

Calendar No. 505

104TH CONGRESS } 2d Session }	SENATE	{ REPORT 104-326
----------------------------------	--------	------------------------

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF
1996

JULY 19, 1996.—Ordered to be printed

Mrs. KASSEBAUM, from the Committee on Labor and Human
Resources, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 969]

The Committee on Labor and Human Resources, to which was referred the bill (S. 969) to require that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill as amended do pass.

CONTENTS

	Page
I. Summary of the legislation	1
II. Background and need for legislation	2
III. Legislative history and committee action	5
IV. Committee views	6
V. Cost estimate	11
VI. Regulatory impact statement	17
VII. Section-by-section analysis	17
VIII. Additional views	20

I. SUMMARY OF THE LEGISLATION

Senate bill 969 requires health plans and insurance carriers to provide coverage for postpartum hospital stays of 48 hours for uncomplicated vaginal deliveries and 96 hours for caesarean sections. Coverage can be provided for shorter hospital stays at the discre-

tion of the attending provider, in consultation with the mother. In the case of an early discharge, health plans must offer patients follow-up care. This legislative structure is based on current medical practice guidelines devised by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), which recommend that when no complications are present, the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for caesarean birth, excluding the day of delivery.

II. BACKGROUND AND NEED FOR LEGISLATION

A. Overview

Senate bill 969 requires health plans and insurance carriers to provide coverage for postpartum hospital stays of at least 48 hours for uncomplicated vaginal deliveries and 96 hours for caesarean sections. Coverage can be provided for shorter hospital stays at the discretion of the attending provider in consultation with the mother. In the case of an early discharge, health plans must offer follow-up care. This structure is based on current medical practice guidelines devised jointly by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), which recommend that when no complications are present, the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for caesarean birth, excluding the day of delivery.

The legislation was introduced in response to a growing trend among insurers and health plans to limit coverage to postpartum care. With health costs rising rapidly, many plans now cover stays of only 24 hours, including the day of delivery. In some cases, insurers limit postpartum coverage to as little as 12 hours, or even 8 hours.

While efforts to limit postpartum coverage have received national attention only recently, unwarranted early discharge has been a source of concern for women and their doctors for some time. Clinical data has shown that, in many cases, early discharge increases the health risks for mothers and newborns, including health risks from preventable medical conditions. For example, infants released from the hospital in 24 hours or less have experienced an increase in conditions such as severe jaundice which, left untreated, can result in brain damage or death.

In addition, physicians have been under intense pressure from payers to limit stays to 24 hours or less, even when their medical judgment suggests the need for a longer stay.

In the past year, 26 States followed New Jersey and Maryland in enacting legislation or adopted regulations to address postpartum coverage for mothers and their newborns.

Despite these State efforts, the committee believes that federal legislation is necessary to provide protection for adequate coverage for postpartum care. There are many women who are not affected by State legislation because they receive health benefits through employer-sponsored self-insured health plans shielded from State insurance laws by the preemption provisions of the Employee Retirement Income Security Act (ERISA). In the State of Kansas, for

example, only 40 percent of companies providing insurance offer insured plans that are subject to State regulation. In addition, as implementation of the New Jersey law has demonstrated, women who live in one State and work in another, or whose employers are based outside of a State that has passed a maternity stay law may not be protected by State legislation.

B. Postpartum length of stay in the United States and medical guidelines

The actual length of hospital stay following the delivery of a child in the United States has decreased over the last two decades. Prior to the 1970s, postpartum hospital stays ranged from 4 to 5 days for a routine vaginal delivery and 1 to 2 weeks for a cesarean delivery. During the 1970s, there was a move toward earlier discharge, much of which has been attributed to consumer demand to decrease medical interventions surrounding childbirth and provide a more family-centered birth experience. The Centers for Disease Control report that between 1970 and 1992 the median length of stay for women who give birth vaginally decreased from 3.9 to 2.1 days, and for those who had a cesarean delivery from 7.8 to 4 days.

This data includes complicated deliveries, meaning that the median length of stay for uncomplicated vaginal or cesarean deliveries was probably considerably shorter. This trend is in sharp contrast with the length of postpartum stays in many European nations and Japan, where the length of stay ranges anywhere from 3 to 7 days after an uncomplicated vaginal delivery.

During the initial trend of decreased hospital stay after delivery, a consensus formed among obstetric care providers about the appropriate length of stay. This consensus was formalized into guidelines in 1983, and ACOG and AAP jointly published the first edition of Guidelines for Perinatal Care. The exact wording of the guidelines has evolved over the years, but the recommendation of a minimum 48-hour postpartum stay has been consistent.

The first edition of the Guidelines stated, "A patient who has had an uncomplicated delivery is usually discharged 48 to 72 hours after deliver * * * the patient should not be discharged until the physician is reasonably certain there are no major postpartum complications." Postpartum stays for cesarean delivery were not addressed in these first guidelines.

The second edition of the Guidelines, published 5 years later in 1988, stated, "When no complications are present (the postpartum stay) ranges from 48 hours for vaginal delivery to 96 hours for cesarean birth, excluding the day of delivery." The guidelines also were revised to state that "special criteria once designed to accommodate early discharge now apply to the average length of stay for most patients." Therefore, it was the view of ACOG and AAP that stays of 48 hours constituted early discharge.

