Health Care Mandates: The Delivery Debate

I. INTRODUCTION

Legislation prescribing minimum in-hospital care for mothers and their newborns has recently been introduced in several states and the United States Congress. In 1996, half the states will propose legislation or impose regulatory measures requiring health insurers to provide at least a forty-eight hour hospital stay following a vaginal delivery.[1] The legislation targets the practice of "drive through deliveries"[2] and aims to curb the trend of health insurers and health maintenance organizations ("HMOs")[3] that provide as little as twelve hours of in-patient hospital care following birth.

Although the changing economics of the health care industry[4] support the practice of early discharge, the medical soundness remains uncertain. With the ability of the health care industry to shift financing methods, the fiscal burden imposed by legislative mandate should not be viewed as unbearable. Part I of this Com-

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[1] Keith H. Hammonds, *Newborn Babies, Bawling Moms*, BUS. WK., Jan. 8, 1996, at 40; *see also New Mexico OKs Maternity Stays Through Regulatory Process*, STATE HEALTH WK., Dec. 4, 1995, at 1 (reporting that New Mexico is the fifth state to impose mandatory maternity stays yet is the first state to do so through regulatory measures).

[2] Milt Freudenheim, *H.M.O.'s Cope With a Backlash on Cost Cutting*, N.Y. TIMES, May 19, 1996, at 1. Thirty-four states have already enacted laws limiting the devices used by managed care organizations to shorten hospital stays. *Id.*

[3] HMOs are an example of a managed care organization. Mark H. Tabak, *What Have We Learned? Managed Care Experience Can Be Model for Health Care*, BUS. INS., March 2, 1992, at 20. Managed care attempts delivery of efficient medical services on a planned basis. *Id.* Managed care differs from the traditional health care model of fee-for-services because procedures are planned and controlled. *Id.*

Pursuant to the Health Maintenance Act, an HMO must:

> (1) maintain an organized system for the provision of health care in a geographic area, or otherwise assure for the delivery of that care; (2) provide agreed-upon basic and supplemental health maintenance and treatment services; (3) permit the voluntary enrollment of a group of people; and, (4) rely upon a community rating.

Sana Loue, *An Epidemiological Framework for the Formulation of Health Insurance Policy*, 14 J. LEGAL MED. 523, 528 (1993) (citations omitted).

Illustrating how managed care differs from the traditional medical services model, an HMO has been defined as a prepaid health care plan in contrast to an indemnity plan. Oswald A.J. Mascarenhas, *Marketing Health Care to Employees: The Structure of Employee Health Care Plan Satisfaction*, 13 J. HEALTH CARE MARKETING 34, 45 (1993). While most traditional health plan subscribers pay on a fee-for-service basis, the HMO subscriber remits periodic fees. *Id.* The HMO sets its own rates and benefits offered, often subject to state statutory requirements. *Id.* Companies participating in an HMO contribute premiums for employees in the same manner as it would for traditional indemnity plans. *Id.*

[4] *See* Section III, *infra.*

ment explains the background and context of the minimum maternity stay legislation focusing on the recently enacted New Jersey law and the federal bill. Part II outlines the arguments in support of the legislative mandates, whereas Part III presents the counter position of health care insurers. In conclusion, Part IV addresses the merits of both positions and determines that until conclusive data prove the safety of early discharge, legislative mandates constitute a valid police power enactment.

A. Background

The average length of a hospital stay following birth decreased dramatically in the last twenty-five years.[5] Perpetuating the trend of early discharge, insurers, the most common third-party payers, will only pay for the shortest hospital stay.[6] In addition, mothers belonging to HMOs are far more likely to be discharged early than mothers with private insurance.[7]

Although the proposed legislation assails the practice of "early discharge," no single definition of "early discharge" exists.[8] Health care practitioners in the United States currently regard early discharge as a hospital stay after delivery of less than forty-eight hours.[9] By comparison, literature published before the 1980s and

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[5] Jerry Geisel, *Maternity Stay Backlash Grows: Bill Would Mandate Minimum Inpatient Stay*, BUS. INS., July 10, 1995, at 1. According to Geisel, the length of the average maternity hospital stay has plunged by 50% since 1970. *Id.*

[6] John R. Britton et al., *Early Discharge of the Term Newborn: A Continued Dilemma*, PEDIATRICS, Sept. 1994, at 291. *See also Rapid Discharges After C-Sections Lead to More Hospital Readmissions*, 3 HEALTH CARE POL'Y REP. 1318, 1319 (BNA) (Aug. 14, 1995) (noting that the trend to discharge within twenty-four hours is much more prominent in the Western states).

California HMOs pioneered the twenty-four hour trend and have even introduced stays of as little as twelve hours. Hammonds, *supra* note 1, at 40. Perhaps surprisingly, the impetus to curb the practice of early discharge came from the Eastern states of Maryland, New Jersey and North Carolina. *See id.*

[7] *Rapid Discharges*, *supra* note 6, at 1319. Participation in an HMO is commonly linked to employment. Rosemary Barber-Madden & Jonathan B. Kotch, *Maternity Care Financing: Universal Access or Universal Care?*, 15 J. HEALTH POL., POL'Y & L. 797, 800 (1990). As a result, the increasing popularity of the HMO form of health care coverage means little for the poor and underinsured. *Id.* Low income recipients of public health benefits, however, often enjoy a longer maternity hospital stay than other patients. Elizabeth Wasserman, *Backlash Building Against U.S. Trend to Shorten Childbirth Hospital Stay*, STAR-LEDGER, July 9, 1995, at 35.

[8] Woodie Kessel et al., *Early Discharge: In the End, It Is Judgment*, PEDIATRICS, Oct. 1995, at 739.

[9] Kessel, *supra* note 8, at 739.

In the United States, physicians classify early discharge patients in three groups: "(1) no additional routine postdischarge services before the standard 2-week well infant visit; (2) an office- or clinic-based visit 1 to 3 days after discharge; and (3) postpar-

European studies characterize early discharge as between five to seven days.[10]

Proponents of the legislative initiatives emphasize the problems alleged to result from shortened maternity stays.[11] For instance, some argue that mothers require more than twenty-four hours of in-patient care to recuperate from delivery.[12] In the days immediately following childbirth, mothers must learn how to feed and care for their babies while physically and mentally recovering from the delivery. Critics of twenty-four hour discharge argue that this learning and bonding is best done under the supervision of medical personnel.[13] Additionally, psychological benefits may result from a longer hospital stay.[14] Newborns who are discharged early potentially face grave problems. They may not receive adequate nourishment because mothers often have not begun to lactate within twenty-four hours of delivery.[15] Additionally, new mothers, in particular, are often unable to detect the signs of jaundice.[16] Health care professionals express concern over the accu-

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tum home visiting." Paula Braveman et al., *Early Discharge of Newborns and Mothers: A Critical Review of the Literature*, PEDIATRICS, Oct. 1995, at 721.

