC. J. 54, 54 (1987). The negotiation of these agreements is frequently contentious; one commentator has described the issue as "the most explosive labor dispute at the operating level of individual railroads." *Id.* When the railroads succeeded in changing the crew consist agreements to their satisfaction, one of the affected unions persuaded the State of Wisconsin that safety reasons justified the enactment of legislation requiring the presence of an additional person on trains operated within the state:

> Calling it the "The United Transportation Union Bill," Wisconsin Gov. Tommy G. Thompson signed into law Monday, Dec. 15, a landmark rail safety bill requiring two persons in all railroad operations in the state. Wisconsin becomes the first state in the country with such a law to promote rail safety. The new law requires a certified railroad locomotive engineer and a qualified railroad

Legislators have been quick to take the bait; the consumer protection legislation that was offered by both Republicans and Democrats in the 106th Congress demonstrated an overwhelming preference for safeguarding physician decision-making from MCO interference.[373] An extended postpartum stay appears to be "just what the doctor ordered"—but to a first, second, and third approximation, such stays are for the providers' benefit—not the patient.[374]

V. WHO WON WHAT FROM THE NEWBORNS' ACT?

Post-enactment assessment of the Newborns' Act has been marked by a tone of decided self-congratulation. The Newborns' Act is invariably presented as a self-evident victory for consumers in general and women in particular. The Newborns' Act was just "common sense,"[375] and it made it clear to MCOs that they are required to behave in a socially responsible fashion.[376]

Unfortunately, as outlined previously, this glowing picture bears no relationship to reality. The Newborns' Act is a remarkably silly piece of legislation. From an economic perspective, the law effectively requires MCOs and insurers to spend money on hospital stays that do not appear to provide any clear benefit—let alone benefits in excess of the costs. The law also constrains the ability of MCOs and insurers to arrange for post-discharge care that does, in fact, provide a benefit well in excess of its costs. From an autonomy/liberty perspective, the law effectively prohibits the parties

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trainman on every railroad train or locomotive operating in the state. "It just makes common sense to have two people on a train," said Thompson.

United Transp. Union, *Wisconsin Governor Signs "UTU BILL" for Rail Safety*, (last modified Jan. 4, 1999) <http://www.utu.org/DEPTS/PR-DEPT/NEWS/NEWS97/2-BILL.HTM>.

Rail safety statutes of this sort were common earlier in this century. *See generally* Douglas M. McCabe, *The Crew Consist Dispute in the Railroad Industry: Developments in Transportation Labor Relations and Public Policy*, 52 TRANSP. PRAC. J. 370, 374–75 (1985) ("By 1959, sixteen states had 'full crew laws' and seven others empowered their public utilities commissions to regulate crew consists."). As with the Newborns' Act, no evidence was offered indicating that train wrecks were more frequent or more severe when there was only one person operating the train. *See id.* Instead, "common sense" was all that was required.

373. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 10–15.

374. Cowley & Springen, *supra* note 1, at 65. "Politically, the act was just what the doctor ordered." *Id.*

375. *See* 142 CONG. REC. S9904 (daily ed. Sept. 5, 1996) (Sup. Docs. No. x1.1/A:142/121) (statement of Sen. Bradley).

376. *See* Annas, *supra* note 289, at 1650 ("The symbolic legislative initiatives on the length of hospital stay after childbirth ... are a shot across the bow of marketplace medicine.").

to an insurance contract from making the coverage arrangements they find most beneficial. From a feminist perspective,[377] the Newborns' Act infantilizes women by allocating decision-making authority to the attending provider and precluding any and all incremental payments from the insurer to the mother in exchange for an early discharge.[378]

The law also does nothing to address the quality of care rendered during the postpartum hospitalization, nor does it encourage the development of better systems (or any systems for that matter) for delivering post-discharge postpartum care. Indeed, the Newborns' Act largely destroys the incentive to develop such systems.[379] Worse still, even if an MCO is willing to develop a system for delivering post-discharge postpartum care, it must demonstrate that the post-discharge visit replicates the services that would have been offered in the hospital—even if women would prefer a different package of services or if a different package of services would be more cost-effective.[380] This implicit legislative bias is particularly problematic because many physicians are unenthusiastic about the development of post-discharge services to begin with.[381]

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377. Admittedly, there is more than one feminist perspective. For a concise review of the varying camps within feminism, see Nancy E. Shurtz, *Gender Equity and Tax Policy: The Theory of "Taxing Men,"* 6 S. CAL. REV. L. & WOMEN'S STUD. 485, 488 n.7 (1998). The critique presented in this Article is based on an equality-feminist perspective.

378. *See* Sheryl Gay Stolberg, *Many Women Wary of Congress's Newfound Interest in Female Health Issues*, N.Y. TIMES, May 26, 1997, at A9 (noting a "sense of paternalism" in Congress with regard to women's health issues). By prohibiting incremental payments or services, the Newborns' Act prevents mothers from contracting out of extended coverage in exchange for something they might value more highly than an extra few hours in the hospital—whether that something is a visit from a nurse, nanny, or lactation consultant, a car seat, or cash.

379. *See* Mariel Garza, *The 48 Hour Fix*, REASON, Feb. 1999, at 52, 52.