The current edition of the Guidelines was published in 1992. In addition to recommending stays ranging from 48 hours for uncomplicated vaginal deliveries to 96 hours for cesarean deliveries, the most recent guidelines further specify that early discharge is acceptable as long as certain criteria are met. These criteria include determination that the course of pregnancy and delivery was uncomplicated, the collection of all pertinent laboratory data for both

the mother and infant, demonstration of maternal readiness to assume independent responsibility for her newborn, and identification of a physician-directed source of continuing medical care for both mother and baby, which should be arranged for within 48 hours of discharge.

C. Scientific data and clinical experience

Available data with regard to the results of early discharge is inconclusive. A recent study by Dr. Judith Frank of readmission rates at New Hampshire hospitals found that within an infant's first 2 weeks of life, there is a 50 percent increased risk of readmission and a 70 percent increased risk of emergency room visits if the infant is discharged at less than 2 days of age. Other studies have indicated that early release of infants may result in jaundice, feeding problems, respiratory difficulties, metabolic disorders, and infections in the cord, ears, and eyes.

However, studies generally provide conflicting evidence on the safety of early discharge, and many are not methodologically sound. A critical review of the existing literature conducted by Bravemen et al. and recently published in *Pediatrics*, found that studies have not yet conclusively demonstrated the safety of early discharge.

There is substantial clinical experience—reflected in the guidelines of AAP and ACOG—to guide obstetrical providers. According to testimony supplied to the committee, the care provided in the first few days after delivery is crucial to the health and well-being of both mother and infant, as significant maternal physiologic changes and newborn adaption occur during the first few days of life. Moreover, not all serious maternal or newborn complications are evident within the first few hours following birth.

In addition, there is increasing anecdotal evidence of serious problems in newborns following early discharge. These problems, such as decreased completion of newborn screening and undetected jaundice, have resulted in more serious medical conditions and led to increasing hospital readmission. While these conditions have been more prevalent among infants of women who are young, uneducated, and poor, they are by no means confined to those populations. The committee heard from three witnesses from varying backgrounds whose newborn infants had experienced a range of health problems—in one case, resulting in the death of a child—following early discharges.

While early discharges can create health problems for newborns, providers who testified before the committee also explained that it takes time for mothers, especially first-time mothers, to recover from the pain and exhaustion of labor. Moreover, opportunities for educating new mothers in the care of their newborns, including learning to feed and identify health problems, are lost when inappropriate early discharge occurs. For example, the initiation of breast-feeding and lactation is a very important process that occurs over the first few days following birth. Dehydration in infants can occur if mothers experience difficulty in breast-feeding. Such difficulty is not uncommon among new mothers, regardless of whether a woman feels adequately prepared to care for her infant. In fact, many of the anecdotal reports of infant dehydration associated with

early discharge have occurred in infants of middle-class, well-educated mothers who were experiencing difficulty breast-feeding.

Some have proposed that home care services can adequately provide education regarding maternal recovery and newborn care. However, such instruction may not always be an effective substitute for the education and care provided in the hospital and may preclude the opportunity for expert observation of both the mother and infant. Moreover, the availability, structure, and content of home care services vary widely across the country.

III. LEGISLATIVE HISTORY AND COMMITTEE ACTION

The Newborns' and Mothers' Health Protection Act of 1996, S. 969, was first introduced on June 27, 1995, by Senators Kassebaum, Bradley, and Rockefeller. The bill seeks to assure that mothers and their newborn children will not be forced to leave the hospital in the first few critical days following birth because of arbitrary insurance company or health plan limits on the number of hours or days patients may remain in the hospital. The bill allows new mothers and their doctors, rather than insurance companies and other third-party payers, to make decisions about the appropriate length of stay.

The Senate Committee on Labor and Human Resources held hearings on S. 969 on September 12, 1995. The bill was reintroduced on March 28, 1996, by Senators Bradley, Kassebaum, Frist, and DeWine et al., and currently has 42 cosponsors (27 Democrats and 15 Republicans). Representative Solomon (R-N.Y.) and Representative Miller (D-CA.) introduced a companion measure in the House of Representatives.

In executive session on April 17, 1996, the full committee considered an amendment in the nature of a substitute offered by Chairman Kassebaum and voted to report that measure favorably by a roll call vote of 14 to 2.

YEAS	NAYS
Kassebaum	Gregg
Jeffords	Faircloth
Coats	
Frist	
DeWine	
Ashcroft	
Gorton	
Kennedy	
Pell	
Dodd	
Simon	
Harkin	
Mikulski	
Wellstone	

Before adopting the amendment in the nature of a substitute, three amendments directing the Secretary of HHS to conduct studies regarding maternal and child health, early discharge, and the impact of the legislation were agreed to by voice vote. Those studies are contained in section 11 of the legislation.

After a division, a separate amendment offered by Senate Jeffords to sunset the bill in 5 years was defeated on a tie roll call vote of 8 to 8.

YEAS	NAYS
Jeffords	Kassebaum
Coats	Kennedy
Gregg	Pell
Frist	Dodd
DeWine	Simon
Ashcroft	Harkin
Gorton	Mikulski
Faircloth	Wellstone

IV. COMMITTEE VIEWS

A. General overview of S. 969

According to numerous witnesses who appeared before the committee, it is becoming increasingly common for health plans and insurance carriers to limit the length of hospital stays following the delivery of a child—in some cases to 24 hours or less. The Centers for Disease Control report that between 1970 and 1992 the median length of stay for women who give birth vaginally decreased from 3.9 to 2.1 days, and for those who had a cesarean delivery from 7.8 to 4 days. Because this data includes complicated deliveries, the median length of stay for uncomplicated vaginal or cesarean deliveries was probably considerably shorter. In contrast, joint guidelines issued by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) indicate that the length of hospital stay following uncomplicated births should range from 48 hours for vaginal delivery to 96 hours for cesarean delivery, exclusive of the day of delivery.

