PROPOSED
MANDATED HEALTH INSURANCE BENEFIT
FOR
MATERNITY AND NEWBORN CARE

A Report to the
Joint Standing Committee on
Banking and Insurance
of the
117th Maine Legislature

Prepared by the
Bureau of Insurance
March 1996

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EXECUTIVE SUMMARY

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on January 31, 1996, directed the Bureau of Insurance to review LD 1732, "An Act to Promote the Health of Newborns and Their Mothers." The review was to be conducted using the criteria outlined in 24-A M.R.S.A. § 2752 regarding the social and financial impact of the proposed mandate, and the medical efficacy of the procedure covered under the proposal.

LD 1732 requires all health insurance policies and Health Maintenance Organizations (HMOs) that provide maternity benefits to provide coverage for a minimum of 48 hours of hospital care following a vaginal delivery and 96 hours following a cesarean section for the mother and infant. A shorter length of stay may be authorized if the newborn meets the medical stability criteria contained in the "Guidelines for Perinatal Care" and an initial postpartum visit is provided. Any decision to shorten the length of stay must be made by the provider in conjunction with the mother. See Appendix E for the medical stability criteria for early discharge.

Due to the very short time frame given to the Bureau to review this mandate only a limited amount of information and data could be collected. The Maine Health Care Finance Commission provided extensive data on hospital stays for mothers and newborns in 1994 and 1995 but time only allowed a cursory review. Recently citizens, health professionals and some health professional associations have reported concern over pressure to shorten post-partum hospital stays to 24 hours or less. National and state data show a decrease in the average length of stay for deliveries and an increase in the percent of one day stays.

Of the Utilization Review Entities responding to a request for the standard length of time preauthorized for uncomplicated deliveries, the majority allow 48 hours for vaginal and 72 for cesarean. Several reported an overnight or 24

hours for vaginal and 48 hours for cesarean. All allow for longer stays at the request of the physician.

Length of hospital stay may affect the recovery of the mother including diagnosis and treatment of infection, and time to practice breastfeeding. For the newborn early discharge may affect stabilization and screening tests. Currently, many tests, including PKU, are required by state law to be done within the very early days of a newborn's life. Early hospital discharges have had a negative affect on these crucial screenings. There has also been documented an increase in hospital readmissions as a result of early discharges.

While there is patient and provider support for this mandate, opponents are concerned with setting specific treatment guidelines that may change. Many states have introduced legislation similar to Maine mandating longer maternity stays. One state removed reference to a specific length of stay and instead requires insurers to follow guidelines set by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. A bill has been introduced in the U.S. Senate which would also require the longer maternity stays. It may be included as an amendment to a larger health care reform proposal currently being debated.

There may be an increase in the cost for maternity coverage for a longer stay or for a postpartum visit if the proposed mandate is enacted for those carriers not already providing this level of coverage. Blue Cross Blue Shield of Maine does not believe that this mandate will affect their benefits or rates because the coverage is already available.

BACKGROUND

The Joint Standing Committee on Banking and Insurance of the 117th Maine Legislature on January 31, 1996, directed the Bureau of Insurance to review LD 1732, "An Act to Promote the Health of Newborns and Their Mothers." The review was to be conducted using the criteria outlined in 24-A M.R.S.A. § 2752 regarding the social and financial impact of the proposed mandate, and the medical efficacy of the procedure covered under the proposal.

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Many states have introduced legislation similar to Maine mandating longer maternity stays. A bill has been introduced in the U.S. Senate which would also require the longer maternity stays.

Due to the very short time frame given to the Bureau to review this mandate only a limited amount of information and data could be collected. The Maine Health Care Finance Commission provided extensive data on hospital stays for mothers and newborns in 1994 and 1995 but time only allowed a cursory review. Appendix D includes various tables and charts with Maine specific data.

EVALUATION OF LD 1732 BASED ON REQUIRED CRITERIA

SOCIAL IMPACT

A. The social impact of mandating the benefit which shall include:

1. The extent to which the treatment or service is utilized by a significant portion of the population;

Obstetrical delivery is the most frequent cause of hospitalization. Four million babies are born each year in the United States and the average cost of a hospital stay is about $1,000.

The federal Centers for Disease Control report that from 1970 to 1992 the average length of stay for women delivering babies vaginally dropped from 3.9 to 2.1 days. The media have reported that post-partum hospital stays of 12 to 15 hours are common, and have identified cases of hospital releases as soon as 8 hours after normal delivery.

2. The extent to which the treatment or service is available to the population;

Recently citizens, individual health professionals and some health professional associations have reported concern over pressure to shorten post-partum hospital stays to 24 hours or less.

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

Maine data from the Health Care Finance Commission shows a decrease of 3.8% (from 3.88 to 3.45 days) from 1991 to 1994 for cesarean sections without complications and a 4.1% decrease (from 2.13 to 1.88 days) for uncomplicated vaginal deliveries. According to the Maine Health Information Center one day stays for normal deliveries in Maine increased from 21.2% in 1993 to 36.9% in the first quarter of 1995.

The Maine Pregnancy Risk Assessment Monitoring System (PRAMS) reports according to responses received that there has been an increase for one night stays from 11% in 1989 to 16.2% in 1993 (includes all types of deliveries). Those reporting stays of two nights remained relatively the same (44.8% to 44.3%). See Appendix D for more details.

3. The extent to which insurance coverage for this treatment or service is already available;

Blue Cross stated in a recent editorial that their coverage already addresses the concerns of the mandate, and the passage of the legislation would not affect Blue Cross benefits. Healthsource has a policy of preauthorizing a 24 hour stay unless the physician requests a longer stay. They also encourage home care visits.

Of the Utilization Review Entities responding to a request for the standard length of time preauthorized for uncomplicated deliveries, the majority allow 48 hours for vaginal and 72 for cesarean. Several reported an overnight or 24 hours for vaginal and 48 hours for cesarean.

There have been allegations that hospital stays as short as 8 hours after delivery may occur in other states but there is no evidence of this in Maine. In general carriers insist that mothers are not sent home if their health care provider recommends a longer stay. Based on anecdotal evidence the longer stay may not always be approved if requested.

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4. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

Decreased length of hospital stay may put mothers at much greater risk of hemorrhage, infection, fatigue and postpartum depression. The shorter stays also do not allow enough time to practice breastfeeding, and may affect the newborn's stabilization and screening tests. Currently, many tests, including PKU, are required by state law to be done within the very early days of a newborn's life. Early hospital discharges have had a negative affect on these crucial screenings because the reliability of the tests is decreased if they are taken too early.

In a study by the Dept. of Pediatrics at Dartmouth Medical School on "The Risk of Readmission and ER Visits in Newborns With Early Discharge," they found that healthy infants discharged at 0-1 day of life have an increased risk of readmission within the first two weeks of life. Infants with stays of two days or longer had a readmission rate of 1.12% compared to 1.61% for discharges in 0-1 days. The three most frequent admitting problems were 1) jaundice (49%), 2) infectious disease, including pneumonia, and 3) GI, including gastroenteritis, dehydration, feeding problems. The study did not differentiate between cesarean sections and vaginal deliveries and therefore the results are statistically flawed.

Discharging women and their infants from the hospital too soon after delivery decreases the ability of the hospital to do an AIMS (Attachment Interaction Mastery Support) Development Indicators study. In a report on Child Deaths and Serious Injuries Due to Abuse or Neglect (June 1995) by the Maine Dept. of Human Services, they recommended expanding the use of this instrument by hospitals to identify high risk infants.

5. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

Most individuals who depend on their insurance coverage to cover the delivery cannot afford an extra day or two in the hospital with charges averaging about $1,000 per day for the mother and about $500 for the infant.

6. The level of public demand and the level of demand from providers for the treatment or service;

During testimony, several individuals and providers stated that they want the longer stays. A representative of the Maine State Nurses Association read several comments from the PRAMS study from women who said that a longer stay would have been beneficial.

7. The level of public demand and the level of demand from the providers for individual and group insurance coverage of the treatment or service;

The Maine Medical Association, representing over 1650 physicians, testified in favor of the mandate. They feel that the bill would return the decision making process to the health care provider in consultation with the patient and remove the pressures the providers receive from managed care requirements by mandating coverage. In addition, there was strong public support demonstrated at the hearing for coverage of the longer stays.

8. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;

No information available.

9. The likelihood of achieving the objectives of meeting the consumer need as evidenced by the experience of other states;

Maryland was the first state in the nation to enact legislation mandating coverage for maternity stays. However, the law has had little effect because insurers have used a provision in the law that allows insurers to require a woman to leave after one day, if they provide a home visit by a registered nurse. The Legislature is reconsidering this legislation. In the meantime, one hospital announced they would offer longer maternity stays even when insurance companies won't pay for them. Implementation has been held up because approval by the Maryland Health Services Cost Review Commission is required before the hospital can start the program.

Massachusetts requires insurers and the hospitals to provide the same length of stay as Maine's proposal. Regulators are uncertain what the effect on hospitals will be if self-insured plans or the uninsured won't pay for the extra length of stay. There is some concern that forcing the hospitals to absorb the cost of the longer stays would exacerbate the financial pressures that close many hospitals. There is also language in their law that prohibits plans from penalizing providers for ordering care consistent with the mandate.

Longer maternity stays were demonstrated by data collected through New Jersey's Electronic Birth Certificate system after their law requiring the same length of stay as Maine's proposal was enacted in June 1995. Before the law took effect, maternity stays average 1.3 and 1.4 days. The average rose to 1.7 by July 1995 and 1.9 during the last quarter of 1995. Their State Health Commissioner stated that, "this law has made an immediate and dramatic difference for women giving birth and for newborns." The state is currently developing a patient satisfaction survey to determine how many were asked to leave the hospital earlier than they wanted to, how they felt about the care they received and what would have improved their stay, among other questions.