> [The Newborns' Act] has made it tougher . . . to convince health plans that [post-discharge] care is important, even though, on average, it takes only one low-cost home visit to determine if the baby is off to a good start. Suddenly, all a health plan had to do to be a good guy was to let women stay in the hospital for two days after delivery. "They think, 'We've met the letter of the law and we don't have to do anything now' " . . . .

Id. (quoting Lucinda Williams, co-founder of Professional Nurse Associates).

380. *See* Newborns' Regulations, *supra* note 110, at 57,548. The regulations noted that the Newborns' Act prohibits payments in cash or in kind to encourage early discharge, but stated that

> a plan or issuer does not violate this prohibition by providing after-discharge, follow-up services to a mother and newborn discharged early if those services are not more than what the mother and newborn would have received if they had stayed in the hospital the full 48 hours (or 96 hours).

Id.

381. *See* Braveman, *supra* note 220, at 524 (explaining that "most physicians have viewed home-based care as the province of nurses, and may be less than enthusiastic about incorporating postpartum nurse home visiting into their routine practice if they see it as a

The principal beneficiaries of the campaign against drive-through deliveries are physicians, who have successfully regained a degree of professional discretion and the ability to dictate at least some of the terms of trade.[382] They have used the campaign against drive-through deliveries as a model for further anecdote-driven anti-managed care efforts[383] and the Newborns' Act as a precedent for additional

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threat to their role or income").

382. At first glance, it might appear that hospitals necessarily benefited from the Newborns' Act because they are effectively ensured a continuing volume of postpartum hospitalizations of a more predictable length. *See* Olmos, *supra* note 298, at A1 (noting that the prohibition on drive-through deliveries has allowed some hospitals "to fill empty beds or open wards previously taken out of service"). In fact, many hospitals have faced significant dislocations as a result of the Newborns' Act. As one group of commentators noted:

> [A]n unanticipated consequence of early discharge legislation has put some hospitals in a difficult position. In a number of cases, hospitals have significantly reshaped their maternity wings by constructing labor, delivery, recovery and postpartum rooms (LDRPs), which are the only rooms a mother uses while in the hospital for maternity care. LDRPs are more expensive to construct and maintain than traditional hospital rooms, but with 24- to 48-hour stays, their occupancy turns over so often that they become economically feasible and also serve as a valuable marketing tool for hospitals. Doubling the length of stay has put great pressure on maternity areas to find space for all the mothers.

Declercq & Simmes, *supra* note 18, at 187; *see also* Ryan, *supra* note 116, at 288 (noting that the increased length of postpartum stay has resulted in overcrowding, so hospitals no longer offers private rooms); Julia Prodis, *2-Day Stay Wins Praise of Doctors, Mothers*, COM. APPEAL (Memphis), Sept. 29, 1996, at 5A ("Most hospitals should be able to accommodate longer stays without causing crowding, although some hospitals that scaled back their maternity wards over the past few years because of the shorter stays probably will have to expand.").

383. *See* Hyman, *Consumer Protection*, *supra* note 3, at 426–40.

> Almost any discussion of consumer protection and managed care results in some anecdotes about a terrible outcome that could have been averted had the MCO only authorized a visit to the ED .... Empirical data on the severity of the problem was sketchy at best, but the American College of Emergency Physicians ("ACEP") used a number of horrific anecdotes to argue that access to the ED had to be safeguarded with consumer protection laws.

Id.; *see also* Hyman, *Regulating Managed Care*, *supra* note 6, at 8–12 (recounting various episodes in which self-interested provider groups circulated bad anecdotes to promote their regulatory agendas).

Perhaps the supreme irony of the campaign against managed care is that it has caused physicians to embrace proof-by-anecdote—even though the systematic rejection of this sort of proof is the foundation of modern medicine. *See* Gina Kolata, *On Fringes of Health Care, Untested Therapies Thrive*, N.Y. TIMES, June 17, 1996, at A1 (noting that scientists and medical researchers reject alternative medicine because of its anecdotal basis). If the history of medicine and attempts to enact tort reform are any guide, skepticism about anecdotal evidence is well founded. *See supra* note 288; Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?*, 140 U. PA. L. REV. 1147, 1159–61 (1992). Saks observed that:

> [A]necdotal evidence is heavily discounted in most fields, and for a perfectly good reason: such evidence permits only the loosest and weakest inferences

restrictions on the market power of MCOs.[384] Ironically, what was sold to the public as "consumer protection" turns out to be provider protection.[385]

Of course, politicians also benefited from the passage of the Newborns' Act and analogous state legislation. By voting in favor of such laws, state and federal politicians symbolically demonstrated that they were in favor of motherhood and opposed to the restrictions imposed by managed care—positions that coincided with voter sentiments and concerns. At the federal level, it seems likely that this effect was magnified by the reality that many in Congress were facing the voters for the first time after two government shutdowns. By using the legislation as a proxy for a variety of issues raised by the growth of managed care and by excluding the populations which would result in on-budget costs, legislators positioned themselves as guardians of the public interest and did so at someone else's expense.