Modeled after the ACOG and AAP guidelines, S. 969 is intended to ensure that mothers and newborns receive adequate care in the critical first few days following birth. The legislation requires health plans and insurance carriers to allow new mothers and their infants to remain in the hospital for 48 hours after a normal vaginal birth, and 96 hours after a caesarean delivery. Mothers and doctors may agree that a shorter hospital stay is appropriate if a follow-up visit is provided. One of the sites offered for follow-up care must be the home.

The committee is concerned that the recent trend toward shorter hospital stays following delivery appears to be driven primarily by financial motivations of health plans and insurers, rather than the clinical judgment of health professionals. Therefore, despite some hesitation about the precedential nature of this legislation, the committee believes this limited legislation is a necessary and appropriate step to help protect the health of mothers and their newborn children. Particularly in the absence of conclusive data about the impact of reduced hospital stays on the health of mothers and newborns, the committee believes that decisions regarding early discharge should be made on a case-by-case basis and should be a mutual decision between the patient and the health care provider.

It has been argued that S. 969 amounts to legislating medical practice. However, nothing in this legislation interferes with a doc-

tor's ability to make a medical decision in the best interest of his or her patient. To the contrary, S. 969 would transfer decision-making authority from third-party prayers to providers and would promote mutual decision making on a case-by-case basis by patients and their providers.

Furthermore, S. 969 would not force mothers to stay in the hospital against their will or to give birth in a hospital. The legislation simply guarantees that insurance will cover the costs of allowing patients and their doctors to determine the appropriate length of stay within a period of 48 hours in the case of a vaginal delivery and 96 hours in the case of a cesarean birth.

The medical community is virtually unanimous in its support of this legislation. For example, Dr. Palma Formica testified before the committee on behalf of the AMA that although "[t]he AMA has long opposed congressional intervention into a physician's clinical decision making," in the postpartum context, "we believe that S. 969 is necessary to stem the tide of insurers who are replacing the physician's judgment of what is best for the patient with what is the cheapest way to pay for health care." Dr. Formica went on to state that "S. 969 would ensure that the decision of when to discharge a mother and newborn is made by the physician and not dictated by financial considerations of the managed care company." Dr. Michael Menutti, representing ACOG, added that "insurers are now pressuring doctors to make decisions based on economics. S. 969 would protect doctors from the continual pressure of insurers for early discharge. In the absence of responsible action by insurers to provide adequate postpartum care coverage, Federal intervention is entirely appropriate."

ACOG has stated that selective, early discharge is safe and desirable for some mothers and babies. However, a decision for early discharge should be individualized and should be a mutual decision between the patient and her obstetric provider—taking into account medical condition, medical risk factors, support systems for the family, and the readiness of the mother to care for herself and her newborn. The trend among insurers of limiting coverage for hospital stays of only 24 hours or less is preventing this sound medical decision-making process from occurring. According to ACOG testimony before the committee:

What we now have is a situation where physicians are pressured to make a decision about early discharge not based on the best medical interests of their patients but, rather, based on the dictates of their patients' insurance policies. This pressure from insurers for early discharge appears to be driven primarily by financial motivations. It is a source of great frustration to ACOG that, after physicians have been encouraged by policy makers for years to develop practice guidelines to encourage uniform, quality patient care, we now see such guidelines completely ignored by insurers who believe they know best.

Senate bill 969 seeks to remedy this situation by requiring insurers to provide adequate postpartum coverage for mothers and their newborns as defined by current medical guidelines and as recommended by individual providers.

B. Overview of substantive changes to S. 969 contained in legislation adopted by the committee

The chairman's amendment in the nature of a substitute adopted by the committee contained several significant changes from the legislation that was originally introduced.

1. Coverage for minimum hospital stay following birth

The chairman's substitute modified the legislation's coverage requirements to make clear that there is a time period of up to 48 hours in the case of vaginal deliveries and 96 hours in the case of cesarean births where ultimate deference is accorded the decisions of providers and patients regarding the appropriate length of stay. As such, the legislation now requires health plans and insurance carriers that provide maternity benefits, including benefits for childbirth, to provide coverage to mothers and their newborns for at least 48 hours of inpatient stay following a normal vaginal delivery and at least 96 hours following a cesarean section without requiring the attending provider to obtain authorization from the health plan for such stays. Health plans and carriers are not required to provide coverage for this period if two conditions are met. First, the attending provider, in consultation with the mother, decides to discharge the mother earlier and, second, the plan provides coverage for postdelivery follow-up care.

2. Postdelivery follow-up care

The chairman's substitute also made changes to the bill's requirements for follow-up care. The modifications are designed to provide more flexibility to health plans and insurers, to assure that follow-up care is appropriate to monitor the health of the newborn and mother, and to provide plans more certainty about the required scope of follow-up care without imposing overly prescriptive requirements. The legislation now provides that where a mother and newborn are discharged from the hospital prior to 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, health plans are required to provide postdelivery follow-up care not more than 72 hours following the discharge. Such care is to be provided by a registered nurse, physician, nurse practitioner, nurse midwife, or physician's assistant experienced in maternal and child health. Care may be provided at home, hospital, doctor's office, birthing center, intermediate care facility, federally qualified health center, State health department maternity clinic, or other setting determined appropriate by the Secretary of Labor in consultation with the Secretary of Health and Human Services (HHS), but mothers must be given the option of receiving care in the home.