Washington state surveyed insurers and received responses from one third of the companies (145 companies). 52% of the respondents stated they observe strict 24 hour only admission policy. This period of time could be extended only at

the request of the attending physician and by permission of the utilization review entity. 20% said they allow a 48 hour admission cycle without review. Washington has legislation pending that would require 3 postpartum home care visits if in-patient coverage is shortened by an attending provider, otherwise at least one postpartum visit is covered. There was also concern that insurers may "evict" mothers immediately after delivery if no minimum stay was required when the 3 home care visits was chosen.

A summary of legislative activity in other states is included in Appendix B. Most legislation in other states is similar to that proposed in Maine. Several states have proposed that the hospital be required to comply with the longer stays.

According to the most recent statistics from the Organization for Economic Co-operation and Development, other industrialized nations provide longer stays than the United States. In 1993, Canada provided an average of 3.4 days for a normal delivery; New Zealand 3.7 days; Switzerland 6.8 days; Ireland 4.6 days while the United States provided an average of 1.7 days.

10. The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

No information available.

11. The alternatives to meeting the identified need;

Virginia's proposed legislation removed the specific time provisions and required insurance companies to follow the guidelines set by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

In Colorado, a coalition representing 95% of that state's health insurers and HMOs has agreed to voluntarily extend the length of hospital stays to follow the rules that a proposed bill would have set down and the legislative mandate proposal was withdrawn. The coalition felt the agreement was a way to avoid unnecessary mandates on the private sector and could help eliminate the impression that HMOs force doctors to release patients prematurely.

Harvard Community Health Plan testified during Congressional Hearings that they studied post partum hospital stays to assure the well-being of the mother and baby and found that educating families about newborn care was often not accomplished in 48 hours in the hospital. They chose to reduce hospital stays to 24 - 36 hours but provide in prenatal and postdischarge care the education, the screening, and the medical assessment necessary to support the mother and newborn safely at home.

12. Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance;

During the Congressional Hearings on a similar bill, the Chicago Department of Public Health listed the potential concerns associated with early discharge (defined as less than 24 hours after delivery) to include:
For the infants: incomplete newborn screening; non-initiation or premature cessation of breastfeeding; missed identification of congenital anomalies; nutrition and feeding problems; dehydration; jaundice and bilirubin toxicity; decreased rates of or incomplete immunization (due to potentially missed Hep-B shot soon after birth); increased rates of rehospitalization; higher post-neonatal mortality; and decreased use of primary care.
For the mother: increased parental anxiety; decreased opportunity for post-partum clinical observation; increased maternal infection; and increased maternal depression.

In March 1995, at a Washington DC conference on the impact on newborn screening due to early hospital discharge, participants agreed that in the long run

current early-discharge practices may prove to be short-sighted for health insurers and all others involved if these practices cause some newborns with disorders to go undetected during the optimal period.

Typically, insurance policies have provided coverage for care that is recommended by the physician or other provider and determined to be medically necessary. Recently with more emphasis on managed care including utilization review and provider contracting, the insurance company has become more involved in determining the different aspects of the delivery of care. Having the option of post-partum visits allows the patient and physician to determine what setting is best suited for continued care and testing.

13. The impact of any social stigma attached to the benefit upon the market;

There is no apparent social stigma.

14. The impact of this benefit upon the availability of other benefits currently being offered; and

No information.

15. The impact of the benefit as it relates to employers shifting to self-insurance plans.

Employers are already required to provide maternity coverage to their employees if coverage is provided for other health conditions. However, employers may opt not to provide insurance coverage for maternity benefit and to self-insure that benefit. In fact, in Washington, one employer has taken the initiative to address the problem of shorter hospital stays before the state passes a mandate. Eddie Bauer Inc. will start a pilot program offering post-partum care to workers at its headquarters in Seattle.

FINANCIAL IMPACT

B. The financial impact of mandating the benefit which shall include:

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next five years;

No information.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years;

No information.

3. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service;

Providing coverage for the longer hospital stays may be viewed as a preventive measure. Although shorter stays are initially less expensive, there is some concern about an increased risk of readmission to the hospital for the mother and infant. Readmission results in direct costs related to the hospital stay and intervention procedures but there may be indirect costs including suffering or death of the infant and/or mother.

4. The methods which will be instituted to manage the utilization and costs of the proposed mandate;

The American Academy of Pediatrics (AAP) issued guidelines published in the October 1995 of "Pediatrics" for mother and newborn hospital stays. The guidelines state that "discharge timing should be a mutual decision" made by the mother and her doctor." The guidelines recommend that mothers and infants

be hospitalized together until 16 conditions are met. See Appendix D for the criteria.

5. The extent to which the insurance coverage may affect the number and types of providers over the next five years;

No information available.

6. The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

Blue Cross Blue Shield of Maine does not believe that this mandate will affect their benefits or rates because the coverage is already available. Thus, we understand that there is no fiscal note for coverage provided by the State Employees Health Plan. Data from the Maine Health Information Center for the state employee plan for 1995 shows that the average length of stay for a vaginal delivery without complications was 2.0 days and for cesarean without complications 3.3 days. The average charge per day for these vaginal deliveries was $1248.19 and cesarean $1641.40. This does not accurately reflect what the cost for an additional day would be because the first day is usually the most expensive.

Opponents in other states have testified that a similar mandate would drive up premiums.

New Mexico's Superintendent of Insurance stated that their new rule requiring longer stays or three home visits if the patient chooses a shorter stay, should not push insurance rates up or spur any insurance companies to leave the state. He added that more than 80 percent of new mothers voluntarily leave the hospital within a day.

In Delaware, a fiscal note was attached to a bill similar to Maine's. They estimated an increased cost to the state employee plan of $480,000 for the next three years to raise the average hospital stay from the current 1.7 days to 2.0 days for approximately 80,000 enrollees. Calculations did not account for the first day of the hospital stay costing more, and this estimate does not reflect the choice for a shorter stay with postpartum visits.

7. The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

Discharging women and their infants too soon after delivery may result in several different types of indirect costs. There are social costs when a high risk situation is not identified and the infant is injured or dies. Because of the difficulty in assuring that proper screenings have been done after discharge, this could result in disabilities or death for the infant or complications for the mother. Additional costs when a complication results from an early discharge are time away from work, stress and worry that are hard to quantify. While there are no studies available to quantify this, testimony in Maine and other states provide examples of these situations and their personal costs to the family.

8. The impact of this coverage on the total cost of health care; and

The cost to health care as a result of this mandate would be the cost of additional hospitals days and postpartum visits that are not currently being provided, reduced by any savings due to the early diagnosis of complications. Opponents feel that physicians and patients should be the ones who dictate benefits and fear if the legislature mandates a specific length of stay for childbirth, that requirements for other procedures may follow. No quantitative estimates of the impact on the total cost of care are available.

9. The effects on the cost of health care to employers and employees, including the financial impact on small employers, medium-sized employers, and large employers.

If the mandated level of care is not currently provided by the insurance plan, there could be an increase in premium to reflect the additional cost of those benefits (additional hospital day or home care visit).

MEDICAL EFFICACY

C. The medical efficacy of mandating the benefit which shall include:

1. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

The little amount of research on early discharge has proved inconclusive and is almost uniformly methodologically flawed. A critical review of existing literature indicates that studies have not yet conclusively demonstrated the safety of early discharge according to the American College of Obstetrics and Gynecology. They have recommended that decisions about the length of post-partum hospital stays be returned to physicians. However, they suggest a 48-hour post-partum stay guideline for normal deliveries and a 96-hour stay for more complex deliveries.

The American Academy of Pediatrics reported recently that "technical advances" have now made it "easier" for quicker birthing discharges but it is unlikely that the required tests and monitoring can be performed in less than two days. They mention there has been a surge of problems after these early discharges and it's clear safety conditions are not being met. Conditions that do not show up in newborns for a few days after birth include: jaundice, dehydration,

infections and metabolism disorders. Other relatively common symptoms such as: fever, vomiting, failure to urinate, bloody stools or no bowel movements, listlessness and sleeping through feedings sometimes indicate serious problems. See Appendix E for more details.

During Congressional Hearings on a similar bill, a physician stated that damage to the nervous system from high levels of serum bilirubin had been just about unheard of in otherwise healthy term newborns since the early 1960's but this devastating condition has reappeared since 1992. He attributes the increase incidents to shorter hospital stays.

In response to the rapidly increasing trend towards early hospital discharge, a conference entitled "Early Hospital Discharge: Impact on Newborn Screening" funded in part by the Maternal and Child Health Bureau of the Health Resources and Services Administrations was held in Washington DC in March 1995. In the report from this conference are a variety of articles and studies discussing the negative impact of short hospital stays for medical screenings.

Insurers maintain that after 24 hours following an uncomplicated delivery the remainder of the hospital stay is usually devoted to postnatal education and follow-up monitoring. These services can be provided on a one-to-one basis in the comfort and privacy of the patient's home. Mothers may want to go home quickly to limit the risk of hospital-acquired infections and to let the family start bonding sooner.

2. If the legislation seeks to mandate coverage of an additional class of practitioners:

a. The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

Not applicable.

b. The methods of the appropriate professional organization that assure clinical proficiency.

Not applicable.

BALANCING THE EFFECTS

D. The effects of balancing the social, economic, and medical efficacy considerations which shall include:

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders; and

According to the Maine Department of Human Services' Genetics Program, early discharge requires more follow-up to assure all infants have a sample adequate for testing for a variety of medical screenings. These screenings are for disabling and often life-threatening diseases. The Maine Medical Association suggests that the cost of an extra day in the hospital for the mother and infant does not outweigh the cost of the second screenings and the costs associated with possible complications.

Proponents of the bill feel that this mandate is intended to require more than a specific length of stay but to also ensure quality and quantity of treatment as determined by medical judgment.

The American College of Nurse-Midwives during a Congressional Hearing on a similar bill, mentioned that the problem is not timing of discharge, but the patient's condition at discharge and what services are available once the mother and infant are discharged. Some women live in areas where home care is not available or there is a shortage of trained care givers. Mandating longer stays, they feel just defers the decision to discharge and creates a false

sense of security but does not guarantee quality care. Additionally, they caution that the mandate could set a standard of care that would be used against clinicians in malpractice litigation. They felt further research into the issues surrounding short stay hospital programs is warranted and strongly encouraged.

