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Drive-Through Deliveries: In Support of Federal Legislation to Mandate Insurer Coverage of Medically Sound Minimum Lengths of Postpanum Stays For Mothers and Newborns

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DRIVE-THROUGH DELIVERIES: IN SUPPORT OF FEDERAL LEGISLATION TO MANDATE INSURER COVERAGE OF MEDICALLY SOUND MINIMUM LENGTHS OF POSTPARTUM STAYS FOR MOTHERS AND NEWBORNS

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President Clinton signed the Newborns' and Mothers' Health Protection Act of 1996 into law on September 26, 1996. The Act requires insurers that provide maternity benefits to cover medically sound minimum lengths of inpatient, postpartum stays according to the joint guidelines of the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. This Note discusses the historical context in which the necessity for passage of protective legislation arose, the interplay between state and federal statutes that created the need for federal legislation to provide desired protections for postpartum patients, and examines the provisions of the Act. This Note endorses the Newborns' and Mothers' Health Protection Act of 1996 as federal legislation necessary to protect postpartum patients from medically inappropriate insurer mandates while still allowing medical providers and their patients flexibility in medical decision making in the postpartum period.

INTRODUCTION

There are approximately four million births in United States hospitals each year, making obstetric delivery the most frequent cause of hospital admission in the country.[1] Medical costs for maternity admissions average one thousand dollars per day.[2] Women with medical insurance depend on their policies to pay these costs; therefore, if all women admitted for obstetric deliveries in one year were insured, insurers could

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1. *See Trends in Length of Stay for Hospital Deliveries—United States, 1970–1992*, 44 MORBIDITY & MORTALITY WKLY. REP. 335, 335 (1995) [hereinafter *Trends*].

2. *See Newborns' and Mothers' Health Protection Act of 1995: Hearings on S. 969 Before the Senate Comm. on Labor and Human Resources*, 104th Cong. 56 (1995) [hereinafter *Hearings*] (statement of Palma Formica, M.D.).

save four billion dollars per year by decreasing the length of each admission by one day.[3] Perhaps a more appropriate characterization of this situation is that insurers could make an additional four billion dollars in profits.

This immense potential for increased profits and the steadily rising costs of hospital care[4] prompted insurers to pressure hospitals and physicians to decrease the length of postpartum (after delivery) hospitalization for both mothers and newborn infants.[5] Between 1970 and 1992 the average hospital stay for women who gave birth vaginally decreased from 3.9 to 2.1 days, and for women who gave birth by cesarean section, from 7.8 to 4.0 days.[6]

The pressure on medical providers and mothers to decrease the length of postpartum hospitalization continued until recently. Some insurers forced physicians to acquiesce to the demands for shorter stays by threatening to drop a noncompliant physician from a list of approved physicians,[7] a practice known as deselection.[8] Some managed care companies[9]

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3. *See id.*

4. *See* U.S. DEP'T OF COMMERCE, THE NATIONAL DATA BOOK: STATISTICAL ABSTRACT OF THE UNITED STATES 1995, at 109–17 (115th ed. 1995) [hereinafter STATISTICAL ABSTRACT] (showing, through statistical tables, the trend of annually increasing medical care costs).

5. *See* Dorothy Brooten et al., *A Randomized Trial of Early Hospital Discharge and Home Follow-Up of Women Having Cesarean Birth*, 84 OBSTETRICS & GYNECOLOGY 832, 832 (1994).

6. *See Trends*, *supra* note 1, at 335.

7. *See Hearings*, *supra* note 2, at 51 (statement of Sen. Bill Bradley). Some insurers maintain a list of approved physicians who are considered preferred providers. *See* Ruth Simon, *A Flawed Remedy: Managed Care*, MONEY, Apr. 1993, at 122. By refusing to reimburse patients or requiring a higher copayment from patients for expenses incurred by visiting physicians who are not on the preferred provider list, insurers encourage patients to seek medical care only from physicians on the preferred provider list. *See id.*

8. *See Hearings*, *supra* note 2, at 57 (statement of Palma Formica, M.D.). If deselected, a physician will lose income from that portion of her patient population that receives its insurance from the insurer with that particular provider list because patients are financially discouraged from seeking medical care from providers who are not on the list. Depending on the percentage of a physician's patient population that subscribes to a particular type of insurance coverage, the drop in the physician's income can be significant. *See, e.g.*, Mimi Swartz, *Not What the Doctor Ordered*, TEX. MONTHLY, Mar. 1, 1995, *available in* 1995 WL 2269039.

9. *See Hearings*, *supra* note 2, at 57. A managed care company is an organization that attempts to control the costs of medical care for its patient population by providing care through a finite number of physicians and hospitals with which the organization has contracted. Physicians and hospitals agree to charge lower rates for medical expenses for the group of managed care patients in exchange for being selected by the managed care company as one of its approved physicians or hospitals. *See* Family Voices, *Questions and Answers About Managed Care*, THE EXCEPTIONAL PARENT, Dec. 1995, at 47.

reduced compensation for physicians who kept mothers and newborns in the hospital for more than twenty-four hours after an uncomplicated (no unexpected problems) vaginal delivery.[10] Alternatively, an anxious mother might have scrambled to get preapproval from the insurer for payment of inhospital costs incurred beyond twenty-four hours after delivery.[11] If such preapproval was not forthcoming, the patient might have been forced to leave the hospital in twenty-four hours or less after an uncomplicated vaginal delivery, or forty-eight hours or less after an uncomplicated cesarean delivery,[12] lest she get stuck with a one thousand dollar per day hospital bill.[13]

This Note examines the trend of health insurers to mandate early postpartum discharge of mothers and infants based on financial, not medical, considerations and examines the need for federal legislation requiring insurers to cover medically sound minimum lengths of inpatient, postpartum stays for mothers and infants. This Note endorses the recently enacted Newborns' and Mothers' Health Protection Act of 1996[14] (the Act) as federal legislation needed to protect mothers and their newborn infants from insurer mandates to inappropriately and prematurely discharge postpartum patients. The Act requires health insurers that provide maternity benefits to cover minimum inpatient, postpartum stay lengths of forty-eight hours after vaginal delivery and ninety-six hours after cesarean delivery.[15]

Part I of this Note outlines the inherent dangers of inappropriate early postpartum discharge of mothers and infants, and the need for stringent psychosocial, educational, and medical screening of mothers to determine whether early discharge is appropriate. Determining the time of postpartum discharge based on this screening, rather than on cost savings, eliminates the increased risk of harm to mothers and infants that results from failing to adhere to medically safe parameters.

Part II delineates the lack of legislative controls on health insurer practices in the area of postpartum hospitalization

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10. *See Hearings, supra* note 2, at 51 (statement of Palma Formica, M.D.).

11. *See New Laws Place FPs Who Deliver Babies in Catch-22*, FP REP., Mar. 1996, at 3 [hereinafter *New Laws*].