10 Braveman, *supra* note 9, at 721; *see also* Kessel, *supra* note 8, at 740 (describing 48 hours as early discharge in the United States, while in Europe discharge within five days of delivery is considered early).

Other countries, such as Canada, have also initiated movements against "drive-through deliveries". Nicole Parton, *'Drive-through Deliveries' Assailed as a Dangerous Trend*, VANCOUVER SUN, Dec. 2, 1995, at B8. Ironically, the average maternity stay after a vaginal birth is three days in British Columbia. *Id.*

11 Sen. Bradley (D. NJ) enumerated reasons why such legislation is necessary including: health problems suffered by newborns such as jaundice and dehydration; risk of infection to the mother; and inadequate education regarding the care of a newborn. 141 CONG. REC. S9175 (daily ed. June 27, 1995).

12 Jacqueline Shaheen, *Physicians Protest Maternity Insurance*, N.Y. TIMES, Mar. 5, 1995, § 13, at 1; *see also* Braveman, *supra* note 9, at 720 (discussing the possibility of "[i]nfection or breakdown of episiotomy or cesarean wounds [which] may not manifest for 1 or 2 days after delivery").

13 Shaheen, *supra* note 12, at 1. The in-hospital teaching affected includes "breast-feeding, infant care, women's health needs, and family planning, and for maternal and family psychosocial assessment." Braveman, *supra* note 9, at 720.

14 *See* Beth Ginzinger, *The Revolt Against the One-Day Stay*, HEALTH CARE STRATEGIC MANAGEMENT, Jan. 1996, at 6 (stating that patient satisfaction surveys typically indicate that mothers who are discharged after 24 hours perceive the care received as inadequate).

Proponents of early discharge also use psychosocial benefits as an argument in support of the practice. Britton, *supra* note 6, at 291. Supporters of early discharge cite enhanced interaction with family and increased bonding and breastfeeding to be among the benefits. *Id.* Nonetheless, the results of studies indicating the psychological benefits of early discharge are questioned. *Id.* at 291-92.

15 Shaheen, *supra* note 12, at 14; *see also* Braveman, *supra* note 9, at 720 (discussing the problem of delayed lactation).

16 *Id.* Jaundice is a symptom of hyperbilirubinemia which can cause brain damage

racy of tests diagnosing mental retardation and congenital defects.[17] These tests are most accurate when performed twenty-four hours after a newborn's first feeding.[18]

B. New Jersey Forty-Eight Hour Maternity Legislation

In 1995, the New Jersey Legislature, responding to concerns over the health care industry's standard practice of discharging mother and child twenty-four hours after a vaginal delivery, mandated a minimum hospital stay.[19] The New Jersey statute requires all providers of maternity benefits to pay for "[forty-eight] hours of in-patient care following a vaginal delivery and a minimum of [ninety-six] hours of in-patient care following a cesarean section" for both the mother and newborn.[20] The New Jersey law excepts from the coverage of the statute hospital service corporations that provide home care services to a mother and newborn.[21] A health care facility, however, cannot be exempted from the statutory mandates if additional in-patient care is required by the attending physician.[22]

Maryland pioneered the effort to apply the brakes on "drive-through-deliveries," passing the first law to mandate minimum maternity stays.[23] The New Jersey law differs from the Maryland statute because the New Jersey law gives the mother, not the physician, the choice to stay in the hospital.[24] Despite the sweeping attempt to assure all mothers of minimum hospital care, the New Jersey law

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and hearing loss. *Id.* "Jaundice usually peaks at around 3 days after delivery . . . ." Braveman, *supra* note 9, at 720.

17 Shaheen, *supra* note 12, at 14. Phenylketonuria, commonly referred to as PKU, is a condition which can lead to mental retardation. *Id.* Most states mandate that a PKU test be performed before a newborn is released from the hospital. *Id.*

18 *Id.*

19 Terri P. Guess, *Whitman Signs Maternity Bill, Bringing the 'OB Express' to a Halt*, STAR-LEDGER, June 29, 1995, at 19. The bill passed the state assembly unanimously. *Id.* The legislators proposed the bill, in response to the death of newborn Michelina Alanna Bauman. *Id.* Michelina Alanna died within two days of birth of a massive strep infection. *Id.* The infant and her mother were discharged from a Gloucester County hospital after little more than 24 hours from delivery. *Id.*

20 N.J. STAT. ANN. § 26:2J-4.9(a) (West 1996).

21 N.J. STAT. ANN. § 26:2J-4.9(b) (West 1996).

22 *Id.*

23 MD. CODE ANN. HEALTH-GEN. § 19-1305.4 (Supp. 1995).

24 N.J. STAT. ANN. § 26:2J-4.9(b) (West 1996). The Maryland law allows a one-day stay conditioned upon the insurer providing home care follow-up on the second day following delivery. *Statelines Maryland: Maternity Stay Law Having "No Effect,"* AM. HEALTH LINE, Dec. 4, 1995, at 6. Nevertheless, hospitals find that the law proves ineffective in increasing the length of hospital stay because insurers refuse to relax their guidelines. *Id.*

allows a plan to circumvent the legislation by providing home care follow-up that is significantly less expensive than a hospital stay.[25]

The most significant deficiency of the state law is its inability to affect the health plans of self-insured companies.[26] Furthermore, as a result of federal preemption in the field of employee benefits, New Jersey cannot force out-of-state corporations to comply with the hospital stay mandates.[27] Thus, those who work in New York or Pennsylvania yet live in nearby New Jersey may not be covered by the statute. The only means of curing the inadequacies of the state legislation is the enactment of a federal law.[28]

C. *Federal Legislation*

Senators Bill Bradley (D-NJ) and Nancy Kassebaum (R-Kan) proposed The New Borns' and Mothers' Health Protection Act of 1995 to the United States Senate on June 28, 1995.[29] The bipartisan federal bill, modeled after the New Jersey legislation, incorporates the recommendations of the American College of Obstetricians and Gynecologists and the American Academy of Pe-

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25 N.J. STAT. ANN. § 26:2J-4.9(b) (West 1996); *see* Joan Whitlow, *Blues Birth Coverage Shifts to 24-Hour Stay*, STAR-LEDGER, Dec. 16, 1993, at 8 (discussing the onset of early discharge in New Jersey).