2. The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders.

Traditionally, group policyholders do not view mandated offerings as desirable unless the benefit is highly sought by their certificate holders. In this case those groups which contain members who have a high probability of utilizing the service (families with women of child-bearing age) are more likely to request coverage. This would lead to higher premiums for the coverage because the risk would not be spread over as many covered individuals, and those with coverage are more likely to utilize the service. This is an example of adverse selection.

The situation is the same for individual policies, because this coverage would be more likely to be requested by women or families who are planning to have children, thus the risk would be spread among far fewer individuals, making the premiums high for the optional coverage. That is, only those who think they are likely to need the service would purchase coverage.

APPENDIX A

LD 1732

Charge to the Bureau

117th MAINE LEGISLATURE

SECOND REGULAR SESSION-1996

Legislative Document No. 1732

S.P. 670 In Senate, January 23, 1996

An Act to Promote the Health of Newborns and Their Mothers.

(EMERGENCY)

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 26. Reference to the Committee on Banking and Insurance suggested and ordered printed.

MAY M. ROSS
Secretary of the Senate

Presented by Senator GOLDTHWAIT of Hancock.
Cosponsored by Senators: AMERO of Cumberland, BENOIT of Franklin, BUTLAND of Cumberland, LAWRENCE of York, LONGLEY of Waldo, McCORMICK of Kennebec, PENDEXTER of Cumberland, PINGREE of Knox, SMALL of Sagadahoc, Representatives: AULT of Wayne, CAMERON of Rumford, DAVIDSON of Brunswick, DORE of Auburn, ETNIER of Harpswell, GOULD of Greenville, LUTHER of Mexico, MADORE of Augusta, MARVIN of Cape Elizabeth, McELROY of Unity, MERES of Norridgewock, PINKHAM of Lamoine, PLOWMAN of Hampden, RICE of South Bristol, ROWE of Portland, SHIAH of Bowdoinham, TREAT of Gardiner.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, insurers, nonprofit hospital and medical service organizations and health maintenance organizations across the United States have implemented health care plans generally covering no more than 24 hours of hospital care for mothers and newborns following childbirth; and

Whereas, insurers, nonprofit hospital and medical service organizations and health maintenance organizations operating health care plans in Maine could initiate limits on hospital stays at any time; and

Whereas, the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, recommend a hospital stay of 48 hours after childbirth; and

Whereas, it is the intent of the Legislature to prevent the adverse impact of inappropriate early discharge of maternity patients and newborns; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2318-A is enacted to read:

§2318-A. Maternity and newborn care

1. Guidelines for hospital services; length of stay. Individual and group contracts issued by a nonprofit hospital and medical service organization that provide maternity benefits, including benefits for childbirth, must provide coverage for a minimum of 48 hours of inpatient hospital care following a vaginal delivery and a minimum of 96 hours of inpatient hospital care following a cesarean section for a subscribing mother and her newborn child. If the minimum length of stay expires after 6 p.m., inpatient hospital care benefits must be provided until the following day at the request of the mother.

2. Authorization for shorter stays. Notwithstanding subsection 1, a shorter length of stay may be authorized by a nonprofit hospital or medical service organization if the newborn

meets the medical stability criteria contained in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, and the organization provides benefits for an initial postpartum home visit made by a physician, certified nurse midwife or a registered nurse competent in newborn and maternal assessment. Any decision to shorten the length of stay must be made by the attending physician or the attending certified nurse midwife in conjunction with the mother. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn.

Sec. 2. 24-A MRSA §2743-A is enacted to read:

§2743-A. Maternity and newborn care

1. Guidelines for hospital services; length of stay. An insurer that issues individual contracts providing maternity benefits, including benefits for childbirth, must provide coverage for a minimum of 48 hours of inpatient hospital care following a vaginal delivery and a minimum of 96 hours of inpatient hospital care following a cesarean section for an insured mother and her newborn child. If the minimum length of stay expires after 6 p.m., inpatient hospital care benefits must be provided until the following day at the request of the mother.

2. Authorization for shorter stays. Notwithstanding subsection 1, a shorter length of stay may be authorized by an insurer if the newborn meets the medical stability criteria contained in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, and the insurer provides benefits for an initial postpartum home visit made by a physician, certified nurse midwife or a registered nurse competent in newborn and maternal assessment. Any decision to shorten the length of stay must be made by the attending physician or the attending certified nurse midwife in conjunction with the mother. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn.

Sec. 3. 24-A MRSA §2834-A is enacted to read:

§2834-A. Maternity and newborn care

1. Guidelines for hospital services; length of stay. An insurer that issues group contracts providing maternity benefits, including benefits for childbirth, must provide coverage for a minimum of 48 hours of inpatient hospital care following a vaginal delivery and a minimum of 96 hours of inpatient hospital

care following a cesarean section for an insured mother and her newborn child. If the minimum length of stay expires after 6 p.m., inpatient hospital care benefits must be provided until the following day at the request of the mother.

2. Authorization for shorter stays. Notwithstanding subsection 1, a shorter length of stay may be authorized by an insurer if the newborn meets the medical stability criteria contained in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, and the insurer provides benefits for an initial postpartum home visit made by a physician, certified nurse midwife or a registered nurse competent in newborn and maternal assessment. Any decision to shorten the length of stay must be made by the attending physician or attending certified nurse midwife in conjunction with the mother. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn.

Sec. 4. 24-A MRSA §4234-A is enacted to read:

§4234-A. Maternity and newborn care

1. Guidelines for hospital services; length of stay. Individual and group contracts issued by a health maintenance organization that provide maternity benefits, including benefits for childbirth, must provide coverage for a minimum of 48 hours of inpatient hospital care following a vaginal delivery and a minimum of 96 hours of inpatient hospital care following a cesarean section for an enrolled mother and her newborn child. If the minimum length of stay expires after 6 p.m., inpatient hospital care benefits must be provided until the following day at the request of the mother.

2. Authorization for shorter stays. Notwithstanding subsection 1, a shorter length of stay may be authorized by a health maintenance organization if the newborn meets the medical stability criteria contained in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, and the organization provides benefits for an initial postpartum home visit made by a physician, certified nurse midwife or a registered nurse competent in newborn and maternal assessment. Any decision to shorten the length of stay must be made by the attending physician or attending certified nurse midwife in conjunction with the mother. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved.

STATEMENT OF FACT

This bill requires all individual and group contracts of nonprofit hospital or medical service organizations, insurers and health maintenance organizations providing benefits for maternity and newborn care to provide coverage for a minimum of 48 hours of inpatient hospital care following a vaginal delivery and a minimum of 96 hours of inpatient hospital care following a cesarean section. Shorter stays may be authorized by the attending physician or certified nurse midwife if the newborn meets the criteria for medical stability contained in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology and an initial postpartum home visit for both mother and newborn is provided.

SENATE

I. JOEL ABROMSON, DISTRICT 27, CHAIR
MARY E. SMALL, DISTRICT 19
DALE MCCORMICK, DISTRICT 18

COLLEEN MCCARTHY, LEGISLATIVE ANALYST
MARIANNE MACMASTER, COMMITTEE CLERK

HOUSE

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LISA LUMBRA, BANGOR
ARTHUR F. MAYO III, BATH

STATE OF MAINE

ONE HUNDRED AND SEVENTEENTH LEGISLATURE

COMMITTEE ON BANKING AND INSURANCE

January 31, 1996

Brian K. Atchinson, Superintendent
Bureau of Insurance
State House Station 34
Augusta, Maine 04333

Dear Brian:

24-A MRSA § 2752 requires the Joint Standing Committee on Banking and Insurance to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing. While we understand that the Bureau feels a review can not be completed before the end of the session, the Joint Rules prohibit bills from being carried over in the Second Regular Session. Because of that prohibition, the committee would like to take final action on the bill during this session. We hope that the Bureau will be able to accommodate our request.

Pursuant to § 2752, we request the Bureau prepare a review and evaluation of the following proposal:

LD 1732 - An Act to Promote the Health of Newborns and their Mothers.

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in 24-A MRSA § 2752 and submit the report to the committee on or before March 15, 1996. If you have any questions, please feel free to contact either one of us.

Sincerely,

I. Joel Abromson
Senate Chair

Marc J. Vigue
House Chair

cc: Nancy Johnson, Deputy Superintendent
Marti Hooper, Senior Insurance Analyst
Banking and Insurance Committee members
Sen. Jill Goldthwait

115 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0115 TELEPHONE: 207-287-1314

APPENDIX B

States With Mandates

INSURANCE COVERAGE FOR POST-DELIVERY CARE					1/29/96
STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
ALABAMA					
ALASKA	SB 193	In Comm	Requires coverage of min. 48 hrs. of inpatient care for vaginal birth; min. 96 hrs. for cesarean.	Not addressed.	
ARIZONA					
ARKANSAS					
CALIFORNIA	AB 1841 replaces AB 1978	In Comm	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean section. Permits earlier discharge if mother & child meet medical stability criteria and if plan covers 1 home visit within 48 hrs.	Requires visit to include parent educ., assistance with breast/bottle feeding and necessary tests.	
COLORADO	HB 1015	In Comm	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesaresan. Permits earlier discharge if joint decision by mother and physician.		Defines "attending provider" as OB, pediatrician, other physician, nurse midwife.
CONNECTICUT					
DELAWARE	HCR 30	In Comm			Creates task force
	HB 357	In Comm	Requires coverage of at least 48 hrs. inpatient care if health care provider prescribes it.	Not addressed.	
DISTRICT OF COLUMBIA					
FLORIDA	HB 103, SB 350	Prefiled for 1996	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Permits earlier discharge if mother and infant meet guidelines of Agency for Health Care Administration or if coverage provided for home or office visit within 48 hrs.	Required to include infant feeding education, physician referral, assessment of mother and child, metabollic tests.	