12. *See No Clear-Cut Answers Emerge in the Debate over Hospital Length of Stay Following Delivery*, FP REP., Mar. 1996, at 3 [hereinafter *No Clear-Cut Answers*].

13. *See supra* text accompanying note 2.

14. Pub. L. No. 104-204, 110 Stat. 2874 (West, WESTLAW through 1996 2d Sess.).

15. *See* 110 Stat. 2874; *see also* discussion *infra* Part IV.

prior to the enactment of the Act. In general, federal legislation places the primary responsibility of controlling the behavior of health insurers on state legislatures. State governments, then, should have been the vanguard of any attempt to quell the practice of shortening postpartum hospital stays. This Part examines individual state responses to this threat to the health and safety of mothers and newborns as well as loopholes in state regulation of health insurers.

Part III reviews the current joint guidelines for appropriate lengths of inpatient, postpartum stays for mothers and newborns promulgated by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), *Guidelines for Perinatal Care*[16] (the *Guidelines*). The *Guidelines* recommend longer postpartum stays than insurers mandated prior to passage of the Act, and postpartum home health care for those mothers and infants who are discharged earlier than otherwise recommended by the *Guidelines*. Additionally, Part III discusses insurer opposition to legislation supporting the *Guidelines*. Finally, Part III explains that national physician organizations generally dislike legislation that usurps physicians' decision-making power. These physician organizations, however, support the recent enactment of the Act mandating insurer coverage of minimum lengths of inpatient, postpartum stays as recommended by the *Guidelines*. These organizations support the Act not only because early discharge of mothers and infants is generally unsafe, but also because such legislation is considered the only effective method currently available to protect the health of mothers and newborns.

Part IV outlines the Act and its requirement that insurers cover minimum lengths of inpatient, postpartum stays for mothers and newborns. This Note analyzes the provisions of the Act, endorsing the Act as federal legislation needed to protect the postpartum health of mothers and newborns in the United States. Part V urges that because the *Guidelines* aim to protect the health and safety of *all* mothers and newborns in the United States, the *Guidelines* should be followed irrespective of the mother's and newborn's insurance coverage.

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16. AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE (3d ed. 1992) [hereinafter GUIDELINES].

I. DANGERS OF EARLY DISCHARGE

Although containment of medical costs is a laudable goal, the United States government must avoid allowing insurers to seek such a goal at the expense of safe, quality health care for its citizens. A danger of increased morbidity (non-lethal injury) and mortality exists for mothers and infants who are inappropriately and prematurely discharged.

In a 1995 report, the Centers for Disease Control and Prevention (CDC) noted that although most studies reviewed by the CDC have not detected an increase in the rate of morbidity associated with early postpartum discharge, the studies were "conducted among carefully selected women at low risk for postpartum complications."[17] Any pregnant women who had "significant pregnancy problems, chronic illness (such as diabetes, hypertension), [a] previous uterine scar [or] fail[ed] to complete [a] designated prenatal education series" were excluded from the studies.[18] The women included in the studies also had home visits by nurse practitioners[19] after discharge to ensure prompt diagnosis and treatment of postpartum complications—"a practice not routinely used by health-care providers."[20]

Although these studies were rigorously designed, they were small and included only carefully selected and prepared populations of mothers and infants at low risk for psychosocial problems.[21] The studies were well designed to control factors affecting the women and infants studied, but the groups studied were too small and too specialized to justify generalization of the results to the greater postpartum population.[22] The groups were composed of highly motivated and medically

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17. *Trends*, *supra* note 1, at 336.

18. Selman I. Welt et al., *Feasibility of Postpartum Rapid Hospital Discharge: A Study from a Community Hospital Population*, 10 AM. J. PERINATOLOGY 384, 384–85 (1993) (listing parameters for exclusion from an early postpartum discharge study).

19. Nurse practitioners are nurses with special training in medical diagnosis and treatment. *See* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1163 (28th ed. 1994).

20. *Trends*, *supra* note 1, at 336–37.

21. *See* Paula A. Braveman, *Short Hospital Stays for Mothers and Newborns*, 42 J. FAM. PRAC. 523, 523 (1996). Psychosocial factors include, but are not limited to: child-rearing skills, home environment, maternal emotional stability, and infant health status and development. *See* GUIDELINES, *supra* note 16, at 105.

22. *See* Braveman, *supra* note 21, at 523.

compliant mothers and their infants, distorting the results that might be found with groups more representative of the general population.[23] Finally, because the groups excluded patients with significant pregnancy problems, chronic illness, previous uterine scars, and an apparent predisposition to disregard medical care instructions, the results of the studies were thereby skewed further in favor of early postpartum discharge. The results of these studies cannot be generalized to support shorter hospital stays for the greater postpartum population. At most, the studies suggest that in very circumscribed situations early discharge may be appropriate.[24]

A recent review of the literature on early postpartum discharge of mothers and infants, conducted by Paula Braveman, describes a study claiming that early discharge of indigent mothers and children is safe.[25] Braveman notes that the researchers' data actually demonstrate that with early discharge, infant hospital readmission rates are 2.6 times higher as compared with infants discharged after forty-eight hours. Additionally, the data evidences a nine percent rate of failure of mothers to bring early discharge infants to a postdischarge follow-up appointment, compared with a zero percent failure rate when follow-up is provided inhospital, before discharge.[26] Early follow-up is necessary to examine patients for postpartum illness. Without early follow-up, postpartum illnesses and complications that require less medical intervention when discovered early in their course are not discovered by medical providers until a later date when the illnesses may be life threatening and often require more intensive medical intervention. This study suggests that early postpartum discharge is actually more dangerous than later discharge coupled with initial inhospital follow-up. With early discharge, the mothers and infants cannot easily be examined for medical complications because they are no longer in the hospital during the immediate postpartum period. Contrary to the claimed results of this study, without adequate follow-up care the risk for injury from postpartum complications increases, as demonstrated by higher readmission rates.[27]

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23. *See* Paula Braveman et al., *Early Discharge of Newborns and Mothers: A Critical Review of the Literature*, 96 PEDIATRICS 716, 722 (1995).
24. *See id.*
25. *See id.*
26. *See id.*
27. *See id.*

Braveman notes that in another study which concluded that early discharge is safe, the researchers' data show a twenty-six percent no-show rate for recommended follow-up visits.[28] Failure to receive medical evaluation and screening that would have been provided inhospital if postpartum patients were discharged after forty-eight hours increases the chance of morbidity and mortality of those patients. This increased risk is due to medical conditions that could have been diagnosed and treated early (or prevented through instruction and monitoring of mother and infant) during the forty-eight hour postpartum period being permitted to progress to more dangerous stages.[29]

Yet another study that claims that early discharge is safe found twice as many infant complications among twenty-one infants discharged after twelve to twenty-four hours, compared with twenty-one infants whose mothers chose to remain in the hospital thirty-six to eighty hours after delivery.[30] The mothers in this study self-selected their lengths of stay, and notably, a higher proportion of the early discharge group lacked insurance coverage.[31] Despite the claims of this study's authors, infants and mothers who are discharged early without sound medical analysis as the basis for such discharge sustain an increased risk of medical complications. Such complications could be avoided or dealt with in a more timely fashion during a longer postpartum hospital stay.