26 Donna Leusner, *Insurers Overlooking Maternity Loophole*, STAR-LEDGER, Aug. 5, 1995, at 8. Despite the loophole for self-insured employers, hospitals find significant voluntarily compliance with the law. *Id.* at 1.

27 *Id.* at 8. The Employee Retirement Income Security Act ("ERISA") constrains state action, reserving the power of the federal government to regulation benefit packages. *Physicians Blame Insurance Profits for Trend in Early Hospital Releases*, 3 HEALTH CARE POL'Y REP. 37 (BNA) (Sept. 18, 1995). Because ERISA preempts state law with regard to out-of-state corporations, no state will be able to entirely close the loopholes. *Id.*

28 Leusner, *supra* note 26, at 8.

29 S. 969, 104th Cong., 1st Sess. (1995). Although the Bradley-Kassebaum legislation is the bill receiving the most media attention, five similar bills have been introduced: New Borns' and Mothers' Health Protection Act of 1995, H.R. 1948, 104th Cong., 1st Sess. (1995) (referred to the House Commerce Committee); Postnatal Protection Act of 1995, H.R. 1968, 104th Cong., 1st Sess. (1995); Obstetrical Benefits Under the Federal Employees Health Benefit Program, H.R. 1936, 104th Cong., 1st Sess. (1995) (referred to the Committee on Government Reform and Oversight); Mother-Infant Health Protection Act of 1995, H.R. 1955, 104th Cong., 1st Sess. (1995) (referred to the Committee on Economic and Educational Opportunities); Mothers' and Infants' Good Health Act of 1995, H.R. 1970, 104th Cong., 1st Sess. (1995).

In contrast to the other bills which are essentially identical, H.R. 1970 does not include a provision excepting home delivery. *Legislative Summaries: Newborns' and Mothers' Health Protection Act*, HEALTH LEGIS. & REGULATION, July 26, 1995 at 5. Rather, H.R. 1970 requires a plan to provide 48 hours of home-care. Mothers' and Infants' Good Health Act, H.R. 1970, 104th Cong., 1st Sess. § 2(a)(2) (1995).

diatrics.[30] The bill requires health plans that provide maternity benefits to "ensure that coverage is provided for a minimum of [forty-eight] hours of in-patient care following a vaginal delivery and a minimum of [ninety-six] hours of in-patient care following a caesarean section for a mother and her newly born child in a health care facility."[31]

Like the New Jersey law, the federal legislation includes an exception for plans which provide post-delivery home care for the mother and newborn.[32] Another significant similarity to the New Jersey law prohibits exemption from the requirements of the bill if the mother or physician requests a hospital stay despite an offer of home care.[33] Recently approved by the Senate Committee on Labor and Human Resources, the bill applies to self-insured companies[34] and gained the support of President Clinton.[35]

II. ARGUMENTS IN SUPPORT OF LEGISLATIVE ACTION

A. *Pervasive Scheme of Health Care Regulation*

The movement of state and federal lawmakers legislating a minimum maternity stay is by no means an isolated incident of health care regulation. Embracing the HMO model of health care finance as an attractive means to cut costs while providing quality health care,[36] Congress enacted the Health Maintenance Organization Act in 1973.[37]

In light of the failure to pass President Clinton's American

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30 Charles E. Schmidt, Jr., *Managed Care Faces Stinging Backlash*, BEST'S REVIEW, LIFE/HEALTH, Nov. 1995, at 22.

31 S. 969, 104th Cong., 1st Sess. § 2(a) (1995).

32 *Id.* at § 2(b)(1).

33 *Id.* In addition, the health care insurer is prohibited from contracting with the mother for less coverage than the minimum statutory requirement. *Id.* at § 2(c).

The bill's effect on private contracts has not gone unnoticed by the sponsors. Mary Jane Fisher, *Sen. Bill Addresses Hospital Stays For Moms, Newborns*, NAT'L UNDERWRITER, LIFE & HEALTH/FIN. SERVICES, July 10, 1995, at 4. In fact, Senator Kassebaum noted her reservations related to legislation which restricts private contracting. *Id.* at 4, 6. Nevertheless, the senator stated that, "[w]hat is at stake here is not merely an impediment to the traditional doctor-patient relationship, but instead the health and safety of millions of America's children." *Id.* at 6.

34 Robert Pear, *Bill Lengthens Hospitalization After Births*, N.Y. TIMES, April 18, 1996, at A20.

35 Robert Pear, *Clinton Says Maternity Plans Need to Offer 2 Hospital Days*, N.Y. TIMES, May 12, 1996, at A27.

36 Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?*, 83 GEO. L.J. 1821, 1822-23 (1995).

37 *See* 42 U.S.C. § 300e (1991) (codifying the requirements of HMOs).

Health Security Act of 1994,[38] state legislatures address the need for health care reform by enacting *ad hoc* measures rather than a pervasive scheme of federal health regulation.[39] States, including New Jersey, regulate the minimum services that an HMO must provide to maintain certification.[40] The regulation is so precise that the New Jersey HMO statute clearly details the services that must be provided to subscribers at different age levels.[41] Perhaps the most invasive measure, New Jersey regulates the maximum cost of such service.[42] States also regulate the grievance procedures when an HMO subscriber is denied care by the health care provider.[43] Accordingly, legislation aimed at overseeing the practice of health care providers is well-charted territory.

B. History of State Interest in Newborn Health

Legislatures often invoke police powers to protect the health and welfare of its citizens.[44] The states' special protective interest in the health of new mothers and infants reveals itself in the abortion context.[45] For instance, many state legislatures restrict women's access to abortion in apparent concern for the well-being of

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[38] *See* H.R. 3960, 103d Cong., 2d Sess. (1994) (proposing to ensure quality health care for all Americans).

[39] Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 325 (1995) (discussing financial incentives to coerce hospitals into providing care for the uninsured). "[T]here is no national policy, no underlying system, for assuring that even the most basic services are available and affordable. Rather, what exists is a patchwork of public programs and funding mechanisms for the uninsured and an ever-increasing number and type of private insurers." Barber-Madden & Kotch, *supra* note 7, at 798.

[40] *See, e.g.*, N.J. STAT. ANN. § 26:2J-4.6 (West 1994) (enumerating a variety of services which must be provided by HMOs); *see also* CAL. INSURANCE CODE § 11512 et seq. (West 1993) (delineating required services).

[41] N.J. STAT. ANN. § 26:2J-4.6(a) (West 1994).

[42] N.J. STAT. ANN. § 26:2J-4.6(b) (West 1994).