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

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
GEORGIA	HB 1114	In Comm	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Requires decision on shorter stay to be made by attending provider in consultation with mother.	Requires coverage of 1 follow-up visit if discharged in less than 48/96 hrs., including physical assessment, parent ed., breast/bottle feeding, home support assessment & necessary tests.	Defines "attending provider" as OB, pediatrician, other physician or nurse midwife.
	SB 482	In Comm	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Requires decision on shorter stay to be made by attending physician in consultation with mother. Excludes policies covering home visits.	Min. 3 visits by RN within 24 hrs. of discharge, between 25-48 hrs. & between 96-120 hrs., including parent ed., breast or bottle feeding, necessary clinical tests.	"Attending physician" defined as pediatrician, OB, or certified nurse midwife.
	HB 1189	In Comm	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Permits shorter stay if decision made by provider in consultation with mother.	Min. 2 visits, the 1st within 48 hrs. of discharge, including: physical assessment, parent ed., home support, assistance with breast/bottle feeding, necessary tests.	
HAWAII					
IDAHO					
ILLINOIS	HB 2514, SB 1221, SB 1222	In Comm	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Excludes policies covering home visits unless hospital stay determined to be medically necessary by attending physician.	Min. 3 visits by RN within 24 hrs. of discharge, between 25-48 hrs. & between 96-120 hrs., including parent ed., breast or bottle feeding, necessary clinical tests.	"Attending physician" defined as pediatrician, OB, or other physician.

INSURANCE COVERAGE FOR POST-DELIVERY CARE

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
IL, cont.	HB 2557	In Comm	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Excludes policies covering home visit unless hospital stay determined to be medically necessary by attending physician.	Requires coverage of 1 visit if discharged prior to 48/96 hrs. or if prescribed by physician. Visit by RN within 48 hrs. of discharge including physical assessment of baby, feeding assistance, assessment of home support system, & necessary care.	"Attending physician" defined as OB, pediatrician, or other physician.
	HB 2558	In Comm	Requires health dept. to adopt rules requiring hospitals to comply with AAP/ACOG recommendations on duration of hospital stay. Adds right to such length of stay to Medical Patient Rights Act.		
INDIANA	SB 59, SB 68, HB 1068	In Comm	Requires coverage of 48 hrs. of inpatient care for vaginal birth; 96 hrs. for cesarean section.		
	HB 1075	In Comm	Requires coverage of inpatient care for mothers and newborns as recommended in most recent Guidelines for Perinatal Care. Permits earlier discharge if newborn meets criteria for medical stability and followup visit is covered.	Min. 1 visit within 48 hrs. of discharge, including parent ed., assistance with breast/bottle feeding, necessary tests.	
	SB 310	In Comm	Requires coverage of min. 48 hrs. inpatient care for vaginal birth, 96 hrs. cesarean, excluding policies covering home visit unless physician determines inpatient care to be medically necessary.	Min. 1 visit by RN, including parent ed., breast/bottle feeding assistance, necessary tests within 24 hrs. of discharge.	

INSURANCE COVERAGE FOR POST-DELIVERY CARE

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
IOWA	SB 2038	In Comm	Requires coverage of min. 48 hrs. of inpatient care for vaginal birth; 96 hrs. for cesarean. Requires coverage of longer stay if believed necessary by physician or requested by mother.		
	HB 2047	In Comm	Requires coverage of min. 48 hrs. of inpatient care for vaginal birth; 96 hrs. for cesarean. Permits earlier discharge if attending provider and mother agree.	Min. 1 visit within 48 hrs, including physical assessment of newborn, assistance with breast/bottle feeding, necessary tests, assessment of home support.	
	HB 2052				
KANSAS	HCR 5030	In Comm	Urges insurers to cover 48/96 hrs. of inpatient care.		
	House Bill 2052				
KENTUCKY	HJR 3	In Comm	Urges insurers to cover at least 72 hrs. of inpatient care.		
	SB 458	In Comm	Requires coverage of at least 48 hrs. inpatient care. Permits earlier discharge if: physician and mother agree on shorter stay, mother and newborn meet AAP/ACOG Guidelines for Perinatal Care, and plan provides for initial postpartum visit.		
	HB 82	In Comm	Requires coverage of at least 72 hrs. inpatient care after birth.		
	SB 43	In Comm	Requires coverage of min. 48 hrs. inpatient care for mother and child following vaginal birth;96 hrs. after cesarean. Excludes policies covering home visits unless hospital stay determined to be medically necessary by provider.	Min. 3 visits by RN within 24 hrs. of discharge, between 25-48 hrs. & between 96-120 hr., including parent ed., breast or bottle feeding assistance, necessary tests.	Defines "attending physician" as OB, pediatrician, or other physician.
LOUISIANA					

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
MAINE					
MARYLAND	SB 677	Enacted 1995	Permits discharge of mother and infant if newborn meets AAP/ ACOG Guidelines for Perinatal Care medical stability criteria.	Requires coverage of 1 in-home visit if mother, child discharged in less than 48 hrs. Visit must include collection of sample for hereditary and metabollic screening.	
MASSACHUSETTS	SB 2057 formerly SB 2000	Enacted 1995	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean. Prohibits earlier discharge unless in accordance with health dept. regulations, thus applying to ERISA plans also. Earlier discharge must also be in consultation with the mother.	To be addressed in health dept. regulations develoged with advisory committee that includes pediatric representative. Requires 1st home visit to be provided by RN, nurse midwife, or physician.	"Attending physician" defined as obstetrician, pediatrician, nurse midwife, or other physician.
MICHIGAN	HB 5109	In Comm	Requires HMOs to provide coverage of min. 48 hrs. inpatient care for vaginal delivery, 96 hrs. for cesarean section. Excludes policies covering home care unless mother requests inpatient care or physician determines it to be medically necessary.	Min. 3 visits by RN within 24 hrs. of discharge, between 25-48 hrs. & between 96-120 hr., including parent ed., breast or bottle feeding assistance, necessary tests.	Attending physician may be obstetrician, pediatrician, or other physician.
MINNESOTA	HB 2008	In Comm	Requires coverage of min. 48 hrs. inpatient care for vaginal birth; 96 hrs. cesarean if care determined medically necessary by provider in consultation with mother.	Min. 1 home visit by RN within "reasonable" time after discharge. To include: parent ed., assistance with breast/bottle feeding, necessary tests.	
MISSISSIPPI					

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
MISSOURI	SB 512, SB 533	In Comm	Requires coverage of min. 48 hrs. inpatient care for vaginal birth; 96 hrs. for cesarean. Permits earlier discharge if: baby meets criteria of Guidelines for Perinatal Care; physician and mother approve discharge and insurer covers one postpartum visit.	Coverage of one postpartum visit including collection of hereditary and metabollic samples for testing.	Defines "attending physician" as OB, pediatrician, or other physician.
	SB 581, HB 936	In Comm	Same as above.	Same as above, but requires visit to occur within 48 hrs. of discharge.	
	HB 1069	In Comm	Same as above, except insurer must cover min. 3 home visits if discharged early.	Requires home visits within 24 hrs., 25-48 hrs. and 96-120 hrs., including physical assessment of newborn, parent ed., assistance with breast/bottle feeding, tests.	
MONTANA					
NEBRASKA	LB 1071	In Comm	Requires coverage of min. 48 hrs. inpatient care for vaginal birth; 96 hrs. cesarean. Permits shorter stay if decision made by physician and child meets medical stability criteria of Guidelines for Perinatal Care.	Not addressed.	
NEVADA					
NEW HAMPSHIRE	HB 1352	In Comm	Requires coverage of inpatient care, postpartum visits as determined by provider; if shorter than 48/96 hrs., must be at provider's recommendation in consultation with mother, must cover neonatal visit.	1 neonatal visit for genetic and metabollic tests; 2 postpartum visits to include: feeding, injury prevention, infant behavior, physical assessment & infant & maternal health.	Prohibits insurer from penalizing provider for following bill's provisions.

INSURANCE COVERAGE FOR POST-DELIVERY CARE

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
NH, cont.	SB 627	In Comm	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Excludes policies covering home visits unless hospital stay determined to be medically necessary by physician or requested by mother.	Min. 3 home visits by RN within 24 hrs., 25-48 hrs., & 96-120 hrs. after discharge. Must include parent ed., necessary tests, assistance with breast or bottle feeding.	
NEW JERSEY	AB 2224	Enacted 1995	Requires coverage of min. 48 hrs. for vaginal birth, 96 hrs. cesarean. Excludes policies covering home visits unless hospital stay determined to be medically necessary by attending physician or is requested by mother.	Min. 3 home visits by RN within 24 hrs., 25 to 48 hrs & 96 to 120 hrs. after discharge. Must include parent educ., assistance with breast/bottle feeding, & necessary tests.	"Attending physician" defined as obstetrician, pediatrician, or other physician.
NEW MEXICO	Regulation	Effective 3/1/96	Requires coverage of 48 hrs. of inpatient care for vaginal birth, 96 for cesarean, unless earlier discharge in accordance with Guidelines for Perinatal Care.	Min. 3 visits by licensed personnel	
NEW YORK	AB 8125	Passed	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Not addressed.	
	SB 5322	In Comm	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Not addressed.	
	SB 5742	Passed	Requires coverage of min. 48 hrs. inpatient care for vaginal birth; 96 hrs. cesarean. Permits mother discretion as to early discharge if physician believes pair are ready.	Min. 1 home visit within 24 hrs of discharge, including parent ed., assistance with breast/bottle feeding, necessary tests.	
NORTH CAROLINA	SB 345	Enacted 1995	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Not addressed.	
NORTH DAKOTA					