Additional research supports the conclusion that early postpartum discharge of infants is generally unsafe. A study of 14,720 total births (vaginal and cesarean) in New Hampshire in 1993 by the Department of Pediatrics at the Dartmouth Medical School found a 43.75% increase in risk of readmission within two weeks for healthy infants discharged up to one day after delivery, as compared to healthy infants discharged two days or more after delivery.[32] In the same study, information on 11,734 births demonstrated a 24.14% increase in the risk of emergency room visits within two weeks for the early discharge group of infants as compared to the later discharge group.[33] This study suggests that early discharge of infants is

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28. *See id.*
29. *See* GUIDELINES, *supra* note 16, at 100–09.
30. *See* Braveman et al., *supra* note 23, at 722.
31. *See id.*
32. *See* Judith Frank et al., *The Risk of Readmission and ER Visits in Newborns with Early Discharge: A Population-Based Study*, 37 PEDIATRIC RES. 255A, 255A (1995).
33. *See id.*

not generally safe. Infants discharged early are at increased risk for medical complications requiring emergency room visits and hospital readmission. Although the overall rates of readmission for the early discharge group (1.61%) may not seem significant, the most common causes of readmission for this group were jaundice, infectious disease (including pneumonia and sepsis), and gastrointestinal problems (including dehydration).[34] These afflictions are detectable and treatable during the forty-eight hour postpartum period. The occurrences of these conditions are unpredictable[35] and can result in permanent brain damage or death of the infant.[36] The studies discussed indicate that early postpartum discharge without careful medical screening and follow-up increases the risk of morbidity and mortality of infants.

Mothers discharged early also experience adverse medical outcomes. Early discharge of mothers reduces the time available for inhospital teaching of child care techniques, learning how to breast feed properly, and for monitoring of maternal physical and mental health. It also affords less professional supervision in the postpartum period, and consequently, results in parents who are unsure of their infant caretaking skills.[37] Early discharge forces medical providers to attempt important inhospital education during the first twenty-four hours after delivery, a time when mothers commonly experience significant impairment of their ability to remember new instructions.[38] Early discharge also compromises a mother's wound, bladder, and breast care, as well as screening for potential infection, bleeding problems, and other medical conditions.[39]

If stringent psychosocial, educational, and medical screening of mothers, and stringent medical screening of their newborns is provided along with adequate follow-up medical care (through home visits and easy access to needed inhospital services), case-by-case early discharge after uncomplicated delivery may be safe.[40] This conclusion is supported by the

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34. *See id.*
35. *See* Welt et al., *supra* note 18, at 386.
36. *See id.*; *Hearings*, *supra* note 2, at 56–57 (statement of Palma Formica, M.D.) (recounting the story of an infant who appeared well at discharge and 23 hours after birth but developed jaundice shortly after arriving home with her parents and died of meningitis two days after she was born).
37. *See* Braveman et al., *supra* note 23, at 720.
38. *See id.*
39. *See* GUIDELINES, *supra* note 16, at 96–98.
40. *See* Braveman, *supra* note 21, at 523.

results of the studies discussed above. It is particularly important to have longer inpatient, postpartum care for indigent and low-income mothers because the no-show rate for follow-up appointments in these two groups is high, putting these mothers and newborns at increased risk for morbidity and mortality in the early postpartum period.[41]

This Note supports federal legislation mandating insurer coverage of medically sound minimum lengths of postpartum stays because state legislation is not meeting this need for all the country's insured mothers and newborns. As explained in Parts II and III, federal legislation has been needed to ensure that: (1) medical providers conduct psychosocial, educational, and medical screening of mothers and newborns for time of discharge without pressure from insurers holding purse strings; (2) upon completion of the screening, medical providers make correct time of discharge decisions according to the findings of the screening, and not financial considerations; and (3) physicians and other medical providers, not insurers, make discharge decisions in collaboration with the mothers of newborns. This Note supports the Newborns' and Mothers' Health Protection Act of 1996[42] because, while mandating insurer coverage of medically sound minimum lengths of inhospital postpartum stays, it allows physicians and mothers to decide together when the actual time of discharge of mothers and newborns will be on a case-by-case basis.

II. PRIOR LEGISLATIVE CHECKS ON HEALTH INSURERS

Prior to passage of the Act, some states enacted legislation requiring insurers to cover minimum lengths of inpatient, postpartum stays. Even in the states with protective legislation, not all insured mothers and newborns were actually protected from insurer mandates for shorter postpartum stays. This Part examines the interplay of federal and state law that created this scenario, and supports the Act as federal legislation needed to remedy the situation.

Prior to passage of the Act, the health care industry could garner significant savings through the practice of early discharge—despite the increased rates of readmission and

41. *See id.*

42. Pub. L. No. 104-204, 110 Stat. 2874 (West, WESTLAW through 1996 2d Sess.).

emergency room visit resulting from the early discharge of infants.[43] Unfortunately, these savings were obtained with a concomitant increase in the morbidity and mortality of infants. Consider Michelina Bauman.[44] Michelina was an infant discharged from a hospital approximately one day after her birth. At the time of discharge, it was not known that she was born infected with Group B Streptococcus,[45] a treatable yet deadly illness common in newborns.[46] Because of the early discharge, inhospital medical personnel did not have an opportunity to observe the infant at the time she developed symptoms of this infection. Although Michelina's parents made multiple timely calls to the outpatient medical system covered by their insurance, the medical personnel in that system did not help the Baumans to access medical treatment in time to save Michelina's life.[47] Medical personnel gave phone advice that was inappropriate for Michelina's illness and did not advise the Baumans to bring Michelina to a hospital or other medical facility for examination.[48] This resulted in a delay in the treatment of Michelina's illness, and Michelina died. The outpatient medical system into which the Baumans were discharged was so deficient that the home health care personnel who were required to provide nurse visits twenty-four hours after discharge were unaware that Michelina had been born.[49] Had Michelina remained in the hospital for a full forty-eight hours after delivery, medical personnel would have been afforded the opportunity to promptly note the symptoms of infection through routine protocols for care of infants in the nursery, and lifesaving antibiotic therapy would have been provided.[50]

Until the passage of the Act, the tragic set of circumstances leading to Michelina Bauman's death could have been legally repeated throughout much of the United States. Prior to the recent enactment of the Act, a number of states passed legislation requiring health insurers offering maternity coverage to provide benefits for minimum lengths of inpatient, postpartum