[43] *See, e.g.*, N.J. STAT. ANN. § 26:2H-12.2 (West Supp. 1995) (requiring notice to the Medical Practitioner Review Panel if a staff review of a physician's conduct or patient care occurs); OHIO REV. CODE ANN. § 1742.14 (Anderson 1991) (requiring that HMOs establish a complaint system approved by the state's superintendent of insurance); W. VA. CODE § 33-25A-12 (1995) (providing that the subscribers receive detailed information of the complaint system and open access to the HMO grievance coordinator).

[44] Some famous examples of state's invocation of police powers occurred in Commerce Clause challenges to legislative enactments. *See, e.g.*, Brotherhood of Locomotive Firemen & Enginemen v. Chicago, Rock Island & Pac. R.R., 393 U.S. 129, 144 (1968) (upholding a statute requiring trains to carry additional crew, thus imposing substantial cost upon railroad); Hipolite Egg Co. v. United States, 220 U.S. 45, 57 (1911) (upholding a prohibition on the interstate transport of contaminated foods).

[45] *See, e.g.*, Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 846 (1992) (reiterating the states' interest in newborn health and welfare); City

fetuses.[46] A number of states require that newborns be tested for PKU.[47] Some jurisdictions have gone so far as to criminalize behavior that may result in harm to a fetus,[48] such as ingesting narcotics during pregnancy.[49]

These statutes are indicative of a state's interest in the protection of infants. Consequently, if medical problems arise as a result of inadequate treatment by the health care industry, one may infer that the state will be compelled by public opinion to exercise its police powers.[50] In fact, infringing upon the decision-making of health care providers is a less drastic measure than other legislative attempts to safeguard the health of a newborn.[51]

Although the bill substitutes legislative decision-making for that of the physician, proponents of mandatory hospital stays contend that the exceptions in the federal legislation provide enough

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of Akron v. Akron Ctr. For Reprod. Health, 462 U.S. 416, 434 (1983) (reaffirming the state's compelling interest in prenatal health).

46 *See* Ruth Colker, *An Equal Protection Analysis of United States Reproductive Health Policy: Gender, Race, Age, and Class*, 1991 DUKE L.J. 324, 328 n.12 (discussing literature concerning the abortion debate centered on fetuses without regard to mothers). Colker criticizes aspects of abortion legislation, such as parental notification. *Id.* at 328. The argument against such legislation stems from judicial mandates of two parent notification without considering the socioeconomic position of the pregnant minor. *Id.* By contrast, the mother and newborn maternity legislation accounts for socioeconomic differences by allowing a mother to opt out of the required hospital stay if her home situation is supportive. S. 969, 104th Cong., 1st Sess. § 2(b)(1) (1995).

47 Sandra G. Boodman, *Early-Discharge Infants Risk Metabolic Disorder*, WASH. POST, Dec. 19, 1995, (Health), at 5; *see supra* note 17 (discussing PKU).

48 For example, one may be convicted of fetal neglect for failure to follow physician's advice. James J. Nocon, *Physicians and Maternal-Fetal Conflict: Duties, Rights and Responsibilities*, 5 J.L. & HEALTH 1, 2 (1990-91).

49 *Id. But see* Sheriff, Washoe County v. Encoe, 885 P.2d 596, 599 (Nev. 1994) (holding that statute criminalizing child endangerment was not applicable to a pregnant woman who ingested narcotics which were subsequently transmitted to the fetus through the umbilical cord).

50 In particular, critics of fetal protective legislation argue that the rights of the fetus are placed in a position superior to that of the mother. *See, e.g.*, Kevin J. Curnin, Note, *Newborn HIV Screening And New York Assembly Bill No. 6747-B: Privacy And Equal Protection Of Pregnant Women*, 21 FORDHAM URB. L.J. 857, 860 (1994) (arguing that mandatory HIV testing for newborns is violative of the mother's right to equal protection under the law); *see also* Rebecca Manson & Judy Marolt, *A New Crime, Fetal Neglect: State Intervention to Protect the Unborn - Protection at What Cost?*, 24 CAL. W. L. REV. 161, 161-62 (1988) (stating that "conferring of separate fetal rights without proper protection, may lead to violations of the mother's rights to privacy, bodily integrity, parental autonomy, and equal protection").

51 *See, e.g.*, Manson & Marolt, *supra* note 50, at 171 (noting that under some statutes a woman's physician "could be required to report a pregnant woman for activities that might endanger her fetus").

flexibility to preserve the doctor's authority.[52] Increasingly, however, traditional insurers and managed care advocates decry the unwelcome precedent set by legislative mandates and seek to preserve the physician's role.[53]

C. *Disadvantaged Often Affected By a Shortened Stay*

Legislatures often act where the disadvantaged are affected. In the maternity context, first time mothers and those who are economically disadvantaged run a disproportionate risk of being readmitted to the hospital after an early discharge.[54] Unfortunately, many women whose financial situation dictates early discharge are most likely to be at risk for inadequate follow-up or recognition of medical problems.[55]

In a reported study, ten percent of low income mothers failed to return for follow-up hospital visits despite having signed a contract to return.[56] Health problems and risk of medical complications are higher for low income women and their newborns.[57] By contrast, studies indicating that there are no significant effects of early discharge are commonly compiled using information about middle-class women who typically receive support from a network of family and friends at home.[58]

D. *Employee Protective Legislation*

The police powers of the state also extend to workplace protection, particularly regarding employee-employer contracts.[59]

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52 Christina Kent, *Bill Would Put the Brakes on 'Drive-through Deliveries'*, AM. MED. NEWS, Oct. 2, 1995, at 1, 19.

53 *Maternity Stay Mandates at Issue In Labor Committee Hearing*, HEALTH LEGIS. & REG., Sept. 13, 1995, at 2 [hereinafter *Maternity Stay Mandates*]; *See also* Christine Jordan Sexton, *48-Hour Maternity Stay Bill In Florida*, NAT'L UNDERWRITER, LIFE & HEALTH/FIN. SERVICES, Nov. 20, 1995, at 18 (discussing the managed care lobby's opposition to the Florida bill); *see infra* note 142 and accompanying text for a discussion of the HMO physician's limited autonomy.

54 Jon Nordheimer, *New Mothers Gain 2d Day In Hospital*, N.Y. TIMES, June 29, 1995, at B1, B5.

55 Britton, *supra* note 6, at 293.

56 *Id.*

57 Colker, *supra* note 46, at 334-35. Colker demonstrates this point with evidence of the increased infant mortality rate in African-American and Hispanic communities. *Id.*

58 Diane West, *N.Y. HMO Group Offers Own Maternity Stay Bill*, NAT'L UNDERWRITER, LIFE & HEALTH/FIN. SERVICES, Oct. 30, 1995, at 5.