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
OHIO	HB 458	In Comm	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Not addressed.	
	SB 199 HB 486	In Comm	Requires min. of 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean.	Requires coverage of 3 home visits by RN within 24 hrs., 25-48 hrs., & 96-120 hrs., including parent ed., breast/bottle feeding assistance, necessary tests.	
OKLAHOMA	SB 684	Prefiled for 1996	Requires coverage of min. 48 hrs inpatient care for vaginal birth, 96 hrs. for cesarean.		
	HB 2302, HB 2330	Prefiled for 1996	Requires coverage of min. 48 hrs. inpatient care for vaginal birth, 96 hrs. for cesarean, excluding policy covering home visits, unless inpatient care determined medically necessary by provider/requested by mother.	Min. 3 home visits by RN including assistance with breast/bottle feeding, parent ed., necessary tests. Visits to occur within 24 hrs., 25-48 hrs. and 96-120 hrs.	Insurance commissioner and health dept. to define medically necessary.
	HB 2655	Prefiled for 1996	Requires coverage of inpatient care sufficient to meet medical stability criteria of Guidelines for Perinatal care & min. of 96 hrs. for cesarean section. Permits earlier discharge when decision made by provider in consultation with mother	Follow-up visit within 48 hrs. of early discharge, including physical assessment of newborn, breast/bottle feeding, parent ed., home support assessment and necessary tests.	
OREGON					

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
PENNSYLVANIA	HB 1747, HB 2225	In Comm	Requires min. of 48 hrs. for vaginal birth, 96 hrs. for cesarean.	If covered must consist of at least 3 visits conducted: within 24 hrs. of discharge; within 25-48 hrs., and within 96-120 hrs. by RN & include breast feeding assistance & medical evaluation.	
	HB 1977	In Comm	Requries coverage of min. 48 hrs. of inpatient care, excluding day of delivery. Permits coverage of shorter stay if mother and child meet medical criteria of Guidelines for Perinatal Care and if plan covers initial postpartum visit.		
	SB 1237	In Comm	Requires coverage of min. 48 hrs. of inpatient care for mother & baby.	Not addressed.	
PUERTO RICO					
RHODE ISLAND	HB 5858-A	Enacted 1995			Creates task force to study issue.
	SB 2074	In Comm	Requires coverage of min. 48 hrs. inpatient care for vaginal birth; 96 hrs. for cesarean. Permits earlier discharge in accordance with Guidelines for Perinatal Care and in consultation with mother.	Not addressed.	
SOUTH CAROLINA	HB 4396	In Comm	Requires coverage of min. 48 hrs. inpatient care for vaginal birth; 96 hrs. cesarean.	Not addressed.	
SOUTH DAKOTA					
TENNESSEE					

STATE	BILL NUMBER	STATUS	COVERAGE REQUIRED FOR VAGINAL BIRTH/CESAREAN	COVERAGE OF POST DISCHARGE CARE	COMMENTS
TEXAS					
UTAH	SB 23	In Comm	Prohibits insurers from limiting coverage of maternity benefits due to failure to obtain preapproval for customary and reasonable maternity care expenses.		
VERMONT	HB 650 , SB 292	In Comm	Requires coverage of min. 48 hrs. inpatient care for vaginal birth; 96 hrs. cesarean.	Not addressed.	
VIRGINIA	HB 87	In Comm	Prohibits limitations on inpatient care coverage of less than 48 hrs. after vaginal birth; 96 hrs. after cesarean. Permits shorter stay if: mother consents in writing; discharge is in accordance with Guidelines for Perinatal Care; coverage of one home visit.	Min. 1 home visit.	
WASHINGTON	SB 6120	Prefiled for 1996	Prohibits denial of coverage for 48 hrs. inpatient care after vaginal birth; 96 for cesarean if determined to be medically necessary by provider or requested by mother.	Prohibits denial of coverage of up to 3 home visits if requested by mother or provider.	Defines "provider" as physicians, certified nurse midwives, midwives, advanced registered nurse practitioners.
WEST VIRGINIA					
WISCONSIN	AB 573, SB 463	In Comm	Requires coverage of min. 48 hrs after vaginal birth and 96 hrs. after cesarean section, of either inpatient care or home care, or combination of both. Requires type of care and duration to be at mother's discretion in consultation with provider.	Requires health commissioner to develop rules on home care, including who may provide care, and its frequency and duration.	
WYOMING					

APPENDIX C

Preauthorized Length of Stay

Table 1: Utilization Review Entities Preauthorized Length of Stay for Uncomplicated Deliveries

Company Name	Preauthorized Length of Stay		Requests for longer stays in ME
	Vaginal (Hrs)	C-Section (Hrs)	
John Alden	1 day following day of delivery	2 days following day of delivery	Did not track but has been liberal in certifying add. days
Anthem Health	24	48	1995-2 were requested & 2 granted
Beech Street	24	72	no requests for longer stays in ME
EBP Health Plans	48	72	no requests
ENCOMPASS	Does not assign a fixed length of stay but follows each admission according to specifics of the case		no requests for longer stays in ME
Equifax	48	72	no information
ETHIX	24	72	no maternity reviews
FIRST HEALTH	24	48	still collecting information
GENEX Services	48	72	3 - 1994 3 - 1995
Health Direct	1 overnight if delivery before 6pm otherwise 2	3 overnights	no requests for longer stays in ME
Health International	48	72	no requests for longer stays in ME
HealthCare COMPARE	48	96	1995 - 4 requests, 3 granted
Health Care Excellence	48	72	no requests for longer stays in ME
HealthWatch	48	will approve 96 if clinically approp.	no requests for longer stays in ME
Hines & Assoc.	24	48	no maternity reviews
IntraCorp	avg length of stay 1994 - 2.05 1995 - 1.70	avg. length of stay 1994 - 4.83 1995 - 3.58	Requested Approved 1994 60 53 1995 29 22
Medical Resource	48	72	no maternity reviews
MedTrac	48	96	no requests for longer stays in ME
National Health Services	Use "Quality Check Day": 24 hours unless delivery after 6pm then 48 hours	Same as vaginal except 72 & 96	Requested Approved 1994 1 1 1995 4 4
National Utilization Management	48	48	no reviews
Nationwide	48	72	no reviews
Preferred Plan	1 overnight with grace period for late deliveries	2 overnights w/ grace pd. for late delivery	one delivery reviewed in ME - granted 4 days for complicated vaginal
Prudential	24		
United HealthCare Management	48	96	no reviews

March 11, 1996

Marti Hooper
Senior Claims Analyst
Department of Professional and Financial Regulation
Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: LD 1732 Length of Maternity Stays

Dear Ms. Hooper:

In compliance with your request of February 1, 1996, and per our telephone conversation, I am providing you with information regarding maternity length of stay. The information below pertains to information for MetraHealth, for the calendar years 1994 and 1995. Please note that the information is divided between the former MetLife HealthCare and the former Travelers Insurance Company information.

MetraHealth (Former Travelers Insurance Company)
1995
Requests for longer stay: 56
Of these requests, number granted: 56

Average Length of Stay:

Vaginal: 2 days
Cesarean Section: 3 days

No penalties or reductions have been recommended.

1994

Requests for a longer stay: 44
Of these requests, number granted: 44

Average Length of Stay:

Vaginal: 2 days
Cesarean Section: 4 days

No penalties or reductions have been recommended.

MetraHealth (Former MetLife)

1994

Number of requests denied in Maine: 2

Number of normal vaginal deliveries: 93

Number of cesarean section deliveries: 23

Average length of stay for a normal vaginal delivery: 1.81 days

Average length of stay for a cesarean section delivery: 2.28 days

1995

Number of normal vaginal deliveries: 88

Number of cesarean section deliveries: 16

Average length of stay for normal vaginal deliveries: 1.80 days

Average length of stay for cesarean section deliveries: 2.00 days

No denials are noted in 1995. Penalties and reductions are not mechanisms used in this utilization review program.

I trust that this information will respond to your request. If I can be of any further assistance, please contact me at 212-723-3870.