The only real lesson of the Newborns' Act appears to be that we want MCOs to cut costs in ways that are less visible—hardly an ideal incentive, all things considered. Indeed, the potential for overly vigorous cost-containment by MCOs is such that it is far more sensible to encourage MCOs to cut costs in a manner that is open and obvious.[386] Unfortunately, the Newborns' Act creates precisely the wrong incentives, because it signals that overly transparent cost-cutting will result in a legislative backlash. As such, cost-cutting which is well hidden will not be questioned. The Newborns' Act may have stemmed the tide of short postpartum stays, but it undermines the very goal of quality managed care at an affordable price at which it was ostensibly aimed.

> about matters a field is trying to understand. Anecdotes do not permit one to determine either the frequency of occurrence of something or its causes and effects .... Anecdotes have the power to mislead us into thinking we know things that anecdotes simply cannot teach us.

Id.

384. *See supra* note 117 and accompanying text; *infra* note 402 and accompanying text.

385. *See supra* note 16 and accompanying text.

386. *See* Gail B. Agrawal, *Chicago Hope Meets the Chicago School*, 96 MICH. L. REV. 1793, 1812–14 (1998) (noting arguments that the moral legitimacy of managed care depends on the ex ante agreement to contain costs, but suggesting that the choice of insurance product is not necessarily indicative of such an agreement, especially in light of marketing efforts of MCOs); Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. (forthcoming November 1999) (arguing that MCOs have an incentive to cheat on quality given the nature of the health insurance coverage market and that legislation may well make sense as a way of addressing the problem).

VI. A NARRATIVE PERSPECTIVE

For those who prefer narrative scholarship, I offer a story.[387] Once upon a time, there was a group of professional providers. These providers had considerable discretion in how they did their jobs. Because the providers frequently were called upon to make fine distinctions involving matters of life and death, they underwent years of post-graduate training and were carefully selected on the strength of their intellect, educational achievement, and the like. For many years, the providers had been allowed to exercise their best judgment as they saw fit, without much external oversight.

Unfortunately, empirical studies revealed that there was a considerable degree of variation among providers in how they handled similar cases, including variation in the length of stay at treatment facilities. The providers insisted that there were good reasons for the variation and argued that the country was better off if each provider was left free to exercise his discretion to the best of his (considerable) abilities. All complaints were dismissed with the observation that only providers were competent to judge one another's efforts, and that the public should continue to allow providers to exercise their discretion, pay for the results, and be satisfied that the providers were "doing the right thing."

Those footing the bill finally grew impatient with the intransigence of the providers and decided that the best way to systematize provider behavior was to eliminate their discretion in many cases. Accordingly, after several years of study, they introduced guidelines specifying the appropriate length of treatment for a wide variety of cases. Some flexibility was maintained by providing for variation in cases that were considerably more or less severe than normal, but providers still found their professional

387. Narrative scholarship has been booming, despite criticisms of its typicality and truthfulness. *See generally* Hyman, *Lies*, *supra* note 23, *passim* (using the Emergency Medical Treatment Active Labor Act as a vehicle for considering the effects of narrative on legislative action). Those who are uncomfortable with the application of fables and metaphorical imagery to sensitive issues like health care have not been paying attention to the literature. *See, e.g.*, Memorial Hosp. v. Maricopa County, 415 U.S. 250 app. at 274–76 (1973) (Douglas, J., concurring) (employing the fable of the people of Gourmand, who devoted all of their resources to increasingly fine restaurants, to illustrate the difficult economic issues raised by medical care); Uwe E. Reinhardt, *Review*, 13 J. HEALTH POL. POL'Y & L. 182, 182–84 (1988) (using the metaphor of changing a light bulb to explain different systems of health care organization and financing); Uwe E. Reinhardt, *That'll Be $135 for Your First Lecture*, WASH. POST, Apr. 26, 1988, at Health Insert 20 (providing a narrative account of how higher education would be priced if it followed the health care model).

discretion sharply constrained.

Needless to say, the providers were less than thrilled with this development and resisted it mightily. Some quit, arguing that the degree of discretion given to providers was what had attracted them to the job in the first place and that they were unwilling to continue if they could not exercise that discretion. Others argued that the guidelines simply were wrong because the specified treatments reflected a poor balancing of costs and benefits. Still others claimed that those drafting the guidelines had no business meddling in such matters because they lacked the required expertise. Others argued that it was simply impossible to arrive at rational guidelines because each and every case was unique and needed to be handled as such. Using these arguments, the providers steadfastly resisted the guidelines. After the providers won some of the preliminary skirmishes, legal action ultimately vindicated the right of those paying the bills to constrain the discretion of the providers.

The narrative bears a striking resemblance to the debate over drive-through deliveries, with the single exception that the providers lost on all counts in the narrative, but have done considerably better with drive-through deliveries. It is tempting to dismiss the narrative as a work of fiction, designed simply to make a larger point about the relative indeterminacy of professional judgment and the tradeoffs between uniformity and professional discretion. That facile interpretation is insufficient; the narrative is not a work of fiction, but is instead an accurate rendition of the circumstances surrounding the drafting and implementation of the federal sentencing guidelines.[388] The sentencing guidelines changed the world of criminal justice "[f]rom an indeterminate sentencing system under which judges were given broad authority to decide whether an offender would be incarcerated and for how long . . . to a binding sentencing guideline