3. Plan prohibitions

The chairman's substitute includes a new consumer protection section designed to prohibit health plans and insurers from: (1) dropping mothers and newborns from health insurance coverage because they comply with the act; (2) providing monetary payments or rebates to mothers to encourage them to request less than 48/96 hours of stay; (3) penalizing doctors because they comply with the act; or (4) providing incentives to doctors to induce them to provide treatment in a manner inconsistent with the act.

4. Applicability

This section was added in the chairman's substitute to clarify that States have primary responsibility for enforcing the requirements of this act with respect to insurers and health maintenance organizations as they do under current law, that the Secretary of Labor has sole responsibility for ensuring that the requirements of the act are met by employer-sponsored ERISA plans, and that nothing in this act should be construed to affect or modify the preemption provisions of ERISA.

5. Enforcement

As introduced, S. 969 did not contain any enforcement provisions. The chairman's substitute specifies how the requirements of the legislation are to be enforced. States are to enforce the requirements of the act with respect to insurers and HMOs, and States may apply whatever penalties for noncompliance they deem appropriate. Employer-sponsored plans may be subject to civil enforcement penalties contained in sections 502, 504, 506, and 510 of ERISA. If a State fails to "substantially" enforce the requirements of the act, the Secretary of Labor, in consultation with the Secretary of HHS, will enforce the requirements with respect to insurers and HMOs using civil penalties provided under ERISA. This construct is necessary to ensure enforcement but to avoid imposing unfunded mandates on the States.

6. Definitions

This section of the chairman's substitute defines the terms "Attending Provider," "Beneficiary," "Employee Health Benefit Plan," "Group Purchaser," "Health Plan," "Health Plan Issuer," "Participant," and "Secretary." Of particular note is the expansion of the term "Attending Provider" to include "obstetrician-gynecologists, pediatricians, family physicians, nurse practitioners, nurse midwives, or other physicians primarily responsible for the care of a mother and her newborn child" (the original bill only applied to "physicians").

7. Preemption

The chairman's substitute clarifies that the act does not preempt those State laws and regulations that: (1) provide greater protection to patients and policyholders; (2) require health plans to provide coverage for at least 48/96 hours; (3) require health plans to provide coverage in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations; or (4) leave decisions about length of stay entirely to the doctor in consultation with the mother. With regard to follow-up care, the act does not preempt State laws providing greater protection to patients and policyholders or providing an option of timely follow-up care in the home.

8. Studies

Separate amendments by Senators Jeffords, DeWine, and Kennedy containing studies and reports on childbirth and the effect of reduced hospital stays were adopted by voice vote during the com-

mittee's executive session. These amendments were then combined into a single section of the bill. In this section, the Secretary of Health and Human Services is directed to establish an advisory panel to review data on health care services provided to mothers and newborns. The Secretary is also to study several issues related to quality of care and length of maternity stay, and to report to Congress within 5 years on a series of issues related to private sector improvements in prenatal and postnatal care. An interim report is required in 18 months.

This section would set up an advisory panel designed to bring together public and private organizations that have been working independently to determine appropriate methods for measuring the quality, safety, and effectiveness of the health care services provided to mothers and newborns following childbirth.

It became evident during the committee's deliberation that there was inadequate data available to suggest an appropriate length of stay and treatment protocol for mother and newborn after delivery. Moreover, the length of stay in the hospital was only one of the factors contributing to the health of mothers and newborns.

There is some data regarding postdelivery health outcomes currently in both the public and the private sectors. The Secretary of Health and Human Services shall, in consultation with the advisory panel, review the current data and conduct additional studies as necessary to explore the factors which affect the health of mothers and newborns.

Health consequences can be linked to specific maternal factors as well as newborn factors. Some maternal factors include the maternal age, number of pregnancies, and health knowledge. Some newborn factors include birth weight, infection, or delivery complications. Health care provider interventions at any point along the continuum can influence ultimate outcomes. The Secretary is directed to study these factors and the influence of these factors on length of stay.

The committee also recognizes that there is a diversity of measures of positive and negative consequences for mothers and newborns. This study should give focus to the particular benefits to be promoted or avoided. For instance, a negative outcome for a newborn could include infant death, jaundice, or a hospital readmission.

Postnatal care has changed significantly over the last several decades as have the settings in which treatment is delivered. An analysis of the advantages and disadvantages of different approaches during the postnatal period is another part of the studies. The introduction of financial incentives by health plans could also have an impact upon the health of mothers and newborns. Incentives have been provided directly to the mothers and/or to providers encouraging shorter hospital stays.

The committee intends for the advisory panel to consist of at least 15 members but no more than 21. The members of the panel should be chosen from public and private organizations and should have knowledge or experience in areas such as patient care, patient education, quality assurance, outcomes research, and consumer issues. The public entities would include federal agencies (such as the Maternal and Child Health Bureau and the Agency for Health

Care Policy and Research) and State associations (such as the National Association of Insurance Commissioners). Private sector organizations would include organizations such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics representing providers, as well as those representing insurers. Other private sector members could include consumer groups, private foundations, the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and employer representatives, including those involved in the development of the Health Plan Employer Data Information Set (HEDIS).