Sincerely,

Kim Sushon

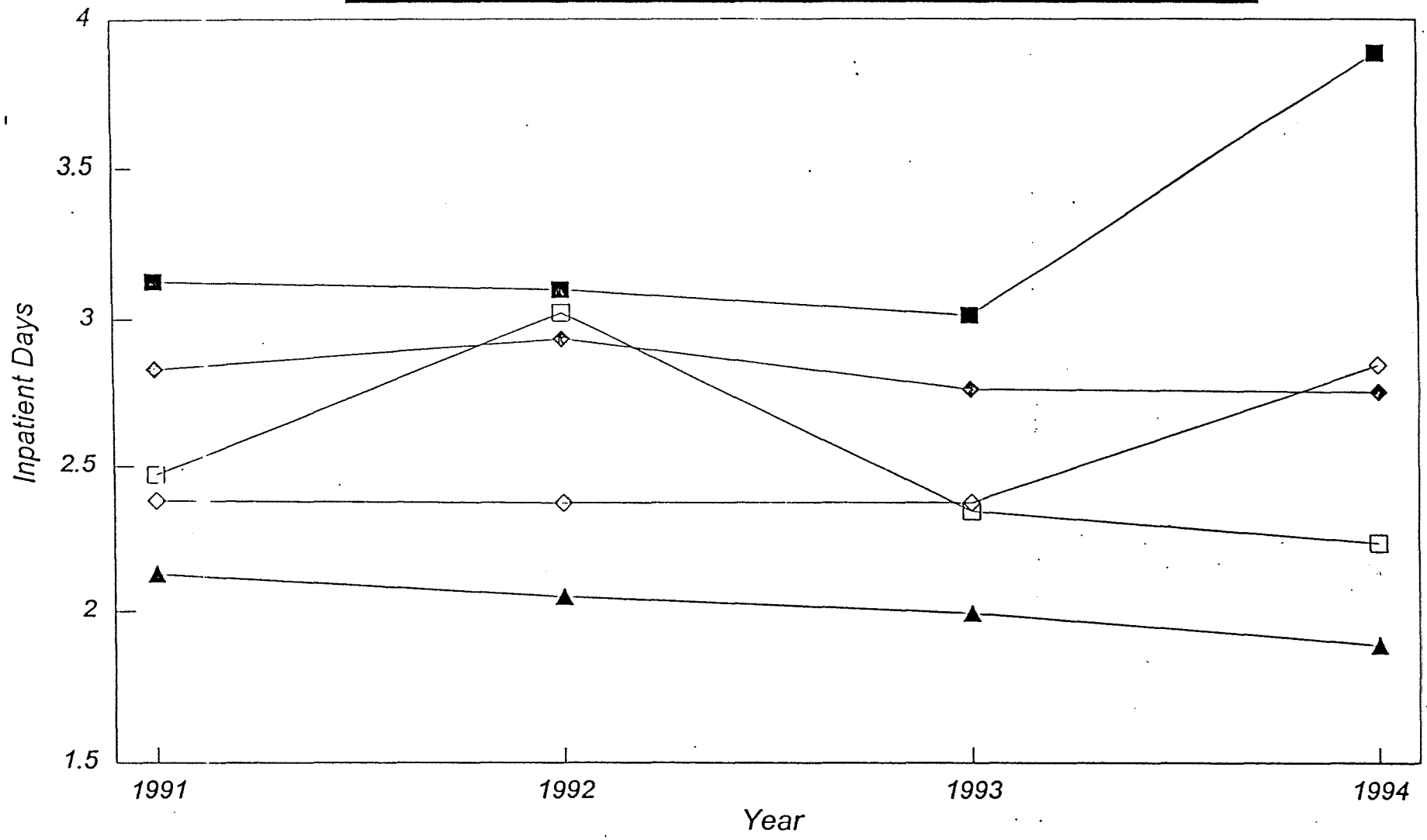
Kim Sushon
Compliance Consultant

APPENDIX D

Maine Data

Inpatient DRG Trends, Maine Hospitals, 1991-1994

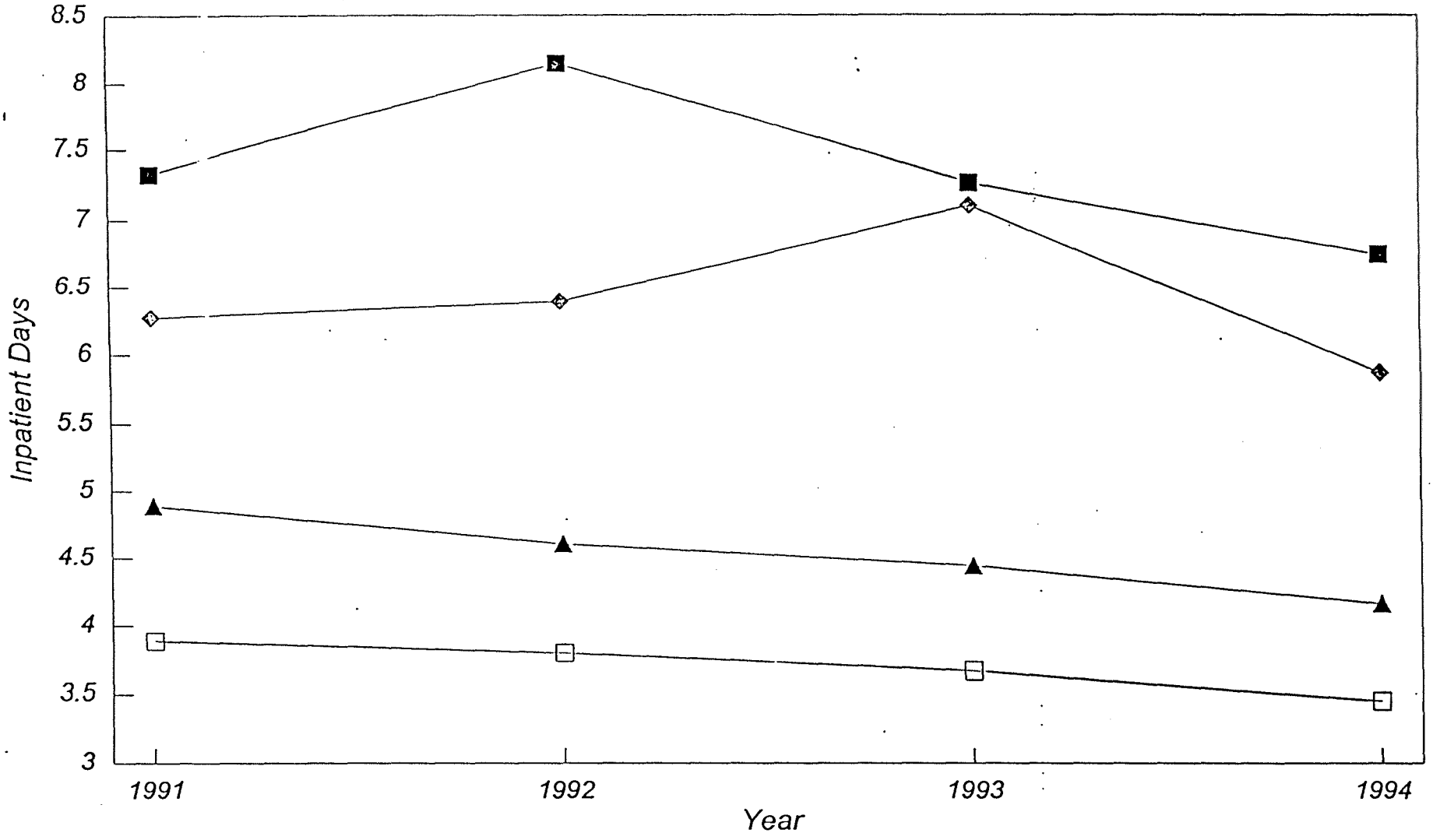
Average Length of Stay



DRG	652	652 HIGH RISK VAGINAL DELIVERY W STERILIZATION AND/						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	77	241	$290,216	3.13	$3,976	6.2626	19.6012	$236
1992	87	270	$367,588	3.1	$4,429	7.0376	21.8408	$297
1993	75	226	$304,334	3.01	$4,542	5.9579	17.9532	$242
1994	84	327	$428,493	3.89	$5,424	6.6729	25.9765	$340
Average	80.75	266	$347,658					
Rate of change	3.7%	13.5%	16.7%	8.5%	11.1%	3.0%	12.8%	16.0%
DRG	372	372 VAGINAL DELIVERY W COMPLICATING DIAGNOSES						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	2634	7465	$6,587,952	2.83	$2,662	214.2306	607.1495	$5,358
1992	2633	7709	$7,342,498	2.93	$2,850	212.9878	623.5940	$5,939
1993	2632	7268	$7,478,300	2.76	$2,951	209.0834	577.3624	$5,941
1994	2608	7170	$8,063,766	2.75	$3,293	207.1768	569.5774	$6,406
Average	2626.75	7403	$7,368,129					
Rate of change	-0.3%	-1.3%	7.0%	-0.9%	7.4%	-1.1%	-2.0%	6.2%
DRG	373	373 VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	8897	18933	$16,313,841	2.13	$1,973	723.6181	1539.8742	$13,269
1992	8361	17124	$16,975,365	2.05	$2,092	676.3354	1385.1892	$13,732
1993	7921	15798	$16,422,663	1.99	$2,184	629.2361	1254.9769	$13,046
1994	7650	14363	$16,292,901	1.88	$2,325	607.7081	1140.9819	$12,943
Average	8207.25	16554.5	$16,501,193					
Rate of change	-4.9%	-8.8%	0.0%	-4.1%	5.6%	-5.6%	-9.5%	-0.8%
DRG	374	374 VAGINAL DELIVERY W STERILIZATION &/OR D&C						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	625	1545	$2,023,227	2.47	$3,470	5.0833	12.5659	$1,646
1992	590	1781	$2,055,930	3.02	$3,607	4.7726	14.4068	$1,663
1993	546	1279	$1,997,595	2.34	$3,917	4.3374	10.1602	$1,587
1994	546	1220	$2,150,180	2.23	$4,309	4.3374	9.6916	$1,708
Average	576.75	1456.25	$2,056,733					
Rate of change	-4.4%	-5.8%	2.1%	-1.7%	7.5%	-5.1%	-6.5%	1.4%
DRG	375	375 VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	187	445	$398,227	2.38	$2,399	15.2092	36.1931	$324
1992	205	486	$513,692	2.37	$2,594	16.5828	39.3134	$416
1993	181	429	$487,323	2.37	$2,738	14.3785	34.0793	$387
1994	167	474	$550,554	2.84	$3,337	13.2663	37.6541	$437
Average	185	458.5	$487,449					
Rate of change	-3.3%	2.7%	12.3%	6.5%	11.8%	-4.0%	1.9%	11.5%

Inpatient DRG Trends, Maine Hospitals, 1991-1994

Average Length of Stay



DRG	650	650 HIGH RISK CESAREAN SECTION W CC						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	113	827	$794,434	7.32	$7,157	9.1906	67.2622	$646
1992	152	1239	$1,224,501	8.15	$8,218	12.2955	100.2248	$991
1993	124	900	$934,814	7.26	$7,856	9.8504	71.4951	$743
1994	127	856	$1,008,748	6.74	$8,549	10.0887	67.9998	$801
Average	129	955.5	$990,624					
Rate of change	6.2%	5.9%	12.8%	-2.2%	6.4%	5.4%	5.2%	12.1%

DRG	651	651 HIGH RISK CESAREAN SECTION W/O CC						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	287	1799	$1,522,364	6.27	$5,878	23.3425	146.3177	$1,238
1992	318	2031	$1,913,709	6.39	$6,173	25.7236	164.2910	$1,548
1993	305	2167	$2,104,529	7.1	$7,232	24.2289	172.1442	$1,672
1994	296	1736	$1,998,742	5.86	$7,063	23.5139	137.9061	$1,588
Average	301.5	1933.25	$1,884,836					
Rate of change	1.3%	-0.1%	10.2%	-1.5%	6.6%	0.5%	-0.9%	9.3%