388. *See* Gregory C. Sisk et al., *Charting the Influences on the Judicial Mind: An Empirical Study of Judicial Reasoning*, 73 N.Y.U. L. REV. 1377, 1381–82 (1998). Of course, the debate over the degree to which we wish to confer discretion on judges (and regulators) is not unique to the sentencing guidelines context. For example, legislatures have striven to bring greater uniformity to family law, particularly in the area of custody and support arrangements, by enacting certain presumptions. *See* Carl E. Schneider, *Discretion, Rules and Law: Child Custody and the UMDA's Best-Interest Standard*, 89 MICH. L. REV. 2215, 2264–82 (1991) (analyzing the costs and benefits of legislative intervention, in the form of statutory presumptions, into child custody decisions). Depending on the issue and the perspective of those commenting, these interventions into the discretion of those involved are either presented as appropriately constraining the unbridled discretion of unaccountable judges and regulators, or unnecessary intrusions reflecting a mix of legislative bias and ignorance.

regime that substantially restrains judicial discretion."[389] After criminal defendants challenged the guidelines on a variety of constitutional grounds, a clear majority of the 300 federal district judges who ruled on the issue struck down the sentencing guidelines.[390] The Supreme Court ultimately upheld the validity of the guidelines,[391] but many judges remain deeply unhappy that their sentencing discretion has been constrained by "bureaucratic penalization."[392] One judge has resigned in protest, and two senior judges refuse to impose sentences in drug cases.[393] Judges who serve on the United States Sentencing Commission reportedly are viewed as traitors by many of their colleagues.[394] Judge Cabranes has condemned the guidelines as "a byzantine system of rules" that "ignore individual characteristics of defendants and sacrifice comprehensibility and common sense on the altar of pseudoscientific uniformity."[395] Recently, Justice Breyer, "an architect and longtime supporter of the Federal Sentencing Guidelines, issued a detailed critique ... and called for Federal judges to regain some of their traditional discretion to make the punishment fit the crime."[396]

Yet, the sentencing guidelines remain the order of the day in

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389. Sisk et al., *supra* note 388, at 1377.

390. *See id.* at 1403 (noting that approximately 61% of the federal district and appellate court judges who considered a constitutional challenge to the sentencing guidelines struck them down).

391. *See* Mistretta v. United States, 488 U.S. 361, 412 (1989).

392. Kate Stith & Jose A. Cabranes, *Judging Under the Federal Sentencing Guidelines*, 91 NW. U. L. REV. 1247, 1254 (1997); *see also* Henry J. Reske, *Judges Irked by Tough-on-Crime Laws*, A.B.A. J., Oct. 1994, at 18, 18 (finding that more than 50% of district judges support elimination of the sentencing guidelines).

393. *See Criticizing Sentencing Rules, U.S. Judge Resigns*, N.Y. TIMES, Sept. 30, 1990, at A22; Saundra Torry, *Some Federal Judges Just Say No to Drug Cases*, WASH. POST, May 17, 1993, at F7; Saundra Torry, *Some Judges Decide a Lifetime on the Federal Bench Is Too Long*, WASH. POST, Jan. 20, 1992, at Washington Business Insert 5. The *Washington Post* Business Insert article notes that:

> Former U.S. District Judge Jay Lawrence Irving of San Diego quit Dec. 31, 1990, in what he now calls "a kind of protest" over the lack of discretion and the "outrageous" penalties he was forced to impose, particularly on youthful, first-time defendants. Raul Ramirez, who quit at 45 after a decade on the bench in Sacramento, said the guidelines turned judges into "nothing more than computers wearing robes."

Torry, *supra*, at 5.

394. *See* Naftali Benavid, *Breyer's Role as Sentencing Pioneer Still Rankles*, LEGAL TIMES, May 16, 1994, at 7 ("Many judges regard as a traitor any colleague who serves on the U.S. Sentencing Commission....").

395. Jose A. Cabranes, Letter to the Editor, *Incoherent Sentencing Guidelines*, WALL ST. J., Aug. 28, 1992, at A11.

396. Linda Greenhouse, *Guidelines on Sentencing Are Flawed, Justice Says*, N.Y. TIMES, Nov. 21, 1998, at A12.

federal courts throughout the land, while health care providers have conversely persuaded Congress to let them dictate the terms of trade—at least when it comes to postpartum care. The only conclusion I can reach is that our society trusts physicians more than it trusts federal judges, although it is the latter who have life tenure,[397] and the former whose misdeeds are maintained in a national databank.[398] Go figure.

CONCLUSION

The anecdotes that led Congress and a majority of states to prohibit drive-through deliveries were heartbreaking, but extraordinarily unrepresentative. As such, they provide further proof that isolated observations do not provide a sound basis for legislation—or much of anything else. Focusing on the "bad-outcomes" anecdotal numerator, without factoring in the "millions-of-successful-deliveries-at-lower-cost" empirical denominator, is a recipe for public policies that are either silly or symbolic—and usually both.[399] When bad anecdotes are combined with romantic notions about the way health care should be delivered in a perfect world, the only certainty is that consumers will end up paying more.