59 Protecting employee benefits and pension plans from the risk of exploitation motivated Congress to enact ERISA. Catherine L. Fisk, Lochner *Redux: The Renaissance of Laissez-Faire Contract In The Federal Common Law Of Employee Benefits*, 56 OHIO ST. L.J. 153, 158 (1995). Pursuant to ERISA, the federal government regulates em-

Employees are often powerless to bargain for benefits they seek; therefore, worker-protective legislation is necessary for employees "who cannot bargain equally with their employers."[60] Courts adhere to the formal concepts of contract law when assessing an employment agreement and enforce the terms expressed in the employee benefit plan document.[61] The benefit plan, written by the employer's attorneys, invariably favors the employer.[62] Significantly absent from these contracts are the notions of bargained-for consent and legitimate negotiation.[63]

The link between maternity benefits and employment is inevitable as most Americans receive health insurance through their employers or the government.[64] Thus, the employer acts as a surrogate for the employee in selecting a health care plan. Nevertheless, because health care plans are often very difficult to assess,[65]

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ployer-sponsored health insurance plans as an employee welfare benefit plan. Loue, *supra* note 3, at 534.

Another example of legislative concern with employee health care benefits is the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). *Id.* COBRA provides that employees may receive continuing medical coverage for a time, after termination of employment, at a specified rate. *Id.* at 536.

Title VII of the Federal Civil Rights Act of 1964 is aimed at protecting employees from workplace discrimination. *See* 42 U.S.C. § 2000e (1981) (establishing minimum standards of employment practices). "The purpose of Title VII is to protect workers from discriminatory employment practices in hiring, termination, compensation, terms of employment, and working conditions." N. Erin Rose Brewer, Note, *California Federal Savings and Loan Association v. Guerra: The United States Supreme Court Upholds California's Mandatory Job Protection For Pregnant Workers*, 19 PAC. L.J. 335, 337 (1988).

Furthermore, Congress expressed an interest in pregnant employees when passing the Pregnancy Discrimination Act of 1978 ("PDA"). *Id.* at 340 (discussing 42 U.S.C. § 2000e(k) (1988)). The PDA endorses the "EEOC guidelines for the treatment of pregnant workers. The guidelines specify that an employer violates Title VII if the employer fails to provide adequate pregnancy leave and then fires an employee for missing work due to a pregnancy disability." *Id.*

Courts, appearing sympathetic to the plight of the worker, protect the worker from limitations favoring employers but not always in the face of express contract terms. *See, e.g.*, Adams Fruit Co., Inc. v. Barrett, 494 U.S. 638, 643 (1990) (allowing injured workers to pursue federal statutory remedies in addition to workers' compensation); California Fed. Sav. & Loan Ass'n v. Guerra, 479 U.S. 272, 291 (1987) (upholding the right of a state to provide more extensive preferential treatment to pregnant women than allowed by Title VII).

60 C.M.A. McCauliff, *Freedom of Contract Revisited: Johnson Controls*, J. CONTRACT L. (forthcoming 1996).

61 Fisk, *supra* note 59, at 155.

62 *Id.*

63 *Id.*

64 David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability For Medical Treatment Decisions*, 25 GA. L. REV. 861, 861 (1991).

65 *See* Frances H. Miller, *Health Insurance Purchasing Alliances: Monopsony Threat Or Procompetitive Rx For Health Sector Ills?*, 79 CORNELL L. REV. 1546, 1552-53 (1994) (discussing the advantages of health care purchasing alliances).

the employer itself has little choice in selecting health care benefits provided to employees.

In addition, the difficulty in analyzing and assessing the information necessary to evaluate the reasonableness of the cost and coverage of different health plans is extremely expensive.[66] In fact, under the Clinton health plan, buyer alliances constituted a necessary element to control the employer's costs in providing health care to all employees.[67] As a result, an employer has little choice in health insurance coverage and the employee has virtually no recourse except appealing for legislative action.[68]

For the eighty percent of the American workforce who do not belong to a union, public law is the source of the most important workplace rights.[69] Furthermore, legislation aimed at protecting employees develops as a reflection of societal expectations.[70] The current demand on state legislatures to curb "drive-through-deliveries" originates from public outrage at stories of jaundiced babies discharged from hospitals only hours after birth.[71]

III. ARGUMENTS AGAINST LEGISLATIVE INTERFERENCE

Health care expenses account for "the fastest-rising costs of doing business in America."[72] Currently, health care spending equals almost twelve percent of the gross national product.[73] If health insurers and HMOs succeed in stemming these rising costs,

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66 *Id.* at 1547-48.

67 *Id.*

68 *See* Robert J. Rabin, *The Role of Union in the Rights-Based Workplace*, 25 U.S.F. L. REV. 169, 169 (1991) (noting that most worker's rights are not derived from collective bargaining agreements). If workplace regulation reflects society's expectation of basic rights, seeking legislative interference is a legitimate course for the aggrieved worker to pursue. *Id.* at 170.

69 *Id.* at 169.

70 *Id.* at 170. Rabin suggests that society desires that "some minimal levels of workplace benefits must be provided . . . and that other miscellaneous regulation of the work relationship is appropriate." *Id.*

71 Wasserman, *supra* note 7, at 35. Accordingly, if Rabin's theory accurately reflects the trend of statutory origination, the public outcry will result in successful legislative movements. *See supra* note 68 and accompanying text.

72 Mascarenhas, *supra* note 3, at 34.

73 Frances H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 L. & CONTEMP. PROBS. 195, 195 (1988) [hereinafter Miller, *Vertical Restraints*].

"Total national health expenditures have increased from $74.4 billion in 1970 to $666.2 billion in 1990 . . . . These expenditures are projected to increase to $1.6 trillion in the year 2000, which will represent 16.4% of that year's gross national product." Loue, *supra* note 3, at 523-24.

patients may unfortunately bear the effects of cost-cutting measures.

To remain financially viable despite the vast increased cost of services, providers of health care must maintain the quality of care while expending less money.[74] Achieving that goal is the oft-cited purpose of managed care.[75] Opponents of legislative oversight of private health insurers contend that no sound medical research conclusively proves that twenty-four hour discharge produces detrimental effects on newborns or mothers.[76] Maternity patients, a generally healthy patient population, prove ideal candidates for reduced in-hospital care at a significant savings to the health care providers.[77]

Insurers counter criticism of early discharge by emphasizing that the amount of time spent in the hospital should not be the focus of a maternity care program.[78] Rather, insurers argue, increasing education before and after birth, so that the mother is more comfortable bringing a new baby home, is a paramount consideration.[79] In providing home care follow-up visits, insurers state that mothers retain more of the information imparted in the relaxed home environment than they do in the hospital.[80]

The health care industry itself appears to be heeding women's demands as health care consumers.[81] The industry recognizes that women constitute approximately sixty percent of the "primary decisionmakers of their families' healthcare choices."[82] As a result, hospitals realize the need to use maternity programs to lure women and promote other medical facilities.[83] The goal of this marketing technique is to encourage the women to choose the same

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74 Tabak, *supra* note 3, at 20.