DRG	370	370 CESAREAN SECTION W CC						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	640	3130	$3,164,551	4.89	$5,088	52.0530	254.5717	$2,574
1992	611	2809	$3,213,635	4.6	$5,294	49.4248	227.2247	$2,600
1993	558	2470	$3,082,658	4.43	$5,751	44.3269	196.2143	$2,449
1994	553	2296	$3,044,349	4.15	$6,077	43.9298	182.3919	$2,418
Average	590.5	2676.25	$3,126,298					
Rate of change	-4.7%	-9.8%	-1.3%	-5.3%	6.1%	-5.4%	-10.5%	-2.0%

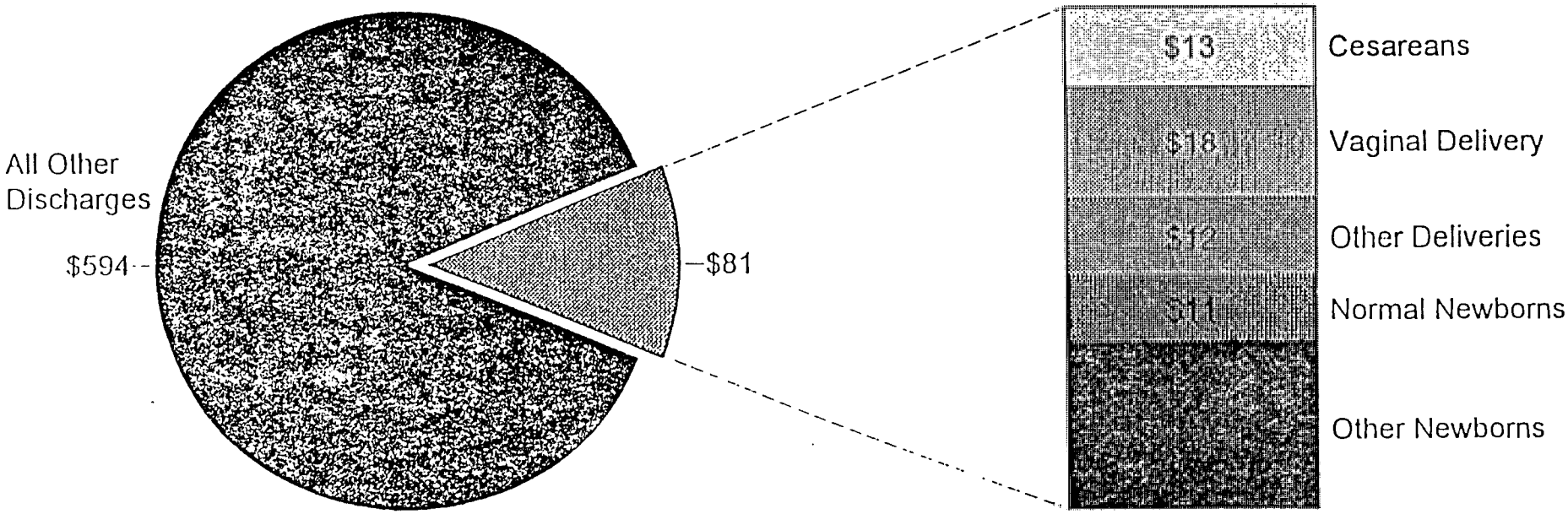
DRG	371	371 CESAREAN SECTION W/O CC						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	2403	9313	$9,569,796	3.88	$4,348	219.5443	75.7453	$7,783
1992	2222	8424	$9,659,910	3.79	$4,508	17.9741	68.1432	$7,814
1993	2049	7500	$9,498,527	3.66	$4,819	16.2770	59.5792	$7,546
1994	1949	6730	$9,439,894	3.45	$5,114	15.4827	53.4624	$7,499
Average	2155.75	7991.75	$9,542,032					
Rate of change	-6.7%	-10.3%	-0.4%	-3.8%	5.6%	-7.5%	-11.0%	-1.2%

DRG	999	blank						
Year	Discharges	Days	Charges	Average LOS	Average Charge	Incidence/10000	Days/10000	Dollars/1000
1991	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR
1992	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR
1993	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR
1994	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR
Average	ERR	ERR	ERR					
Rate of change	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR

Maine Inpatient Hospital Charges

Ages 0 - 64

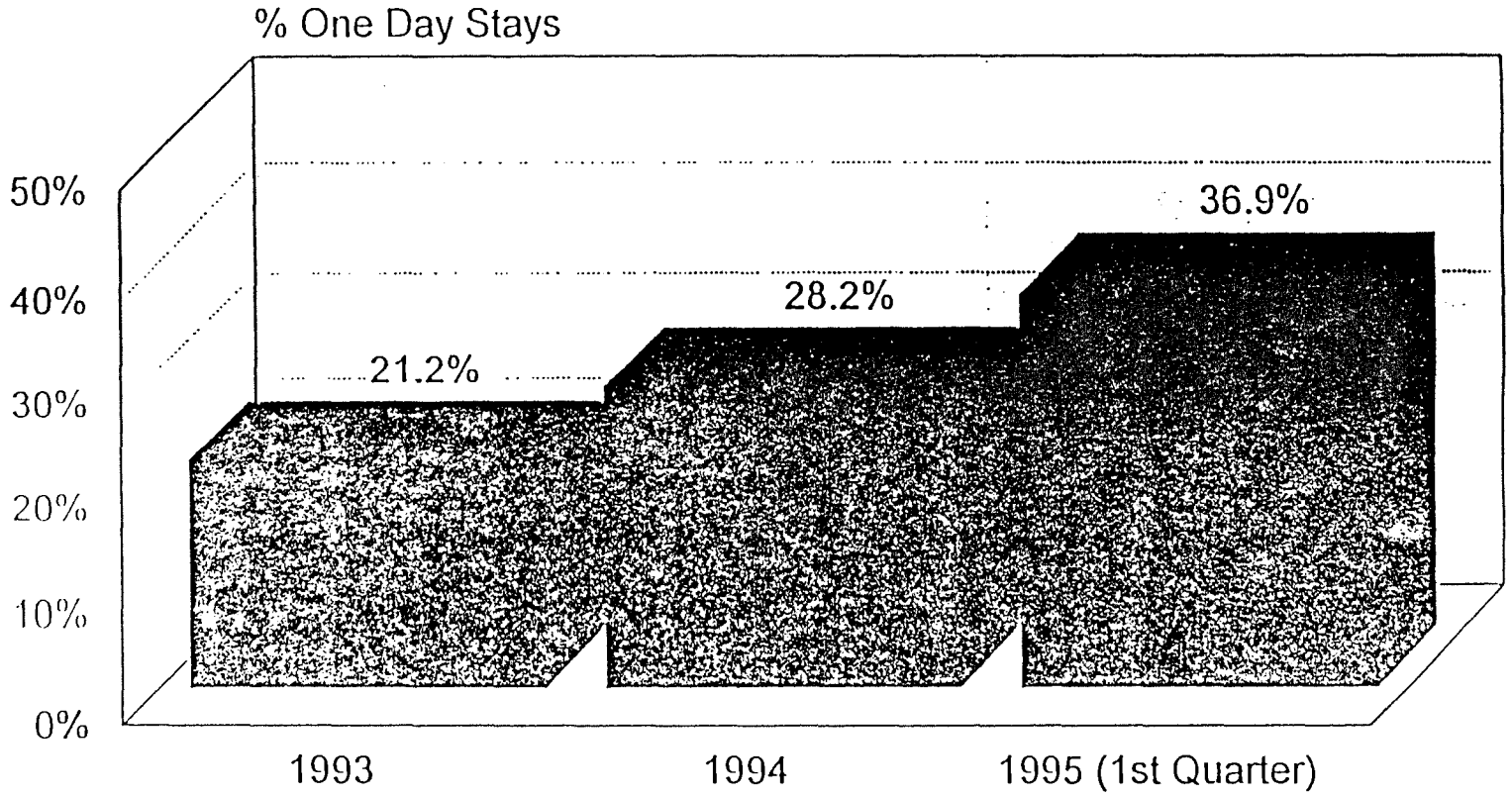
Charges in Millions
Total = $675 million



For Maine Health Management Coalition (11/29/95)