The "consumer protection" law described in this article involves helpless babies and sympathetic postpartum mothers, but the depth

397. U.S. CONST. art. III, § 1 ("The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour . . . .").

398. The National Practitioner Databank contains records on malpractice settlements and disciplinary actions undertaken against physicians. It is not available to the public, but hospitals are required to check it when they grant admitting privileges and thereafter on a biannual basis. *See* 42 U.S.C. § 11135 (1994). Some of this information is also available from private vendors. *See* Medi-Net, <http://www.askmedi.com> (offering information on individual physicians, including "records of sanctions or disciplinary actions taken against a physician's license, if any, from all states" for $12.50 each).

399. Professor Korobkin has argued that consumer protection legislation is a sensible way of handling a number of specific imperfections in the market for health care coverage, including bounded rationality and principal-agent problems. *See* Korobkin, *supra* note 388, *passim*. Because I have responded to Professor Korobkin's arguments in another article, *see* Hyman, *Regulating Managed Care*, *supra* note 6, at 16–36, and because the institutional choice issues raised in his article go well beyond the scope of this Article, I have not addressed the more general question of whether markets or regulation provide the second-best solution across the universe of consumer protection against managed care.

It is worth noting that symbolic blackmail aside, any issue that is significant enough to catch the attention of the legislature is also the kind of issue that is likely to be addressed by normal market forces. More importantly for purposes of the issue of drive-through deliveries, Professor Korobkin analyzes the problem of consumer protection against managed care on a purely theoretical level and correctly observes that each consumer protection initiative must be assessed individually to determine whether it is necessary and appropriate.

and sincerity of our feelings about a subject are no guarantee that a good law or wise policy will result. Indeed, such issues are particularly prone to legislative posturing and opportunistic overreaching, regardless of the actual significance of the "reform."[400] Legislation of this sort is also exceedingly difficult to repeal.[401] Once legislators start down this crowd-pleasing path, there is no telling where they will end up.[402]

More generally, calling something "consumer protection" does not make it so. Even when there is some incremental consumer benefit, it is often not worth the resulting dislocation, cost, and loss of flexibility. When legislators faced even a portion of the costs of their decisions, their principled opposition to drive-through deliveries suddenly developed some interesting (and quite large) loopholes. Equally importantly, the decisions and tradeoffs made by individual citizens are often quite different than the ones the legislators make on their behalf, even when the legislators behave themselves—and they do not always do so.

Of course, one could still argue that the government should get to decide such matters because it is not subject to the same economic constraints and conflicts of interest as the insurer/MCO.[403] Even if

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400. *See* Kassirer, *supra* note 13, at 1747.

> Not only are complexity, lack of context, and expertise an issue, but legislators frequently respond politically to the emotional appeals of their constituents. (How could health-maintenance organizations insist on sending tired-out moms home in 24 hours? . . .) This is decision making by emotional and opportunistic consensus, not by studied, thoughtful reasoning based on evidence.

Id.

401. The Newborns' Act directs the President to create a commission to report on the continued need for the statute. Congress did not see fit to wait for that commission to report, nor were they willing to "sunset" the provisions of the Newborns' Act. *See* S. REP. NO. 104-326, at 6 (1995) (Sup. Docs. No. Y1.1/5:104-326). Congress's failure to sunset the Newborns' Act means that we are almost certainly stuck with extended postpartum stays for the foreseeable future. *See* John P. Dwyer, *The Pathology of Symbolic Legislation*, 17 ECOLOGY L. Q. 233, 287 (1990) ("Once Congress has taken the position that public health must be protected at any cost, it is difficult for the legislature to adopt a more moderate position. Position-taking by other legislators and charges of trading lives for dollars will deter many legislators from supporting such amendments.").

402. *See* Peter Passell, *When Politicians Seek to Please on Medical Benefits*, N.Y. TIMES, Oct. 10, 1996, at D2. Passell concludes:

> Legislating a two-day minimum maternity stay will raise health insurance costs by just a fraction of 1 percent. The real danger here is the precedent in an era of tight government budgets. Elected officials who cannot please constituents with additional spending or tax cuts still have the option of currying favor by mandating private benefits. As long as there is a plausible rationale along with emotional appeal, minimum-benefit creep will be hard to resist.

Id.

403. *See* Annas, *supra* note 287, at 1649 ("Because the market has no inherent

one concedes the premise of this argument and ignores the inherent problems associated with the aggregation of consumer preferences (whether at the state or federal levels), it is precisely because governmental agents are likely to be relatively indifferent to cost (so long as they are not footing it as an on-budget expense) that we should be skeptical about their fidelity to the real interests of their principals. Scarcity is a fundamental reality of human existence, and "those for whom price is no object are never those who ultimately foot the bill."[404]

Alternatively, the Newborns' Act could be viewed as a sub-optimal law that is justified by the defusing of a far more destructive backlash against managed care.[405] Although there are many laws which could conceivably be explained by this phenomenon, the Newborns' Act is not one of them. Indeed, the Newborns' Act inflamed the backlash against managed care and provided a template for further regulations.[406]

Finally, it is worth noting that policy considerations of this sort are not unique to the regulation of managed care. Consider the problem of the IRS's pursuit of "innocent spouses," which has occupied Congress and the Clinton administration of late. Taxpayers who sign a return are jointly and severally liable for any deficiency, so the IRS is free to pursue either individual for any unpaid taxes, even if the couple divorces.[407] The law allows "innocent spouses" to escape responsibility for these deficiencies if they satisfy a series of

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morality, whenever the market is used to produce and distribute goods and services, government regulation is required to protect the welfare of both workers and consumers."). Alternatively, one could rely on one's health care provider to fulfill this role.