75 *Id.*

76 Michelle Malkin, *The Costly Motherhood Mandate*, WALL ST. J., Nov. 16, 1995, at A18.

77 Ginzinger, *supra* note 14, at 6 (stating "with obstetrical admissions contributing to a significant number of patient days in a relatively healthy patient population, length of stay is a prime target for decreasing resource utilization.")

78 Geisel, *supra* note 5, at 22.

79 *Id.* The focus on education is typical of the HMO "emphasis on preventive health care." Loue, *supra* note 3, at 530.

America's largest managed care organization, United HealthCare Corp., emphasizes its approach to education. *See* Schmidt, *supra* note 30, at 24.

80 Schmidt, *supra* note 30, at 24.

81 Other sectors of the economy, most significantly employers, are responding to women in the workforce and increasing maternity coverage. Geisel, *supra* note 5, at 22.

82 Judith Nemes, *Women's Hospitals Redefine Strategy*, MOD. HEALTHCARE, Aug. 26, 1991, at 24.

83 *Id.*

hospital when another member of the family needs hospital care.[84]

Despite the trend toward increased maternity coverage, a mandate to provide minimum in-patient care could result in substantial costs to insurers and employers.[85] Moreover, state mandated health care coverage may force health insurers out of the regional market.[86] Surveys indicate that mandated coverage is chief among reasons cited by insurers that discontinue coverage in some states.[87] Accordingly, legislative efforts demanding extended coverage may lead to unintended, and even damaging, results.

A. Wealth Maximization

In general, wealth maximization constitutes a valid business purpose as the economy demands that employers vigorously scrutinize costs.[88] Accordingly, if an employer provides adequate health care, yet only covers a shortened maternity stay, why impose an additional duty on an employer when the benefit is uncertain?[89] Opponents of minimum stays argue that forcing insurers to pay for extended in-patient care is not a cost-effective solution to the problem of newborn jaundice or detection of other infections.[90] The numbers lend credibility to this argument; the average cost of a maternity hospital stay is $1,000 per day[91] and many of those discharged within twenty-four hours do not require readmission for post-natal problems. The legislation, nevertheless, requires insurers to pay huge sums to fund the additional time.[92] In fact, hospi-

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84 *Id.*

85 Schmidt, *supra* note 30, at 86 (reminding that "any increase in costs created by the longer stays will be passed on to employers in the form of higher premiums").

86 Paul J. Kenkel, *State Legislators Calling for More, Less in Pursuit of Universal Access to Care*, MOD. HEALTHCARE, Apr. 20, 1992, at 33.

87 *Id.* Insurance companies blame the combination of required coverage and difficulty in rate increase approval as the leading reasons for the dearth of insurance options. *Id.* Examples of the coverage required by states include important needs such as fertility services and mammography screening. *Id.* Nevertheless, other frivolous mandates include hairpieces and acupuncturists. *Id.* Some companies opted to fund their own insurance plans to avoid state mandates. *Id.*

88 Mark S. Brodin, *Costs, Profits, and Equal Employment Opportunity*, 62 NOTRE DAME L. REV. 318, 319 (1987) (criticizing Griggs v. Duke Power Co., 401 U.S. 424 (1971) and business necessity as a defense in a Title VII action).

89 *See id.* at 318 (posing a similar question regarding the courts' imposition of costs upon employers in efforts to create equal opportunity). The author concludes that the profit maximization justification undermines the purpose of equal employment opportunity espoused in the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e-1 to e-17 (1982). *Id.* at 320.

90 Malkin, *supra* note 76, at A18.

91 *Id.*

92 *Id.* Other sources concur stating that "reducing stays would save insurers hundreds of millions of dollars a year." Hammonds, *supra* note 1, at 40.

tals must seek to expand maternity units to accommodate the needs of the increased patient population.[93] A more cost-effective solution may be to allow the market to proceed and readmit those with complications on a case-by-case basis.

Managed care companies concede that cost is a factor in reducing in-patient maternity stays because maternity is the most common reason to stay in a hospital.[94] Decreasing the amount of time that a mother and newborn remain in the hospital, therefore, results in significant savings to the health care insurer.[95] Despite the profit incentive, managed care advocates maintain that the industry remains committed to providing a quality health care product.[96]

B. Dictates of Consumer Pressure Will Regulate the Market

Consumer pressure is a relatively new phenomenon in the health care industry.[97] Increasingly, health care providers and insurers feel the force of the competitive marketplace.[98] In this competitive environment, consumer fraud legislation is proving to be "an attractive vehicle for redress of grievances against health care providers."[99] Consequently, if courts respond to marketplace concerns by applying consumer fraud laws to the health care industry, thereby opening another avenue to dissatisfied consumers, patients

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Others argue, however, that retaining the newborns for two days would result in savings to the health plan because the risk of readmission and emergency visits for an infant discharged within 24 hours after delivery is more than 50% greater than newborns who remained in the hospital for several days after birth. Schmidt, *supra* note 30, at 84.

93 Gale Scott, *Law Lengthens Stays for Childbirth, but Some Hospitals Count the Costs*, STAR-LEDGER, Jan. 23, 1996, at 7.

94 Ginzinger, *supra* note 14, at 6.

95 Thom Wilder, *Laws To Curb "Drive-Through Deliveries" Gaining Momentum in State Legislatures*, 3 HEALTH CARE POL'Y REP. 1275 (BNA) (Aug. 7, 1995).

Expenses related to funding plans are fast becoming a leading cost of doing business in America. Mascarenhas, *supra* note 3, at 34. "Employers are reported to underwrite as much as 50% of the total health care costs in the United States." *Id.*

96 Malkin, *supra* note 76, at A18. In fact, because competition within the industry is fierce, managed care companies must produce "what most consumers want at a price they're willing to pay," in order to remain in business. *Id.* Malkin cites that the use of low-cost steroids to prevent premature labor and save billions of dollars has not gained popularity within the managed care industry. *Id.*

97 Miller, *Vertical Restraints*, *supra* note 73, at 195.

98 *Id.* "Delivering medical services is commonly considered big business now, and the same kinds of competitive and anticompetitive behavior that have always been found in commercial markets can be clearly observed in the health industry of the 1980's." *Id.*

99 Lee Ann Bundren, *State Consumer Fraud Legislation Applied to the Health Care Industry*, 16 J. LEGAL MED. 133, 133-34 (1995).

would wield greater leverage when combatting a powerful health insurer.