The committee recognizes the valuable leadership of HRSA's Maternal and Child Health Bureau (MCHB) support for research studies on safe hospital discharge practices for mothers and neonates. The MCHB's approach—in cooperation with such national organizations as the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Medical Association—emphasizes the benefits of bringing sound clinical judgment and state-of-the-art research methodologies to bear in exploring how length of stay and other common postdelivery services can affect health outcomes for mothers and newborns. A Scientific Summit sponsored by the MCHB concerned with "Assuring Quality Care for Moms and Babies" already has brought together researchers, providers, health plans, hospital administrators, consumers, employers, and representatives of federal and State governments to address appropriate medical procedures during the perinatal period, and to identify opportunities to strengthen the family and establish beneficial health care practices during the perinatal and postpartum periods. The committee expects the work of the advisory committee to build upon these timely efforts.

The committee intends for the advisory panel to work to establish consensus among its members as to the appropriateness of the act requiring health plans to provide a minimum length of stay for mothers and newborns following childbirth. The committee also intends that a summary of best practices for the care of newborns and mothers, recommendations for improvements in prenatal, postnatal, and follow-up care, and limitations on the databases in existence on the date of enactment of the act be reported to Congress.

The committee intends that the Secretary of HHS report to Congress at 18 months and at 3 years after the enactment of the act as to the progress and plan developed, and data from the study as available. A final report shall be given by the Secretary at no later than 5 years after the date of enactment of this act.

V. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 17, 1996.

Hon. NANCY LANDON KASSEBAUM,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

DEAR MADAM CHAIRMAN: The Congressional Budget Office (CBO) has reviewed S. 969, the Newborns' and Mothers' Health Protection

Act of 1996, as ordered reported on April 17, 1996. Enclosed are CBO's federal cost estimate and estimates of the costs of intergovernmental and private-sector mandates.

The bill would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on these estimates, we will be pleased to provide them. The CBO staff contacts are identified in the separate estimates.

Sincerely,

JAMES L. BLUM
(For June E. O'Neill, *Director*).

CONGRESSIONAL BUDGET OFFICE FEDERAL COST ESTIMATE

1. Bill number: S. 969.
 2. Bill title: The Newborns' and Mothers' Health Protection Act of 1966.
 3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources, April 17, 1996.
 4. Bill purpose: The bill would require that health insurers cover a mother and newborn for at least two nights in the hospital after most births and at least four nights after a caesarean section. Coverage of fewer days would be permissible if agreed to by the attending provider in consultation with the mother, and if a timely follow-up visit was covered. An advisory commission would be established within the Department of Health and Human Services.
 5. Estimated cost to the Federal Government: CBO and the Joint Committee on Taxation (JCT) estimate that S. 969 would increase the federal deficit by about \$265 million between 1997 and 2002 (see attached table). As a result of increases in employer-paid health premiums, federal income and payroll tax revenues would fall by about \$130 million over that period. Federal outlays for Medicaid would increase by about \$120 million, and mandatory outlays for federal employees' health benefits would increase by about \$15 million over the period. Discretionary spending for benefits of active federal workers and for the advisory commission would rise by another \$20 million, assuming appropriation of the necessary amounts.
 6. Basis of the estimate: CBO estimates that the proposal would initially raise private group health insurance premiums by about 0.06 percent. In response, employers and employees would reduce coverage or drop benefits for other services. Because of these reactions, we assume that employer contributions for health insurance would rise by only 0.02 percent. Most of that increase would be passed back to employees in lower wage. The lower wages, in turn, would reduce federal income and payroll tax revenues. JCT estimates that revenues would fall by about \$130 million between 1997 and 2002.
- CBO assumes that the number of hospital days would increase by about 400,000 under employer-sponsored plans, and that the marginal costs to health plans of each additional hospital day would be \$400. In addition, CBO estimates that the number of home health or other follow-up visits would increase by about 200,000 at a cost of \$100 per visit. The estimated federal cost of

S. 969 is reduced to the extent that states have enacted or are likely to enact similar legislation.

CBO estimates that S. 969 would increase the federal share of Medicaid by about \$120 million over the period. Although the bill's requirements would not necessarily apply to Medicaid as a direct payer, plans contracting to provide care to Medicaid recipients would be affected. CBO assumes that about 80,000 additional hospital days and home health visits would be provided by those plans at a cost of about \$300 for each additional hospital day and \$75 for each home health visit. On average, Medicaid costs would rise by about \$35 million a year, with the federal share increasing by about \$20 million a year and the states' share increasing by about \$15 million a year.

Costs for federal employees' health benefits would also increase slightly. Direct spending for annuitants' benefits would rise by about \$15 million over the period, and discretionary spending for active workers would rise by another \$15 million, assuming appropriation of the necessary amounts.

7. Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act of 1985 set up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

[By fiscal year, in millions of dollars]

	1996	1997	1998
Change in outlays	0	19	20
Change in receipts	0	-13	-20

8. Previous CBO estimate: None.

9. Estimate prepared by: Jeff Lemieux (private insurance and federal employees' benefits) and Jean Hearne (Medicaid).

10. Estimate approved by: Paul N. Van De Water, Assistant Director for Budget Analysis.

S. 969, THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996.

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002	1997- 2002
DIRECT SPENDING AND RECEIPTS							
Outlays:							
Medicaid	17	18	19	20	22	23	119
Federal employees health benefits	2	2	3	3	3	3	15
Total, outlays	19	20	22	23	25	26	134
Revenues:							
Income and payroll taxes	-13	-20	-22	-23	-25	-27	-130
Deficit	32	40	44	46	50	53	264
SPENDING SUBJECT TO APPROPRIATION							
Federal employees health benefits:							
Budget authority	2	2	3	3	3	3	16
Outlays	2	2	3	3	3	3	16
Advisory Commission:							
Budget authority	1	1	1	1	1	0	5
Outlays	1	1	1	1	1	0	5
Total, Discretionary Spending:							
Budget authority	3	3	4	4	4	3	21

S. 969, THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996.—Continued

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002	1997– 2002
Outlays	3	3	4	4	4	2	21

Sources: Congressional Budget Office, Joint Committee on Taxation.

CONGRESSIONAL BUDGET OFFICE ESTIMATED COST OF
INTERGOVERNMENTAL MANDATES

1. Bill number: S. 969.
2. Bill title: The Newborns' and Mothers' Health Protection Act of 1996.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on April 17, 1995.
4. Bill purpose: S. 969 would require health plans, including employer sponsored health plans, that provide maternity benefits to allow mothers and newborns to stay in the hospital for 48 hours after a normal vaginal delivery and 96 hours after a caesarean section. Hospital stays could be shortened if the attending provider, in consultation with the mother, agreed to a shorter stay and if the health plan covered a timely follow-up visit. Finally, health plans would have to notify each participant of the change in maternity benefits within 120 days of enactment.
5. Intergovernmental mandates contained in bill: The maternity benefit and notification requirements are mandates as defined by Public Law 104–4, the Unfunded Mandates Act of 1995. State and local governments as sponsors of health insurance for their employees would have to comply with these requirements.
6. Estimated direct costs of mandates to State, local, and tribal governments:
 - (a) Is the \$50 Million Threshold Exceeded? No.
 - (b) Total Direct Costs of Mandates: S. 1028 would increase the cost of health insurance for covered employees of state and local governments, but this cost would primarily be borne by the employees themselves and not state or local taxpayers. Although the amount of total compensation paid by state and local governments would remain unchanged in the long run, states and local governments would remain unchanged in the long run, states and local governments would face additional costs of \$1 million to \$10 million over about two years as they change other elements of their employees' compensation packages.
 - (c) Estimate of Necessary budget Authority: None.
7. Basic of estimate: CBO estimates that the new maternity benefit would increase health care costs by about 0.06 percent. State and local governments spend about \$40 billion on their employees' health care. Therefore, this bill would raise these costs by about \$25 million. We assume, however, that these cost would be passed on to state and local employees. Economists generally believe, and CBO's cost estimates have long assumed, that workers as a group bear most of the cost of employers' health insurance premiums. The primary reason for this conclusion is that the supply of labor is relatively insensitive to changes in take-home wages. Because most

workers continue to work even if their take-home pay declines, employers have little trouble shifting most of the cost of additional health insurance to workers' wages or other fringe benefits.

During a transition period of about two years, however, state and local governments would face additional costs of \$1 million to \$10 million. State and local governments would be unable to immediately adjust the compensation packages of all their employees. About 40 percent of state and local employees are represented by unions, and many of these employees are covered by collective bargaining agreements, which last about 2 years.

8. Appropriation or other Federal financial assistance provided in bill to cover mandate costs: None.

9. Other impacts on State, local, and tribal governments: The maternity benefit would also apply to managed care plans that contract with states to cover Medicaid recipients. As a result, CBO estimates that Medicaid costs for states would annually increase by about \$15 million. States would have the flexibility to reduce their coverage of optional services or benefits in order to pay for the additional Medicaid costs.

States would have the option of enforcing the requirements of S. 969 on issuers of health insurance in the group and individual markets. If a state decides not to enforce the new requirements, the federal government would do so. Because enforcement would be voluntary, this provision would not impose an intergovernmental mandate as defined in Public Law 104-4. However, the enforcement provisions would have a budgetary impact on state governments. States currently regulate the group and individual markets, and CBO does not expect any state would give up this authority and responsibility. States thus would incur additional costs as they enforce the new requirements. In 1995, according to the National Association of Insurance Commissioners, states spent \$650 million regulating all forms of insurance (health and others). CBO expects that S. 969 would increase their costs only marginally.

10. Previous CBO estimate: None.

11. Estimate prepared by: John Patterson.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE ESTIMATE OF COSTS OF PRIVATE-SECTOR MANDATES

1. Bill number: S. 969.

2. Bill title: The Newborns' and Mothers' Health Protection Act of 1996.

3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on April 17, 1996.

4. Bill purpose: S. 969 would require health plans providing maternity benefits to cover a specified minimum number of postpartum inpatient days for mothers and newborns. Coverage of fewer days would be permitted if agreed to by the attending provider in consultation with the mother, and if the plan covered a timely follow-up visit.

5. Private-sector mandates contained in the bill: S. 969 contains private-sector mandates, as defined in P.L. 104-4, the Unfunded

Mandates Reform Act, that would affect both fully-insured health plans and self-insured employee health benefits plans.

Health plans that provide maternity benefits would be required to cover a minimum number of inpatient days after delivery for both mothers and newborns. (Federal law requires firms with 15 or more employees to cover maternity benefits, if they offer health insurance.) The minimum length of stay would be 48 hours for normal vaginal deliveries and 96 hours for caesarean sections. Those coverage requirements could be waived only if the attending provider, in consultation with the mother, agreed to a shorter stay, and if the health plan covered a follow-up visit within 72 hours of leaving the hospital. Health plans would have to inform plan participants about the minimum length of stay requirements.