404. Hyman, *Consumer Protection*, *supra* note 3, at 456.

405. *See* Mark J. Roe, *Backlash*, 98 COLUM. L. REV. 217, 217 (1998) (noting the phenomenon of government "strategically tempering otherwise efficient rules and institutions to finesse away a more destructive backlash").

One difficulty with Professor Roe's analysis is that it is fundamentally non-falsifiable. One can not distinguish between a legislature that passes an inefficient law because it does not know the difference or has been captured and a legislature that is "strategically tempering otherwise efficient rules and institutions to finesse away a more destructive backlash." *Id.*

406. *See supra* note 117 and accompanying text; *see also* Hospital Length of Stay Act of 1999, H.R. 989, 106th Cong. (1999) (requiring insurers and employee benefit plans to "provide coverage for the length of an inpatient hospital stay determined by the attending physician . . . in consultation with the patient to be medically appropriate").

407. *See* I.R.C. § 6013(a) (1994). Joint and several liability has the obvious administrative advantage of providing two people from whom the IRS can seek to collect, instead of just one.

exceedingly strict standards.[408] The IRS has aggressively litigated such cases, and frequently pursues ex-wives for tax deficiencies attributable to returns prepared by their ex-husbands. The narrative accounts of the legal, financial, and emotional costs imposed on these women are truly awful.[409]

Various solutions to this problem have been suggested, including incremental tinkering with the innocent spouse provisions, abolishing joint returns, and retaining joint returns but adopting proportional liability for any deficiency.[410] Congress was keen to undertake fundamental reform of this area, although the House and Senate differed on whether to tinker with the existing provisions (House) or adopt proportional liability (Senate).[411] The statute emerged from the Conference Committee as a hybrid of both approaches.[412]

Despite its deserved reputation for sensitivity to women's issues, the Clinton administration was lukewarm on incremental reform, vehemently opposed proportional liability, and flatly rejected the elimination of joint returns.[413] The administration's Assistant Secretary for Tax Policy, Donald C. Lubick, has publicly taken a remarkably tough-minded statistical view of the problem:

> Lubick was also critical of reform proposals which have tended to focus on the needs of very small groups of taxpayers. In this regard, he said that the administration cannot support various plans extending relief to "innocent spouses." While many of their problems are compelling,

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408. *See id.* § 6013(e). By common consensus, the innocent spouse provisions are too strict in that some spouses who did not know of the unreported income and did not benefit from it can still be held liable for the taxes. *See* Richard C.E. Beck, *The Innocent Spouse Problem: Joint and Several Liability for Income Taxes Should Be Repealed*, 43 VAND. L. REV. 317 (1990); Jerome Borison, *Innocent Spouse Relief: A Call for Legislative and Judicial Liberalization*, 40 TAX LAW. 819 (1987); Stephen A. Zorn, *Innocent Spouses, Reasonable Women and Divorce: The Gap Between Reality and the Internal Revenue Code*, 3 MICH. J. GENDER & L. 421 (1996); Toni Robinson & Mary Ferrari, *The New Innocent Spouse Provision: 'Reason and Law Walking Hand in Hand'?*, TAX NOTES, Aug. 17, 1998, at 835.

409. *See, e.g., Proposals to Reform the Innocent Spouse Tax Rules: Hearings Before the Senate Committee on Finance*, 98 TAX NOTES TODAY 32-23 *passim* (1998) (reporting four women's emotional testimony before the Senate Committee on Finance describing the IRS' efforts to make them pay for their former spouses' tax debt).

410. Academics, the American Bar Association, the American Institute of Certified Public Accountants, and the New York State Bar Association have favored either proportional liability or the elimination of joint filing status. *See* Robinson & Ferrari, *supra* note 408, at 841–42.

411. *See id.* at 843–44.

412. *See* I.R.C.. § 6015 (West. Supp. 1999); Robinson & Ferrari, *supra* note 408, at 844–45.

413. *See* Robinson & Ferrari, *supra* note 408, at 838.

> Lubick said the number of innocent spouses is too small to reorganize the code under a proportional liability scheme. He noted that a recent General Accounting Office study indicated that of the 49 million joint returns filed, there were only 35,000 situations in which a divorced couple was assessed more than $500 by the Internal Revenue Service. Assuming that a spouse was actually innocent in half of those situations, Lubick questioned the wisdom of reforming the code for the benefit of only 17,000 taxpayers.[414]

Thus, the position of one prominent member of the administration is that "the fix for dealing with 17,000 of 49 million cases seems inordinately costly."[415]

There are many parallels between drive-through deliveries and the innocent spouse provisions. Both involve vulnerable and sympathetic groups who feel they have been victimized by impersonal forces beyond their control. Both involve a small number of really bad outcomes (which may or may not be attributable to the existing rules), mixed in among a far larger population for which the existing rules seem to work out just fine. Both involve a problem that can be fixed with legislative action, but at a significant cost. In both cases, Congress was outraged about the status quo. In one case, however, the Clinton administration eagerly embraced the proposed reform, and in the other, it did its best to shoot it down. It would be nice if there were some principled distinction between the two cases, but the disparity in the handling of these issues has more to do with whether the costs of reform fall on-budget or off-budget than with the merits of the issues.