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43. *See* discussion *supra* Part I; *Hearings*, *supra* note 2, at 80–81 (statement of Judith Frank, M.D.).
44. *See id.* at 79–80 (statement of Michelle Bauman and Steve Bauman).
45. *See id.* at 80.
46. *See* GUIDELINES, *supra* note 16, at 131–32.
47. *See Hearings*, *supra* note 2, at 80.
48. *See id.*
49. *See id.*
50. *See id.*; GUIDELINES, *supra* note 16, at 91, 92–93, 98–99, 131–32.

stays.[51] Other states had no statutory requirement for insurers to follow medical guidelines of any kind in providing or refusing inpatient postpartum care benefits for mothers and infants. As discussed in this Part and Part III, federal legislation was necessary to require all insurers offering maternity coverage in the United States to provide benefits for medically sound minimum lengths of inpatient, postpartum care for mothers and newborns. The mandates of the Act meet these needs.[52]

Section A of this Part examines the federal statutes declaring that public interest supports state legislation of insurance. Section B examines the response of state legislatures to early postpartum discharge. Section C delineates loopholes in state regulation of insurance and argues the need for this federal legislation to require insurers to cover medically sound minimum lengths of postpartum stays.

A. The McCarran-Ferguson Act and State Control

Because of prior federal legislation delegating regulation of the insurance industry to the several states, there has been no uniform regulation of health insurance coverage of postpartum stays from state-to-state. The legislatures of individual states have responded in a variety of ways to the problem of insurer-mandated early postpartum discharge.

In 1994, via federal legislation known as the McCarran-Ferguson Act[53] (MCFA), Congress declared that states would regulate the insurance industry.[54] The first section of the MCFA states the Congressional policy:

> Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the

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51. *See, e.g.*, MD. CODE ANN., HEALTH–GEN. II § 19-1305.4 (1996); N.J. STAT. ANN. § 17:48-6*l* (West Supp. 1996); 1996 N.Y. Laws 56 (to be codified at N.Y. PUB. HEALTH LAW § 2803-n) (effective Jan. 1, 1997); N.C. GEN. STAT. § 58-3-170 (1995).

52. *See* Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874 (West, WESTLAW through 1996 2d Sess.); *see also* discussion *infra* Part IV.

53. 15 U.S.C. §§ 1011–1015 (1994).

54. *See id.* § 1011.

> part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.[55]

The operative language follows:

> (a) State regulation
>
> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) Federal regulation
>
> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .[56]

The MCFA delegates regulation of the insurance industry to the states, unless Congress enacts legislation specifically directed at regulating insurance.[57] Thus, the MCFA delegates regulation of health insurance coverage for postpartum stays to the states unless Congress enacts legislation specifically directed to the regulation of such coverage.[58] Under the MCFA, mothers and infants would not have uniform minimum postpartum stay insurance coverage unless every state passed identical legislation. To ensure a nationwide system of adequate postpartum insurance coverage, each state would have to require insurers to cover medically sound lengths of postpartum, inpatient stays. The states could create this system by requiring insurers to cover postpartum care that is consistent with guidelines delineated by national medical groups with appropriate expertise in this area, such as the AAP and the ACOG.[59] A nationwide system of legislation requiring coverage

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55. *Id.*
56. *Id.* § 1012.
57. *See id.* § 1012(b).
58. *See id.*
59. *See* discussion *infra* Part III.

would also provide legal recourse for those mothers and infants whose postpartum medical care falls below the national standards.

Until passage of the Act, such a uniform interstate system of regulation for inpatient postpartum care insurance coverage after uncomplicated deliveries did not exist. The absence of state-mandated requirements for minimum stay coverage by insurers, in part, allowed insurers to continue decreasing the length of stay for which inpatient, postpartum coverage would be provided. The next section discusses the efforts of state legislatures that considered legislation requiring minimum length postpartum stay coverage.

B. States' Responses to Premature Discharges

Before passage of the Act, a number of state legislatures addressed the trend toward premature discharge of mothers and their infants. Legislators in these states introduced bills mandating minimum lengths of inhospital postpartum stays that insurers must cover.[60] Some of those states actually passed statutes requiring such coverage.[61]

The current or proposed statutes in different states are not uniform in the minimum length of stay for which they require coverage. Thus, mothers and infants cannot be assured of consistent coverage through such state legislation. Some statutes require that health insurers provide coverage for at least forty-eight hours of inpatient care after vaginal deliveries and ninety-six hours of inpatient care after cesarean deliveries.[62] Other states require or propose that health insurers provide coverage in accordance with current medical criteria outlined

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60. *See, e.g.*, S. 1262, 42d Leg., 2d Reg. Sess. (Ariz. 1996); A. 1841, Reg. Sess. (Cal. 1995); H.R. 1015, 60th Gen. Assembly, 2d Reg. Sess. (Colo. 1996); H.R. 1189, 143d Gen. Assembly, 2d Reg. Sess. (Ga. 1996); S. 2318, 18th Leg., Reg. Sess. (Haw. 1996); H.F. 2047, 76th Gen. Assembly, 2d Sess. (Iowa 1996); S. 43, 132d Gen. Assembly, Reg. Sess. (Ky. 1996); H.R. 1069, 88th Gen. Assembly, 2d Sess. (Mo. 1996); H.R. 2655, 45th Leg., 2d Reg. Sess. (Okla. 1996); S. 2279, Jan. Sess. (R.I. 1996); S. 2455, 99th Gen. Assembly, 2d Reg. Sess. (Tenn. 1996); H.R. 4126, 72d Leg., 2d Reg. Sess. (W. Va. 1996).

61. *See, e.g.*, MD. CODE ANN., HEALTH–GEN. II § 19-1305.4 (1996); N.J. STAT. ANN. § 17:48-6*l* (West Supp. 1996); 1996 N.Y. Laws 56 (to be codified at N.Y. PUB. HEALTH LAW § 2803-n); N.C. GEN. STAT. § 58-3-170 (Supp. 1995).

62. *See, e.g.*, A. 1841, Reg. Sess. (Cal. 1995); S. 330, Reg. Sess. (Conn. 1996); N.J. STAT. ANN. § 17:48-6*l* (West Supp. 1996); N.C. GEN. STAT. § 58-3-170 (Supp. 1995).

by some national medical authority,[63] thus ensuring that this statutory language need not be changed in the future if the medical community develops new standards for recommended postpartum stay periods.[64] At least one state proposes different minimum stay requirements and does not actually require that insurers follow these guidelines.[65]

Current and proposed state legislation also varies with respect to who decides whether mother and infant may be discharged early, and under what circumstances such discharge may occur. A New Jersey statute and a house bill in Hawaii require forty-eight hour coverage of inpatient services after an uncomplicated vaginal delivery and ninety-six hour coverage of inpatient services after an uncomplicated cesarean delivery, *unless* the insurer has a home care program that provides coverage for the same period.[66] Under this legislative scheme the insurer can mandate that the mother and infant be discharged and that their care be rendered at home.[67] The potential for a battle—the insured and her physician against the insurer—exists if the mother and physician disagree with the insurer's insistence on early discharge and home care.