Providing other means for dissatisfied patients to voice concerns, consumer groups recently began monitoring health care quality.[100] Within the past year, the largest groups of health care purchasers formed a coalition representing over eighty million purchasers to gauge the performance of HMOs.[101]

Especially in the maternity context, where one chooses which health facility to utilize, the marketplace regulation argument gains credence. Some providers responded to the competitive pressure by providing additional care at no cost if an insurer refuses to reimburse a patient.[102] A hospital administrator, offering an extra day, emphasized that the positive marketplace response to such programs demonstrates that legislative efforts to regulate minimum stays are misplaced.[103] The success of "stay-an-extra-day" as a marketing tool is illustrated by the increase in maternity admissions at hospitals implementing the program.[104]

Nevertheless, other hospitals, attempting to attract lucrative managed care contracts, market comprehensive out-patient services including same day maternity care.[105] In a competitive marketplace, one can reduce costs by decreasing the patient population in the hospital. The large number of maternity patients, coupled with the relative good health of these patients, makes them ideal candidates for a shorter hospital stay.[106] In a field where decisions regarding the allocation of resources are constant, rationing care for relatively healthy patients whose risk of adverse outcome is low may

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100 Schmidt, *supra* note 30, at 85.

101 *Id.*

102 A number of health care providers have taken a different approach to increasing revenue by providing a free day of additional in-patient care if one's health insurance will only pay for 24 hours. *See* Esther B. Fein, *Hospital Adds Day of Care For Mothers*, N.Y. TIMES, Sept. 29, 1995, at B1 (Officials at Greenwich Hospital in Connecticut "felt compelled to act because managed-care companies increasingly cover only 24 hours of post-birth hospital care." Accordingly, Greenwich Hospital offers an additional day of hospital care at no cost to the patient if the patient's insurer will not reimburse).

103 Mary Chris Jaklevic, *Stay-an-extra-day Programs Prove Popular*, MOD. HEALTHCARE, Oct. 2, 1995, at 92.

104 Hammonds, *supra* note 1, at 40. For example, in the six months following the introduction of one hospital's "stay-an-extra-day program," maternity admissions increased by eight percent. *Id.*

105 *See* Ginzinger, *supra* note 14, at 6 (suggesting ways for health care institutions to renovate obstetrical services and facilities to satisfy patients who will stay for only 24 hours and attract managed care contracts).

106 *Id.*

make good business sense.[107]

Under a system known as "capitation," managed care companies pay health care providers a flat fee per patient regardless of medical services rendered.[108] Thus, the hospital determines the best means of allocating scarce resources.[109] Hospital control of the incoming cash flow may mean shorter maternity stays, at a significant cost savings to the hospital.[110] Managed care companies, therefore, contend that they do not have a role in pressuring hospitals to shorten stays.[111] Rather, managed care advocates point out that hospitals bear responsibility for the disturbing trend of early discharge.[112]

Mandating a minimum hospital stay undermines the purpose of the capitation scheme that functions to keep patients out of the health care facility. Although capitation currently accounts for only ten percent of revenues in the health care market, the trend toward this method of cost recovery shows no signs of abating.[113] Hospitals, therefore, face incentives to slash costs "by following guidelines that attempt to standardize treatments for common illnesses."[114] Maternity, as a common condition, clearly falls into this category of procedures that fit the model of standardized treatment.[115]

Providers currently seek to explore cost-effective alternatives to additional hospital time.[116] For example, many HMOs and other health care providers are investigating the effectiveness of

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107 *See* Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 492 (1995). Decisions regarding the rationing of health care resources appears to be omnipresent. *Id.* Rationing, however, has the effect of always disfavoring those with potentially poor outcomes, thus putting those most in need at the greatest risk. *Id.*

108 Freudenheim, *supra* note 2, at A22. Disgusted by the financial incentive to withhold care, health care advocates seek legislative initiatives to ban capitation. *Id.*

109 Ginzinger, *supra* note 14, at 6.

110 *Id.*

111 Barbara Benson, *Hippocrates Takes Econ 101, Pass/Fail*, CRAINS N.Y. BUS., June 27, 1994, at 39.

112 *Id.*

113 *Id.*

114 *Id.* at 3.

115 *See* Karen Sandrick, *Out in Front: Managed Care Helps Push Clinical Guidelines Forward*, HOSPITALS, May 5, 1993, at 30 (discussing managed care organizations' development of clinical guidelines and the financial and non-financial incentives linked to compliance).

116 The use of midwives in the United States has increased significantly in the last twenty years. Colman McCarthy, *What Midwives Can Teach Doctors*, WASH. POST, Jan. 16, 1996, at C10. Midwives are the primary attendants to childbirth in Europe, supervising over 75% of births. *Id.* Patients who opt for the services of midwives enjoy the warm, human approach to delivery. *Id.*

education programs combined with home care follow-up visits by nurses experienced in caring for newborns.[117] Home care is a recognized exception to the New Jersey statute[118] and the proposed federal law.[119] Furthermore, studies indicate that the home health care follow-up is very effective when the patient is in a relatively low-risk socioeconomic position.[120]

In addition, the industry continues exploring ways to remain cost efficient anticipating the enactment of federal law requiring the health care facility to provide a forty-eight hour hospital stay.[121] One method of cost containment is transforming the traditional maternity ward so that extended stay patients do not occupy an expensive birthing room for the entire term of the hospital stay.[122] Suggestions of modifying hospital space to promote efficient use demonstrate that the industry is capable of containing costs while working within the statutory mandate.

Early discharge remains an attractive alternative to those who do not wish to give birth in a hospital.[123] The New Jersey statute addresses this desire by giving the mother the choice to leave the hospital.[124] Indeed, the precursor to the trend of early discharge began in response to consumer demand by women who desired alternative birth experiences, such as home delivery, and sought to make delivery a more family oriented experience.[125]

C. *Who Makes the Decision to Discharge?*

Medical organizations contend that the focus on time of discharge is misplaced, and rather, the medical community should concentrate on the problem of "inappropriate discharge."[126] In setting forth discharge guidelines, the American Academy of Pedi-

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117 Chad Ruble, *Programs To Help New Mothers May Give Birth To More Patients*, AM. MARKETING NEWS, Nov. 20, 1995, at 2.

118 N.J. STAT. ANN. § 26:2J-4.9 (West 1995).

119 S. 969, 104th Cong., 1st Sess. § 2(b)(1) (1995).

120 Braveman, *supra* note 9, at 723. The literature noticeably lacks discussion of home-care follow-up with high risk patients. *Id.* at 724.