What then should have been done about drive-through deliveries?[416] Doing nothing is an underappreciated strategy. Perhaps longer postpartum stays are a good idea, and perhaps they

414. *Id.* at 841 n.71.

415. *Id.*

416. The more general questions raised by the regulation of managed care, the complexities created by the aggregation of consumer preferences, the separation of the ultimate consumer (patient) from the more immediate payor (insurer/employer), and the linkage between insurance coverage and employment are beyond the scope of this Article. In a series of other articles, I have addressed these points. *See* Hyman, *With Friends Like These*, *supra* note 9; Hyman, *Consumer Protection*, *supra* note 3; Hyman, *Regulating Managed Care*, *supra* note 6; Hyman, *Scenes from a Maul*, *supra* note 6. If the Newborns' Act is any indication, and my analysis of a wide range of consumer protection initiatives convinces me it is quite representative, these problems are unlikely to be addressed effectively—let alone solved in anything close to an optimal fashion—by detailed regulations specifying the nature of acceptable treatments and minimum insurance coverage standards. The understandable instinct to regulate should be tempered by the realities of the legislative arena. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 3.

can be done cost-effectively. Perhaps shorter postpartum stays with a follow-up visit from a nurse are a better solution, all things considered. Perhaps hospitals should abandon per diem pricing and adopt a more rational system of charging for their services. Perhaps there are alternative uses for our health insurance premiums that are more beneficial in promoting health, even if they are less loaded with symbolic appeal. Perhaps insurance companies should just stay out of the middle, specify a sum certain they are willing to pay for deliveries, and let patients shop for the birthing experiences (whether inpatient, birthing center, outpatient, or home) they want. Perhaps a "virtuous" HMO or contingent fee arrangement can solve these problems.

No law prevents those involved from employing some or all of these strategies. Prior to the Newborns' Act, some hospitals had started offering *prix fixe* postpartum stays,[417] and since the Newborns' Act, some insurers have started compensating hospitals on a flat-rate basis.[418] Prior to the Newborns' Act, many MCOs and hospitals offered a visiting nurse or some other post-discharge arrangement if the patient stayed for less than forty-eight hours postpartum,[419] although a number of these programs were discontinued once the Newborns' Act effectively forced MCOs to pay for forty-eight or ninety-six hours of postpartum coverage.[420] A number of MCOs have

417. *See* Kuper, *supra* note 59, at 684–86 (cataloging hospitals promising to provide a "free" second day); Seaman, *supra* note 59, at 511 n.128 (same); Smith & Karash, *supra* note 155, at B1 (same); Stephanie L. Stein, *Challenge to HMO's Maternity Limits*, N.Y. TIMES, Jan. 14, 1996, at 13LI9 (noting new policies at several hospitals to guarantee postpartum women stay of at least 48 hours regardless of the amount paid by the insurer).

418. After New Jersey enacted its legislation, a number of insurers responded by setting a flat rate they would pay for each delivery. *See* Ryan, *supra* note 116, at 280. Legislators were outraged and suggested that this conduct should not be allowed. *See id.* One wonders what they were expecting to happen.

Another commentator has decried the growth of such flat fee arrangements, and argued that without a per diem guarantee, hospitals "are likely to pressure mothers into early discharge or suffer the financial impact of lost revenues." Veronica D. Feeg, *The Bittersweet Maternal Health Policy Victory*, 22 PEDIATRIC NURSING 366, 366 (1996).

419. *See* GAO REPORT, *supra* note 82, at 13–16.

420. As the report prepared by the GAO reflects:

> Medical staff at one New Jersey HMO told us patients have learned they can extend their stay (to slightly less than 48 hours) and still receive a follow-up visit at home. According to the staff, the law has significantly increased the HMO's expenses because it must cover a slightly extended in-patient stay as well as the costs associated with home visits. As a result, they are concerned that they may have to implement the 48-hour minimum stay and discontinue their home visit program.

Id. at 16; *see also* Egerter et al., *supra* note 249, at 479 ("Some have warned that legislation requiring that insurers cover either a minimum 48-hour stay or compensatory follow-up after shorter stays will result in more newborns and mothers being discharged at 48 hours without any clinical evaluation on the important third and fourth postpartum days.");

promised to be particularly virtuous with regard to such matters.[421]

It is quite clear that many health care providers are unhappy with the growth of managed care and their concomitant loss of autonomy and income. Not surprisingly, they have used a variety of strategies (including what is usually, but incorrectly, labeled "consumer protection" legislation) in their efforts to maintain the old order. Such efforts obscure the necessary choices, but do not eliminate them; bad decisions are the inevitable result because some of the relevant considerations and choices have been declared off-limits.

Where then should we go from here? Although some commentators have suggested that the prohibition on drive-through deliveries presents a model for the future aggressive regulation of managed care,[422] a more common assessment is that "legislation by body part" is unlikely to lead to beneficial results and that a more "holistic" approach is required.[423] It is clear that "legislation by body part" is a strategy doomed to failure because the correlation between symbolic appeal and practical utility (let alone the legislature's ability or willingness to distinguish between the two) is tenuous at best.

Ryan, *supra* note 116, at 287 (advancing similar arguments).