Although the legislatures of many states considered proposals for statutes requiring minimum-stay coverage for the postpartum period,[68] not all state legislatures passed such laws. The Act provides uniform coverage for mothers and their newborns throughout the United States.[69] Through the mandates of the Act, patients will be assured of the uniform inpatient postpartum care coverage they require regardless of the state in which they find themselves at the time of delivery. Moreover, even if they disagree with the mandates of the Act,

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63. *See, e.g.*, MD. CODE ANN., HEALTH–GEN. II § 19-1305.4 (1995) (requiring health insurers to provide coverage in accordance with the recommendations found in the latest version of the *Guidelines for Perinatal Care* prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists).

64. *See id.*

65. *See, e.g.*, H.J.R. Res. 3, 132d Gen. Assembly, Reg. Sess. (Ky. 1996) (proposing all health insurers providing maternity coverage be "urged" and not required to cover at least 72 hours of inpatient care after either vaginal or cesarean delivery of a newborn).

66. *See* N.J. STAT. ANN. § 17:48-6*l* (West Supp. 1996); H.R. 2530, 18th Leg., Reg. Sess. (Haw. 1996).

67. *See* N.J. STAT. ANN. § 17:48-1 (West Supp. 1996); H.R. 2530, 18th Leg., Reg. Sess. (Haw. 1996).

68. *See supra* note 60 and accompanying text.

69. *See* Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874 (West, WESTLAW through 1996 2d Sess.); *see also* discussion *infra* Part IV.

insurers will be assured of uniform requirements for the coverage they must provide for inpatient postpartum care from state to state.

C. Loopholes in State Legislation and the Need for Federal Intervention

The Act mandates uniform postpartum care coverage and avoids the loopholes present in current state legislation. Even if all jurisdictions in the United States passed legislation mandating identical inhospital postpartum care coverage by insurers according to medically sound guidelines, the legislation would not ensure coverage for all citizens with health insurance. State legislation does not cover the health care benefit plans of out-of-state corporations.[70] Similarly, self-insured companies, having no contract with a commercial health insurer, are not regulated by state legislation.[71] Concomitantly, state legislation cannot regulate any benefit plans regulated by the federal Employee Retirement Income Security Act (ERISA)[72] or other federal legislation.[73] Because no federal legislation required minimum inpatient postpartum stay coverage after uncomplicated deliveries until passage of the Act, and because of the combined language of ERISA and the McCarran-Ferguson Act, employers and benefit plans in these categories were free, until recently, to set their own parameters for coverage.[74]

ERISA specifically prohibits states from regulating the same aspects of insurance addressed by federal legislation.[75]

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70. *See* 15 U.S.C. § 1012(b) (1994); 29 U.S.C. §§ 1003, 1144 (1994); *see, e.g.*, N.J. STAT. ANN. §§ 17:48-1, 17:48-6k (West Supp. 1996); *see also supra* notes 55–57 and accompanying text.

71. *See* 15 U.S.C. § 1012(b); 29 U.S.C. §§ 1003, 1144; *see, e.g.*, N.J. STAT. ANN. §§ 17:48-1, 17:48-6k; *see also supra* notes 55–57 and accompanying text.

72. 29 U.S.C. §§ 1003, 1144.

73. *See* 15 U.S.C. § 1012(b); *see also supra* notes 55–57 and accompanying text.

74. *See* 15 U.S.C. §§ 1011–1015; 29 U.S.C. §§ 1003, 1144.

75. The following language details the preemptive effect of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1003, 1144, and the general situations in which Congress intended these exemptions from state regulation to be available:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws

Although ERISA requires all persons to follow state laws concerning insurance otherwise,[76] ERISA explicitly exempts employee benefit plans (which fall within the ERISA categories that preempt state legislation) from state regulation.[77] The final result is that because of the combined language of these three subsections of ERISA, state regulation of employee benefit plans is preempted by ERISA. Thus, because of ERISA's preemption provisions, federal legislation is needed to mandate insurer coverage of medically sound lengths of postpartum stays for all insureds. The Act meets this need.[78]

Federal legislation explicitly stating its application to insurance coverage of postpartum maternity and infant care throughout the nation ensures the safety of insured mothers and newborns. The Act was drafted according to medically sound guidelines and is applicable to all insurers, including self-insured companies and federal programs such as Medicaid, and thus will avoid the loopholes inherent in state regulation noted above.[79]

III. AAP AND ACOG GUIDELINES FOR LENGTHS OF POSTPARTUM STAYS

The Act ensures the safety of mothers and newborns in the postpartum period by incorporating the guidelines developed

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> insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

Id. § 1144(a). Yet, ERISA also provides: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A). However, under ERISA,

> [n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id. § 1144(b)(2)(B).

76. *See id.* § 1144(b)(2)(A).
77. *See id.* § 1144(a), (b)(2)(B).
78. *See* discussion *infra* Part IV.
79. *See id.*; *see also* discussion *infra* Part IV.

by national physician organizations whose members provide postpartum care. The current *Guidelines For Perinatal Care* promulgated by the AAP and the ACOG state that the lengths of postpartum hospital stays for mothers and their newborn infants should be forty-eight hours for an uncomplicated vaginal delivery and ninety-six hours for an uncomplicated cesarean delivery, excluding the day of delivery.[80] Recognizing the need for determining the time of discharge on a case-by-case basis, the *Guidelines* state that certain criteria must be met before mother and infant can be discharged early.[81] These criteria include: (1) securing the stable condition of mother and infant; (2) obtaining pertinent laboratory determinations of parameters for common perinatal afflictions of mothers and infants; (3) informing the mother of possible complications for her and her infant and of methods for contacting appropriate medical personnel for prompt evaluation and treatment; (4) determining that family or equivalent social support will be available for the mother during the first few days after discharge; (5) assessing whether the mother is ready to assume independent responsibility for her newborn; and (6) making arrangements for a physician-directed source of continuing outpatient medical care for both mother and infant (the initial outpatient examination of the infant to take place within the first forty-eight hours after discharge).[82] These guidelines provide protection for the mother and her newborn in the early postpartum period without tying the hands of the physician and mother with respect to medical decision making. Under these guidelines, minimum lengths are set for postpartum stays according to the type of delivery. If the mother and her physician decide that early discharge is appropriate, however, such discharge is acceptable as long as the safeguards provided in the guidelines are followed.[83]

A. Opposition to Legislation Mandating that Insurers Follow Joint AAP and ACOG Guidelines

Some groups that provide postpartum medical care and insurance coverage have been opposed to legislation mandating