The bill would also prohibit practices that would encourage short inpatient stays. For example, health plans would not be permitted to provide monetary or other incentives to the mother or the attending provider in order to induce behavior inconsistent with the bill's provisions.

6. Estimated direct costs to the private-sector: CBO estimates that the maternity benefit mandates in S. 969 would increase aggregate premium payments for employment-based and individually purchased health plans by 0.06 percent. The additional direct costs to private-sector health plans—those plans that cover private-sector employees and individually purchased plans—would be approximately \$130 million in fiscal year 1997, rising to \$220 million by 2001 (see Table). The provisions would be effective for plan years beginning on or after January 1, 1997.

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001
Direct private-sector cost	130	180	190	200	220

Basis of the estimate: The direct costs of the maternity mandates in S. 969 consist of the costs of the additional hospital days and follow-up visits that health plans would now have to cover. Reductions in future insured costs resulting from the increased services required under the bill would be subtracted from the additional costs, but those savings appear to be relatively small.

After adjusting for state laws that already mandate similar coverage, CBO concluded that about 900,000 insured births a year currently have shorter lengths of stay than the minimums specified in the bill. Under S. 969, some of those births would have an additional inpatient day, while others would have a follow-up visit. But some of the latter group already receive a timely follow-up visit under current law, and so would incur no additional costs. Thus, CBO estimated that the bill would result in about 400,000 additional inpatient days and 200,000 additional follow-up visits annually. Assuming that an additional post-delivery hospital day would have a marginal cost to health plans of \$400 in 1996 and a postpartum visit would cost \$100, CBO concluded that the bill would result in an increase in insured costs of 0.06 percent of all employment-based and individually purchased premiums. Applying that percentage to private-sector premiums only, leads to the esti-

mate that the direct private-sector costs of S. 969 would be about \$130 million in 1997 rising to about \$220 million in 2001.

Not all of those costs would be transformed into higher premiums. Employers, for example, might reduce the generosity of other benefits to offset the increased maternity costs. People purchasing policies in the individual market might also choose to purchase less generous policies rather than pay higher premiums. Any net increases in premiums paid by employers would most likely be passed on to workers in the form of lower wages and other fringe benefits.

CBO's estimates do not take into account any benefits from the additional coverage that might accrue to parties other than health plans—such as to new parents. Nor do the estimates incorporate other indirect costs or benefits. Although such factors may be important for weighing the merits of the bill, the Unfunded Mandates Reform Act restricts CBO's estimates of the mandates' effects to direct costs and savings.

7. Appropriations or other Federal financial assistance: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: James Baumgardner.

10. Estimate approved by: Joseph R. Antos, Assistant Director for Health and Human Resources.

VI. REGULATORY IMPACT STATEMENT

The committee has determined that there will be no increase in the regulatory burden of paperwork as the result of this bill.

VII. SECTION-BY-SECTION ANALYSIS

Section 1. Short title

The act is cited as the “Newborns’ and Mothers’ Health Protection Act of 1996.”

Section 2. Findings

The chairman’s substitute contains a new findings section stating that: (1) the length of postdelivery inpatient care should be based on unique characteristics of each mother and her newborn child, and (2) the decision to discharge a mother and newborn from the hospital should be made by the attending provider in consultation with the mother.

Section 3. Required coverage for minimum hospital stay following birth

This section requires health plans that provide maternity benefits, including benefits for childbirth, to provide coverage to mothers and their newborns for at least 48 hours of inpatient stay following a normal vaginal delivery and at least 96 hours following a caesarean section without requiring the attending provider to obtain authorization from the health plan. Health plans are *not* required to provide coverage for the 48/96 hour period if two conditions are met: (1) the attending provider, in consultation with the mother, decides to discharge the mother earlier; and (2) the health plan provides coverage for postdelivery follow-up care.

Section 4. Postdelivery follow-up care

Where a mother and a newborn are discharged from the hospital prior to 48 hours following a normal vaginal delivery or 96 hours following a caesarean section, health plans are required to provide postdelivery follow-up care not more than 72 hours following the discharge. Such care is to be provided by a registered nurse, physician, nurse practitioner, nurse midwife, or physician's assistant experienced in maternal and child health. Care may be provided at home, hospital, doctor's office, birthing center, intermediate care facility, federally qualified health center, State health department maternity clinic, or other setting determined appropriate by the Secretary of Labor in consultation with the Secretary of Health and Human Services (HHS), but mothers must be given the option of receiving care in the home.

Section 5. Prohibitions

This section of the chairman's substitute prohibits health plans from: (1) dropping mothers and newborns from coverage because they comply with the act; (2) providing monetary payments or rebates to mothers to encourage them to request less than 48/96 hours of stay; (3) penalizing doctors because they comply with the act; or (4) providing incentives to doctors to induce them to provide treatment in a manner inconsistent with the act.

Section 6. Notice

This section of the chairman's substitute requires both insurers and employer-sponsored plans covered by the Employee Retirement Income Security Act (ERISA) to notify plan participants and policyholders of the coverage required by this act.