421. *See* Stuart Auerbach, *Doctors' Alliance Has a Remedy for Managed-Care Limits*, WASH. POST, Dec. 30, 1996, at F12 (noting the formation of a "virtuous" HMO); Rachel Kreier, *How and Why Doctors on L.I. Formed Their Own H.M.O.*, N.Y. TIMES, June 30, 1996, at 13LI4 (same).

422. *See* Feeg, *supra* note 418, at 366.

> Although micromanagement of per diem solutions to troubling discharge practices should not be the government's goal, if it takes addressing [diagnostic related group] by [diagnostic related group] to establish minimum stay policies that protect the public, then so be it. We should take them on one-by-one, keep an eye on who's who, buckle-up our seat belts, and get ready for the long road ahead until we find a better way.

Id.

423. An equally important question relates to the use of anecdotal evidence in addressing these matters. Some advocates insist that such emotionally laden evidence (which invariably takes the form of horror stories about managed care) is both necessary and sufficient to resolve the selection of targets requiring legislative reform, and the specification of the appropriate remedies. *See* Hyman, *Regulating Managed Care*, *supra* note 6, at 8–12 (analyzing such claims). A more nuanced approach would acknowledge the role of emotion in public policy but emphasize its limits.

> Barring the unlikely development of a generalized sense of "statistical compassion," anecdotal evidence will continue to play a major role in the formulation of public policy. As such, we need to develop strategies for dealing with the infirmities of both statistics and narrative.... For anecdotes, the short version is "be exceedingly skeptical," "consider the source," and "don't generalize without additional (non-anecdotal) evidence."

Hyman, *Lies*, *supra* note 23, at 850. Any other approach simply ensures more legislation like the Newborns' Act. *See* D. Don Welch, *Ruling with the Heart: Emotion-Based Public Policy*, 6 S. CAL. INTERDISC. L.J. 55, 75–79 (1997) (arguing that emotion has a place in framing public policy, but it must be appropriately employed).

Even a more "holistic" approach is likely to make *everything* worse, unless the tradeoffs are explicitly put on the table. Unfortunately, "consumer protections" are popular precisely because we are unwilling to admit to ourselves that such tradeoffs must be made—and will necessarily be made by default if we choose not to make them (or have them made by our agents) on the merits.

If a prohibition on drive-through deliveries had been passed in the early 1960s, it would have mandated coverage of approximately six days of postpartum hospitalization after a vaginal delivery. There was nothing magical about 144 hours of postpartum hospitalization and there is nothing magical about 48 hours of postpartum hospitalization. The legislative and regulatory focus should be on what occurs during the hospitalization and the institutional arrangements available post-discharge, not on how long postpartum women and their newborn babies can stay in the hospital. Of course, it is far easier to do a sound-bite demanding "coverage of forty-eight hours of postpartum hospitalization," but that does not change the fact that this strategy will do little or nothing to decrease the frequency of bad outcomes and nothing to improve quality of care.

The Newborns' Act effectively eliminates the incentive to develop and cover appropriate post-discharge care and undermines the incentives to engage in appropriately visible cost-containment, while simultaneously giving the public a false sense of security about the merits of the existing care and coverage—positions that are the precise opposite of what any sensible policy in this area should accomplish.[424] To be sure, given the lack of enthusiasm for cost-containment in any particular case and the potential for symbolic blackmail, it may be impossible to deploy a system that is fully transparent in its cost-containment efforts. It does not follow, however, that we should embrace legislation that will actually make things worse.

Justice Frankfurter believed that "the responsibility of those who exercise power in a democratic government is not to reflect inflamed

424. *See* GAO REPORT, *supra* note 82, at 21 ("[R]equiring insurers to ... cover hospital stays of 48 hours for vaginal births ... may be giving the public a false sense of security."); Braveman et al., *supra* note 213, at 336 ("[W]hile the spirit of the [Newborns' Act] may be laudable, its content does not solve the most important problems regarding the need for early postpartum/postnatal services. The legislation may give the public a false sense of security."); Edmonson et al., *supra* note 215, at 2067 ("In the short run, legislative efforts to regulate LOS [length of stay] are unlikely to have much impact on neonatal outcomes unless they also mandate insurance coverage for services before and after hospitalization.").

public feeling, but to help form its understanding."[425] If the bipartisan campaign against drive-through deliveries is any guide, Justice Frankfurter's view seems to be no longer operative. Indeed, quite the opposite appears to be the case.

In the end, there are only three useful insights to be drawn from this mess, and one need not be an expert on law, medicine, or much of anything else to understand them:

1. Sound bites and unrepresentative anecdotes do not result in good legislation;

2. Outrage is cheap, but health care is expensive; and

3. Don't mess with motherhood.[426]

425. Cooper v. Aaron, 358 U.S. 1, 26 (1958).

426. *See* Evelyn Nieves, *Public Furor over Nursing Baby in a Car*, N.Y. TIMES, Sept. 15, 1996, at 45 (recounting the case of a woman who was nursing her baby in her car when a police officer instructed her to "cut it out or go somewhere else" and arguing that the officer "had violated a golden rule, one that sent powerful H.M.O.'s ducking when they tried to force new mothers out of the hospital within 24 hours: Do not mess with motherhood").