80. *See* GUIDELINES, *supra* note 16, at 107.
81. *See id.* at 107–09.
82. *See id.*
83. *See id.*

coverage of particular lengths of stay. Kaiser Permanente (Kaiser) is a private, nonprofit, integrated health care delivery system, serving more than 6.6 million members in sixteen states and the District of Columbia.[84] Kaiser is the largest private health care program in the United States.[85] Kaiser states that its objective is quality and cost-effective care.[86] Kaiser claims that its physicians are salaried and therefore have no financial incentive to provide excessive care or to withhold care.[87] Kaiser also claims that individualized medical treatment decisions are made by physicians in consultation with their patients, without imposition of limits or restrictions by the Kaiser insurer, Health Plan.[88]

Despite lauding individualized medical treatment, Kaiser admits to having guidelines for medical care.[89] The guidelines are developed by Permanente Medical Group physicians and not by Health Plan.[90] Although technically these are separate medical and insurance groups, both groups are part of the greater Kaiser organization. The potential for increasing provider salaries by decreasing expenditures through earlier discharge of mothers and infants may result in the Permanente Medical Group setting guidelines that either allow or mandate premature and inappropriate postpartum discharge of mothers and newborns, a scenario similar to the shortened postpartum stays mandated by other insurers.

Do the Kaiser guidelines aid physicians in providing for patients or do the guidelines set mandates? If physicians disobey the mandates, do sanctions in reality force the individual physician to observe the guidelines despite Kaiser's claim that it encourages individualized medical decision making? If a physician believes his patients need longer postpartum stays than those set by the Kaiser guidelines, the physician may nonetheless find himself fighting with Kaiser to justify the longer stays because the guidelines set maximum, not minimum, lengths of postpartum stays. This hypothetical situation is possible in a medical care setting in which the providers

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84. *See Hearings*, *supra* note 2, at 62 (statement of Sharon Levine, M.D., Associate Executive Director for Physicians & Professional Support Services, Permanente Medical Group, Inc.).

85. *See id.*

86. *See id.* at 66.

87. *See id.* at 63.

88. *See id.* at 63, 66.

89. *See id.*

90. *See id.*

setting guidelines could benefit directly from savings realized by decreasing services provided to insured patients. Although discussion of the likelihood of the occurrence of this situation is beyond the scope of this Note, the potential conflict of interest that could create such a situation exists in a managed care setting. For example, savings derived from lower patient costs may be translated into utilization bonuses or salary increases for physicians.

Another argument Kaiser uses against minimum-length-of-stay legislation is that although Kaiser supports "a requirement that health benefits plans coverall [sic] medically appropriate maternity and newborn care,"[91] Kaiser cautions against government legislation mandating the content of medical practice. Kaiser is concerned that such legislation "sets a worrisome precedent."[92] Kaiser's concern is that such legislation would freeze standards of care that must evolve as medical science and medical practice progress.[93]

Similar concerns are raised by the Group Health Association of America (GHAA), a national association of Health Maintenance Organizations (HMOs) with 385 member HMOs serving eighty percent of the approximately fifty million Americans receiving health care through HMOs.[94] GHAA believes that it is "inappropriate to establish an inflexible statutory standard for an exact number of hours for a hospital maternity stay" for the same reasons.[95] GHAA asserts that the focus should be on the "quality and comprehensiveness" of perinatal care, rather than on where the care is provided.[96]

Ironically, although GHAA asserts that studies have not been able to reach definitive conclusions about the safety of early discharge,[97] GHAA also notes that its member health plans follow the *Guidelines* in determining when a mother and newborn may be discharged early safely.[98] The Act also incorporates the *Guidelines*.[99] As noted above, the *Guidelines* recommend medically sound minimum lengths of postpartum stays while allowing for physician and mother flexibility in deciding time

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91. *Id.* at 68.
92. *Id.*
93. *See id.*
94. *See id.* at 58 (statement of Richard Marshall, M.D.).
95. *Id.* at 59.
96. *Id.*
97. *See id.* at 60.
98. *See id.*
99. *See* GUIDELINES, *supra* note 16, at 107–09.

of discharge as long as certain safety criteria are met.[100] Managed care organizations that purport to follow the *Guidelines* need not worry about having the hands of their medical decision makers tied by such legislation.

Managed care organizations voluntarily following the *Guidelines* do not obviate the need for protective federal legislation. Kaiser provides health care for 6.6 million members[101] and GHAA's member organizations provide health care for forty million Americans.[102] The 1994 U.S. Census estimated that the total U.S. population was 260 million persons.[103] Thus, the majority of the American population does not receive health care through these organizations. Assuming GHAA member HMOs and Kaiser would follow the *Guidelines* voluntarily, these organizations' practices would not protect the majority of postpartum patients. For the protection of its mothers and newborns, the United States needs the Act to require insurers to cover medically sound minimum lengths of inpatient, postpartum stays.

B. Support for Legislation from National Physician Organizations

Physician organizations do not, in general, support any attempt to legislate the physician-patient relationship, fearing that such laws will dictate how a physician should care for a patient—a dangerous proposition in a profession where science, standards, and practice often evolve swiftly.[104] As recently as July 1995, the American Medical Association (AMA) stated that it opposed the concept of legislating health care because legislation entails insurance companies and lawmakers substituting their judgment for that of physicians.[105] Yet, national physician organizations recognize that legislation may be the only way to force insurers to provide coverage for medically sound lengths of inpatient postpartum stays. While acknowledging

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100. *See supra* notes 80–83 and accompanying text.
101. *See Hearings*, *supra* note 2, at 62 (statement of Sharon Levine, M.D.).
102. *See id.* at 58 (statement of Richard Marshall, M.D.).
103. *See* STATISTICAL ABSTRACT, *supra* note 4, at 1.
104. *See, e.g.*, *No Clear-Cut Answers*, *supra* note 12, at 3.
105. *See, e.g.*, Julie Rovner, *USA Divides over Early Discharge of Mothers*, 346 LANCET 171, 172 (1995).

its historical opposition to congressional interference with a physician's clinical decision making, the AMA endorses the Newborns' and Mothers' Health Protection Act of 1996 as federal legislation needed to mandate insurer coverage of minimum lengths of inpatient postpartum stays.[106] The AMA believes that legislation is necessary to prevent insurers from delivering the cheapest health care possible in spite of the increased medical risks for postpartum mothers and newborns resulting from such a policy.[107]

The American College of Obstetricians and Gynecologists (ACOG) has opined that an ideal world would maintain "commonality" between physicians and insurers, obviating the need to legislate insurance coverage for health care.[108] The ACOG admits, however, that attempts to reach this common ground have failed.[109] Therefore, the ACOG also came to endorse the Act as necessary for the protection of maternity and newborn patients.[110] The ACOG noted that the Act does not interfere with a physician's ability to make medical decisions in the best interest of her patient. Rather, the Act protects physicians and their patients "from the continual pressure of insurers for early discharge."[111] The ACOG states: "In the absence of responsible action by insurers to provide adequate postpartum care coverage, federal intervention is entirely appropriate."[112]

The American Academy of Pediatrics (AAP) also supports the Act.[113] The AAP noted that the Act will place medical decisionmaking back in the hands of physician and patient, and will not allow insurers to dictate the length of postpartum stay coverage according to financial considerations.[114]

Individual physicians have also accepted the need for legislation mandating insurer coverage of medically sound minimum lengths of inpatient postpartum stays. Despite their legitimate concerns about legislating medical decision making, individual physicians noted that legislative intervention is necessary for the protection of postpartum patients.[115] Part IV

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106. *See Hearings*, *supra* note 2, at 56 (statement of Palma Formica, M.D., Member of the AMA's Board of Trustees).