121 Ginzinger, *supra* note 14, *passim* (proposing modifications of hospital space for cost effective use in anticipation of the passage of federal maternity stay mandates).

122 Ginzinger, *supra* note 14, at 7 (recommending "a mix of birthing rooms and ante/postpartum rooms . . . as the most cost-effective and flexible approach").

123 Britton, *supra* note 6, at 294.

124 *See supra* note 24 and accompanying text (discussing the inapplicability of the law's home health care follow-up exception if a mother requests a 48 hour hospital stay).

125 AMA Committee on Fetus and Newborn, *Hospital Stay for Healthy Term Newborns*, PEDIATRICS, Oct. 1995, at 788.

126 Kessel, *supra* note 8, at 740.

atrics noted that the appropriate length of a hospital stay of mother and infant, "should be long enough to allow identification of early problems and to ensure that the family is able and prepared to care for the baby at home."[127] The American Medical Association ("AMA") Committee on Fetus and Newborn prescribed "minimum criteria" that should be met before discharge.[128] Although the committee noted that it is unlikely that the criteria will be met in fewer than forty-eight hours, they emphasized the importance of heeding the guidelines, not the specific time of discharge.[129]

Some health care providers and insurers fear the mechanism of legislative initiatives regulating maternity stays sets an unwelcome precedent.[130] Not only is the concern motivated by a fear of legislatively mandated medical practices, but insurers may be forced to reduce available funds in other areas to compensate for the loss of revenue.[131] Because there is no conclusive proof that twenty-four hour discharge results in adverse consequences to the mother or newborn, revenue raising measures in other areas may prove more damaging.[132]

Insurance groups, such as the Health Insurance Association of America, contend that the decisions regarding discharge are best left to physicians and should not be made on a standardized basis by a legislature.[133] The AMA also argues that doctors should render the decision of when to release based upon medical factors.[134] The AMA emphasized that the decision-making should not be based upon economic considerations.[135] To effectuate the goal of clinical decisions without regard for financial consequences, the AMA proposed modifications to the federal bill.[136] First, the AMA

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127 AMA Committee on Fetus and Newborn, *supra* note 125, at 788.

128 *Id.*

129 *Id.* The committee also mentioned the importance of the physician's judgment over the "arbitrary policy established by third party payors." *Id.*

130 *Maternity Stay Mandates*, *supra* note 53, at 2 (noting concerns by those inside the health industry who question whether legislators will next attempt to regulate other practices).

131 Hammonds, *supra* note 1, at 40.

132 *Id.*

133 Fisher, *supra* note 33, at 6. Compromise may be the solution to the decision-making dilemma as practiced in Colorado where insurers voluntarily agreed to retain mothers for a 48 hour hospital stay before requiring physicians to seek approval for in-patient care. David Algeo, *Insurer's Agreement Kills Hospital-Stay Bill*, DENVER POST, Jan. 30, 1996, at C1.

134 Fisher, *supra* note 33, at 6.

135 *Id.*

136 *Physicians Blame Insurance Profits for Trend in Early Hospital Releases*, 3 HEALTH

recommended that the bill prohibit financial incentives for mothers who opt to leave the hospital before the required period.[137] Second, the physician's group suggested that the bill ban managed care companies from imposing penalties on physicians who retain patients for the entire statutory timeframe.[138] Finally, the AMA proposed that the bill also apply to self-insured plans.[139]

At first glance, allowing doctors to elect the appropriate time of discharge seems wise; however, one must analyze the context in which the doctor decides. Physicians face conflicts within the payment system in which they work.[140] The physician in an HMO is often a salaried employee whose bonus may be tied to the HMO's profiles of appropriate care.[141] The physician, therefore, may be confined by self-interest or employer pressure to follow the prescribed guidelines.[142] The structure of an HMO itself limits the doctor's autonomy through the implementation of utilization review committees and consultants.[143] In fact, the repercussions of deviating from standardized guidelines include reduction of salary and even being dismissed from plan participation.[144] Although the primary physician deems a particular course of treatment as necessary, this decision may be overruled by the utilization review committee.[145]

IV. CONCLUSION

The health care industry has undergone a dramatic reforma-

CARE POL'Y REP. 37 (BNA) (Sept. 18, 1995) (reporting on the testimony before the Senate Labor and Human Resources Committee).

137 *Id.*

138 *Id.*

139 *Id.*; *see supra* note 27 and accompanying text (discussing federal intervention as the only means of regulating self-insured plans). To effectively regulate the operation of self-insured health care plans, Congress must amend ERISA which bars governmental interference with such plans. Kent, *supra* note 52, at 19.

140 Loue, *supra* note 3, at 531; *see also* Mascarenhas, *supra* note 3, at 34 (outlining the conflicts of buyer and seller in the health care market).

141 Loue, *supra* note 3, at 531.

142 *Id.* The author notes that HMO physicians typically earn a lower income than their counterparts who receive compensation on a fee-for-service basis. *Id.* Deviations from standardized profiles of care can directly impact the physician's salary bonus. *Id.* In addition, the HMO physicians have less flexibility in determining their own schedules and must work within the "dictates of the organization." *Id.*

By contrast, Professor Hall argues that physician bedside rationing is an effective means of cost control. Mark A. Hall, *Rationing Health Care At The Bedside*, 69 N.Y.U. L. REV. 693, 700 (1994).

143 Loue, *supra* note 3, at 530.

144 Schmidt, *supra* note 30, at 84.

145 Loue, *supra* note 3, at 530.

tion within the last twenty-five years.[146] Accordingly, the patient-consumer must adjust to the new marketplace and changing means of financing health care. Nevertheless, the practice of discharging a mother and newborn from a hospital before the mother is adequately prepared to care for the child or before the child is assured to be in good health cannot continue. Both sides to the debate cite inconclusive data analyzing the effects of early discharge as support for their position. Albeit anecdotal evidence is not always persuasive, the ramification of ignoring this proof is too serious to leave to chance. In the heath care milieu, therefore, it is prudent to err on the side of caution.

Although twenty-four hour discharge appears to make good business sense and may eventually prove to be low risk, the health care industry is allowing our most vulnerable to bear the brunt of a cost-cutting experiment. The health care market will find means to cut costs within the statutory constraints of mandatory forty-eight hour retention.[147] The exceptions to the statutes already allow for leeway by giving the consumer the power to choose to stay an extra day. Accordingly, the laws protect both the patient and provider from expending monies for an unwanted or unnecessary hospital stay.

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146 Miller, *Vertical Restraints*, *supra* note 73, at 195.

147 *See supra* note 121 and accompanying text (discussing the cost effective alternatives available in the health care industry).