Section 7. Applicability

This section, which works in conjunction with Section 8 on "Enforcement," clarifies that States have primary responsibility for enforcing the requirements of this act with respect to insurers and HMOs—as they do under current law, that the Secretary of Labor has sole responsibility for ensuring that the requirements of the act are met by employer-sponsored ERISA plans, and that nothing in this act should be construed to affect or modify the preemption provisions of ERISA.

Section 8. Enforcement

This section specifies that States enforce the requirements of the act with respect to insurers and HMOs and that they may apply whatever penalties for noncompliance they wish. Employer-sponsored plans may be subject to civil enforcement penalties contained in sections 502, 504, 506, and 510 of ERISA. If a State fails to "substantially" enforce the requirements of the act, the Secretary of Labor, in consultation with the Secretary of HHS, will enforce the requirements with respect to insurers and HMOs using civil penalties provided under ERISA. This construct is necessary to ensure enforcement but to avoid imposing unfunded mandates on the States.

Section 9. Definitions

This section of the chairman's substitute defines the terms "Attending Provider," "Beneficiary," "Employee Health Benefit Plan," "Group Purchaser," "Health Plan," "Health Plan Issuer," "Participant," and "Secretary." Of particular note is the expansion of the term "Attending Provider" to include "obstetrician-gynecologists, pediatricians, family physicians, nurse practitioners, nurse midwives, or other physicians primarily responsible for the care of a mother and her newborn child" (the original bill only applied to "physicians").

Section 10. Preemption

The act does not preempt those State laws that: (1) provide greater protection to patients and policyholders; (2) require health plans to provide coverage for at least 48/96 hours; (3) require health plans to provide coverage in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical association; or (4) leave decisions about length of stay entirely to the doctor in consultation with the mother. With regard to follow-up care, the act does not preempt State laws providing greater protection to patients and policyholders or providing an option of timely follow-up care in the home.

Section 11. Study and reports concerning childbirth

The act directs the Secretary of Health and Human Services to establish an advisory panel to review data on health care services provided to mothers and newborns and postpartum care. It also directs the Secretary to study several issues related to quality of care and length of maternity stay, and to report to Congress within 5 years on a series of issues related to private sector improvements in prenatal and postnatal care. An interim report is required in 18 months.

Section 12. Effective date

The act is effective on the first day of the plan year or contract year beginning on or after January 1, 1997.

ADDITIONAL VIEWS OF SENATOR JAMES M. JEFFORDS

We have never in the past stepped legislatively in the realm of defining what, specifically, should be covered by a health plan in treating a particular disease or medical condition. This Act suggests a specific treatment guideline for the length of stay after child-birth and follow-up care in federal legislation. The Act refers to a specific “window of time” in which providers and mothers can make their own decision about when to leave the hospital. The time frame is 48 hours after a vaginal birth and 96 hours after cesarean section.

During consideration of the “Newborns’ and Mothers’ Health Protection Act of 1996” in Committee it became apparent that there has not been enough data collected on the impact of shorter hospital stays for mothers and newborns. It is a problem that some health plans have moved ahead with shorter and shorter stays without such data, but it is also concerning that we commit ourselves in legislation to a specific length of hospital stay without this data in order to solve this problem.

Medical practices change over time with innovations, new clinical information, public pressure and changes in the social environment. Several years ago it was thought that longer stays in the hospital for mothers and newborn were necessary than are routinely practiced today. In addition, health outcomes for mothers and newborns are dependent upon the continuum of care they receive before, during and after the delivery event involving a broader range of factors than simply the care given in the hospital setting. For example, a young inexperienced mother might have the same length of hospital stay as a more experienced mother, but the outcomes would be very different because maternal education is a very important factor influencing outcomes. Both the health plans and the medical community would concur on this: there is not enough data out there to say what is the “optimum length of stay” for mothers and newborns after delivery.

I supported this legislation out of the Committee because I believe we should err on the side of caution. I am concerned about the health risks for mothers and their newborns if they are being discharged from the hospital too soon. I also believe that we need to do the required research to make an informed decision about the optimum length of stay and best practices for mothers and newborns while essentially putting a moratorium on health plans shortening the length of stay. As more information is available on the optimum length of stay for mothers and newborns the federal role should be minimized.

We are in an era of cost containment for our health care delivery system. Hospital inpatient stays are more costly than managing patients on an outpatient basis. There was no formal CBO scoring on this legislation, but by some estimates a .5% increase in pre-

miums is anticipated. Legislation such as this also inhibits the manner in which plans work toward cost-containment by specifying what should be covered by them. Requiring specific hospital stays impedes market competition among plans to achieve the most cost-effective care.

I offered an amendment that would sunset this bill in 5 years after an advisory panel reports to Congress as to the appropriateness of the requirements of this Act. My amendment directed the Secretary of Health and Human Services to establish an advisory panel of experts in maternal and child health and health outcomes that would review the data currently available and then recommend that, if required, additional data be gathered through the appropriate channels. It is anticipated that such review and research can be successfully done in approximately 3 to 5 years. The advisory panel, composed of representation from both the public and private sectors, will come to consensus about the length of stay and best practices for mothers and newborns after childbirth so that deliveries can be both safe for mothers and newborns, and cost effective for plans. The Secretary of Health and Human Services shall then report this information to Congress and thus, raise again the question as to the need for this legislation. It may be found by that time that 48 hours time for a hospital stay for mother and newborn after delivery is obsolete. Unfortunately only the study portion of my amendment was passed by the committee. I believe the combined study with the potential sunset best keeps this Act timely, accurate and responsible.

JIM JEFFORDS.