107. *See id.* at 56, 57.

108. *See* Rovner, *supra* note 105, at 172.

109. *See id.*

110. *See Hearings*, *supra* note 2, at 53 (statement of Michael Mennuti, M.D.).

111. *Id.*

112. *Id.*

113. *See id.* at 76 (statement of the American Academy of Pediatrics).

114. *See id.*

115. *See, e.g.*, *New Laws*, *supra* note 11, at 3 (providing an example of a physician who does not support laws mandating how physicians care for patients, but admits

discusses the Newborns' and Mothers' Health Protection Act of 1996, endorsed by this Note as federal legislation needed to mandate adequate postpartum care coverage.

IV. THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996, enacted September 26, 1996,[116] is endorsed by the AMA, the ACOG, and the AAP.[117] The Act is intended to "ensure that mothers and newborns receive adequate care in the critical first few days following birth."[118] The Senate Committee on Labor and Human Resources stated that it "believes this limited legislation is a necessary and appropriate step to help protect the health of mothers and their newborn children."[119] The Committee also stated that although some may view passage of the Act as legislating medical practice, it will actually return decision making authority to medical providers in postpartum care situations and "promote mutual decision making on a case-by-case basis by patients and their providers."[120]

In accordance with the *Guidelines*,[121] the Act requires health plans or employee health benefit plans offering maternity benefits (including childbirth benefits) to provide insurance

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that New Jersey's maternity stay law has helped him to provide appropriate medical care to his patients).

116. *See* Pub. L. No. 104-204, 110 Stat. 2874 (West, WESTLAW through 1996 2d Sess.). The Newborns' and Mothers' Health Protection Act of 1996 was originally introduced as the "New Borns' [sic] and Mothers' Health Protection Act of 1995," *see* S. 969, 104th Cong. (1995), on June 27, 1995. *See* 141 CONG. REC. S9175, S9176 (daily ed. June 27, 1995) (statement of Sen. Bradley). Senate Bill 969 was reintroduced with amendments as the "Newborns' and Mothers' Health Protection Act of 1996." *See* 142 CONG. REC. S3248 (daily ed. Mar. 29, 1996) (statement of Sen. Bradley). The Senate Committee on Labor and Human Resources approved these amendments on Apr. 17, 1996, *see* 142 CONG. REC. D324 (daily ed. Apr. 17, 1996), and ultimately recommended passage of the bill as amended. *See* 142 CONG. REC. S8373 (daily ed. July 19, 1996). President Clinton signed Senate Bill 969 into law as part of House Bill 3666. *See* 142 CONG. REC. D1021 (daily ed. Sept. 26, 1996).

117. *See* 142 CONG. REC. S3248-49 (daily ed. Mar. 29, 1996) (statement of Sen. Bradley).

118. S. REP. NO. 104-326, at 6 (1996).

119. *Id.*

120. *Id.* at 7.

121. *See* GUIDELINES, *supra* note 16, at 107–09.

coverage for inpatient, postpartum stays of a minimum of forty-eight hours after an uncomplicated vaginal delivery and a minimum of ninety-six hours after a cesarean delivery.[122] The Act applies to any group or individual health plan or health insurance issuer.[123] Thus, the requirements and standards of the Act apply to all health insurers offering maternity benefits in the United States, including the health plans regulated by the states and employee health benefit plans regulated by the federal government under ERISA.

Although the Act requires minimum stay coverage as delineated in the preceding paragraph, legislators recognize that "the length of post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child,"[124] and that "the timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother,"[125] taking into consideration the factors discussed in Part III of this Note.[126] With the passage of the Act insurers that provide maternity benefits are now obligated to cover the costs of the designated minimum postpartum stay lengths, and prohibited from requiring attending providers to obtain authorization from the insurers to keep mothers and newborns inhospital for these stays.[127] Although the Act is designed to guarantee that insurers cover the costs of postpartum stays of up to forty-eight hours after a normal vaginal delivery and ninety-six hours after a cesarean delivery, it does not force mothers to stay in hospitals against their will.[128] Nor does the Act force mothers to give birth in hospitals.[129] If an attending provider, in consultation with the mother, decides to discharge an insured mother and her newborn before the expiration of the applicable

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122. *See* §§ 711(a), (b), 2704(a), (b), 2751(a), 110 Stat. 2874 (to be codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. § 300gg-4, -51).

123. *See id.*

124. *Id.* § 602(1).

125. *Id.* § 602(2). "Attending providers" include obstetrician-gynecologists, pediatricians, family physicians, nurse practitioners, nurse midwives, and other physicians primarily responsible for the care of a mother and her newborn. S. REP. NO. 104-326, at 9 (1996).

126. *See.* § 602(1), (2), 110 Stat. 2874 (to be codified at 42 U.S.C.A. § 300gg-4).

127. *See id.* §§ 711(a), 2704(a), 2751(a) (to be codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. § 300gg-4, -51).

128. *See id.* §§ 711(c)(1)(B), 2704(c)(1)(B), 2751(a) (to be codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. § 300gg-4, -51); S. REP. NO. 104-326, at 6–7.

129. *See id.* §§ 711(c)(1)(A), 2704(c)(1)(A), 2751(a), 110 Stat. 2874; S. REP. NO. 104-326, at 6–7 .

recommended minimum stay length, the insurer is not required to provide coverage for postpartum inpatient care beyond this postpartum discharge time.[130] Thus, the Newborns' and Mothers' Health Protection Act of 1996 offers attending providers and their maternity and newborn patients flexibility in determining the manner of delivery of postpartum care, while mandating insurer coverage of this postpartum care for enrollees.

The Act prohibits health plans and employee health benefit plans from denying enrollment, renewal, or continued coverage to participants on the basis of their compliance with the statute.[131] Insurers are also prohibited from providing monetary incentives to mothers to encourage mothers to request shorter postpartum hospital stays than the minimum stays required under the Act or providing any incentive to attending providers to inappropriately discharge postpartum patients early.[132] Similarly, insurers are prohibited from penalizing providers for providing treatment in compliance with the requirements of the statute.[133] Thus, the Act protects against insurer practices that might circumvent mandates intended to unfetter, from insurer dictates, an attending provider's ability to make medical decisions in consultation with a mother.

The Act does not preempt any state law that requires the same or better insurer postpartum benefits coverage than the Act itself or that requires insurers to provide postpartum care in accordance with guidelines established by the AAP and the ACOG.[134] This provision permits state legislatures to require greater insurer postpartum benefits coverage if the state wishes. This provision also permits states to require insurers to provide postpartum care coverage consistent with joint AAP and ACOG guidelines that may change in the future.

Finally, the Act requires the Secretary of Health and Human Services, in consultation with an advisory panel, to conduct a study of factors affecting the health of mothers and newborns, including examination of factors that determine the

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130. *See id.* §§ 711(a)(2), 2704(a)(2), 2751(a), 110 Stat. 2874 (to be codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. § 300gg-4, -51).

131. *See id.* §§ 711(b), 2704(b), 2751(a) (to be codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. § 300gg-4, -51).

132. *See id.*

133. *See id.* §§ 711(b)(3), 2704(b)(3), 2751(a) (to be codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. § 300gg-4, -51).

134. *See id.* §§ 711(f), 2704(f), 2751(a), (c) (to be codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. § 300gg-4, -51).

length of postpartum stays and evaluation of maternal and infant outcomes following childbirth.[135] Ongoing research and review of the factors affecting maternal and newborn postpartum outcomes will provide valuable information for making medically sound decisions concerning the appropriate manner and modes of postpartum care delivery in the future.

Although the Act provides much needed protection for mothers and their newborns in the postpartum period, there are a few areas in which the Act should be stronger. First, the Act has an effective date of January 1, 1998.[136] Congress gives no explanation—not even insurer financial hardship—for the delay of fifteen months (after passage of the Act) in implementing the Act. Postpartum patients need the protections of the Act immediately.

Second, Senate Bill 969 required that insurers provide coverage for attending provider post-discharge care, and that such care occur within twenty-four to seventy-two hours of discharge.[137] This provision was removed from the enacted legislation. Congress gives no explanation for removal of this safety measure from the enacted legislation. The proposed requirement would further ensure protection of the health and safety of postpartum patients through assuring provision of timely medical attention, and it therefore should not have been removed from the enacted legislation.

Third, Senate Bill 969 contained provisions delineating the state and federal officials responsible for enforcing the Act.[138] These provisions were deleted from the Act. Presumably the Act will now be enforced through injured patients bringing suit against any insurer that violates the Act's mandates. Although patients harmed by insurer violation of the Act may engage in litigation to gain recompense for their injuries, insurers might have greater incentives to refrain from "testing" the Act if, in addition to the threat of tort liability, insurers knew that substantial financial or other penalties might be imposed by state or federal officials. Thus, removal of the enforcement provisions of Senate Bill 969 from the enacted legislation served to weaken the strength of the Act's protections.

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135. *See id.* § 606(b), (c) (to be codified at 42 U.S.C.A. § 300gg-4).
136. *See id.* §§ 604, 605, 606 (to be codified at 42 U.S.C.A. § 300gg-4).
137. *See* S. 969, 104th Cong. § 4 (1995).
138. *See id.* §§ 7(a)(1)–(2), 8(b).

Despite these criticisms of the Act, this Note endorses the Newborns' and Mothers' Health Protection Act of 1996[139] as federal legislation needed to protect mothers and their newborns from insurer mandates to inappropriately discharge postpartum patients early. As explained above, the Act applies to all insurers providing maternity benefits and mandates insurer coverage of medically sound minimum lengths of postpartum stays, yet permits early discharge of postpartum patients in appropriate situations. In accordance with the *Guidelines*, the Act details the criteria to be considered in determining whether early postpartum discharge is medically sound. Still, the Act does not require that mothers stay in hospitals against their wills, nor does it require mothers to give birth in hospitals. The Act prohibits insurers from rewarding mothers or attending providers for early discharge of mother and newborn. The Act prohibits insurers from penalizing mothers or attending providers for complying with the provisions of the Act.

Toward the goal of increasing the information available to make medically sound postpartum care decisions in the future, the Act requires ongoing study of postpartum outcomes. Finally, the Act allows states to enact legislation that requires greater insurer coverage of postpartum care than that required by the Act. Thus, the recent enactment of the Newborns' and Mothers' Health Protection Act of 1996[140] will protect mothers and newborns from insurer mandates to decrease inpatient, postpartum care coverage, and will encourage case-by-case, medically sound decision making by attending provider and mother in the postpartum period, without fear of reprisal from insurers.

Whether and how well the threat of tort liability will prevent insurers from violating the coverage mandates of the Act remains to be seen. Still, the Act is a very positive step in the battle to protect the health and well-being of mothers and newborns in the United States. With the passage of the Act, the federal government sends a message to insurers that protection of the health of mothers and newborns in the United States is of national importance.

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139. *See* 110 Stat. 2874.
140. *See id.*

V. UNINSURED MOTHERS AND NEWBORNS

The *Guidelines* are meant to protect the health and well-being of *all* mothers and newborns in the United States during the perinatal period.[141] The *Guidelines* make no mention of considering the extent of a patient's insurance coverage in determining the appropriate length of inpatient, postpartum stay.[142] Although it does not explicitly address uninsured mothers and newborns, the Act explicitly follows the *Guidelines*.[143] Physicians should follow the *Guidelines* irrespective of patients' insurance coverage status, making sound decisions regarding lengths of inpatient, postpartum stays based only on rigorous psychosocial, educational, and medical screening.[144]

CONCLUSION

Dangers inhere in inappropriate early discharge of mothers and newborns in the postpartum period. The economic incentives for insurers to demand early discharges, and the inability of physicians to combat insurer mandates for early discharge have combined to threaten the health and safety of mothers and newborns in the United States. Although some states addressed the problem of insurer-mandated early postpartum discharge, a number did not enact legislation to protect mothers and newborns from such practices. This inconsistent state-by-state response, together with the loopholes in state legislation of health insurance practices, indicates that federal legislation is necessary to ensure adequate and medically sound care for mothers and newborns in the postpartum period.

National physician organizations have recognized the need for federal intervention, and therefore endorse the Act. This Note endorses the recently enacted Newborns' and Mothers' Health Protection Act of 1996, as federal legislation needed to mandate insurer coverage of medically sound minimum lengths of inpatient postpartum stays, while preserving flexibility in medical decision making.

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141. *See* GUIDELINES, *supra* note 16, at xi–xii.
142. *See id.* at 107–09.
143. *See* S. REP. NO. 104-326, at 6 (1996).
144. *See* discussion *supra* Part I.