Maine Trends In One Day Stays

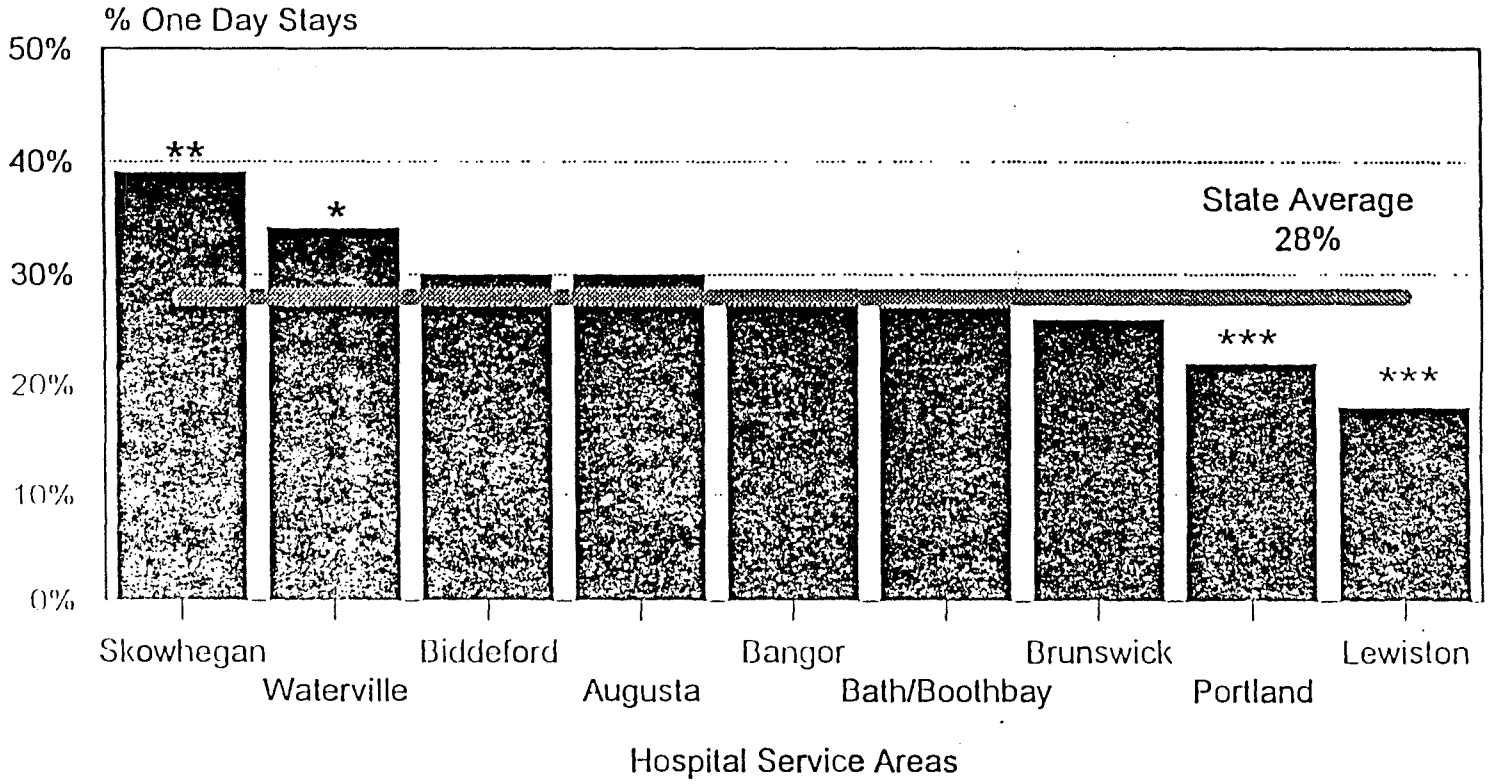
Normal Deliveries (NYDRG 373)



For Maine Health Management Coalition (11/29/95)

Variation In One Day Stays

Normal Deliveries (NYDRG 373)
1994 Maine Discharges

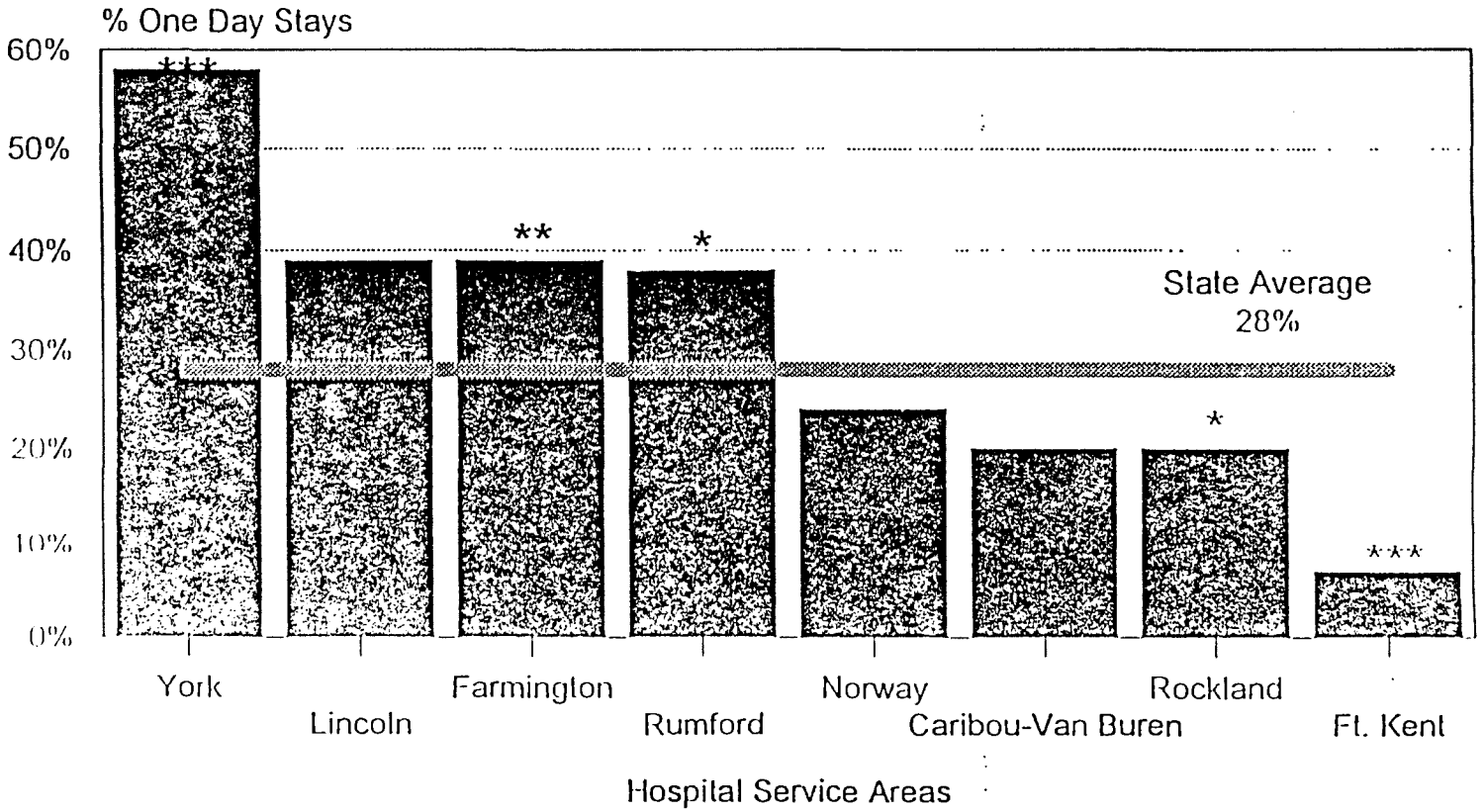


Significance = * .05 ** .05 *** .001

For Maine Health Management Coalition (11/29/95)

Variation In One Day Stays

Normal Deliveries (NYDRG 373)
1994 Maine Discharges



Significance = * .05 ** .05 *** .001

For Maine Health Management Coalition (11/29/95)

STATE OF MAINE INPATIENT DELIVERIES AND NEWBORNS
BASED UPON CLAIMS PAID IN 1995

DRG	DESCRIPTION	TOTAL MEMBERS	TOTAL DAYS	AVG LOS	TOTAL CHARGES	AVG CHARGE PER CASE	AVG CHARGE PER DAY
372	VAGINAL DELVRY W/COMPLIC DX	37	73	2.0	110,054.51	2974.45	1507.60
373	VAGINAL DELVRY W/O COMPLIC DX	198	402	2.0	501,772.22	2534.20	1248.19
374	VAGINAL DELVRY W/STERIL OR D&C	1	3	3.0	5,464.30	5464.30	1821.43
	VAGINAL DELIVERIES	236	478	2.0	617,291.03	2615.64	1291.40
370	CESAREAN SECTION W/CC	6	19	3.2	31,541.46	5256.91	1660.08
371	CESAREAN SECTION W/O C.C	55	179	3.3	293,810.96	5342.02	1641.40
	CESAREAN SECTIONS	61	198	3.2	325,352.42	5333.65	1643.19
385	NEONATES, DIED OR TRANSFERRED	4	4	1.0	10,123.39	2530.85	2530.85
386	EXTREME IMMATURITY, NEONATE	1	9	9.0	36,424.97	36424.97	4047.22
387	PREMATURITY W/MAJOR PROBLEMS	5	56	11.2	18,978.09	3795.62	338.89
388	PREMATURITY W/O MAJOR PROBLEMS	7	16	2.3	6,438.01	919.72	402.38
389	FULL TERM NEONATE W/MAJ PROBL	12	32	2.7	15,054.21	1254.52	470.44
390	NEONATES W/OTH SIGNIFIC PROBL	71	178	2.5	108,564.10	1529.07	609.91
391	NORMAL NEWBORNS	263	505	1.9	224,578.72	853.91	444.71
	NEWBORNS	363	800	2.2	420,161.49	1157.47	525.20

WELL BABY CARE

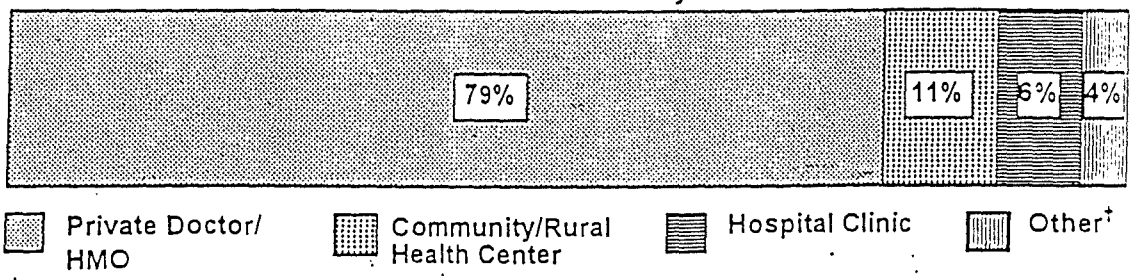
Data from the
MAINE PREGNANCY RISK ASSESSMENT MONITORING SYSTEM (PRAMS)
1988-1992

- Well babies who visit a health care professional have opportunities to receive timely, preventive interventions against specific diseases, to have other illnesses detected and treated, and to have potential developmental or psychosocial disorders identified.[1]

- One of the National Health Objectives for the Year 2000 is to increase, to at least 90%, the proportion of babies aged 18 months and younger who receive recommended primary care services at the appropriate intervals.[2]

- In Maine, the setting where most well baby care is received is the private doctor's office.

Sources of Well Baby Care



†Other includes military facilities, Indian Health Service, and any other write-in response.

- Most Maine babies obtain a sufficient or more than sufficient number of well baby visits for their age, in comparison with the guidelines issued by the American Academy of Pediatrics[1] (1% get an exceptionally low* number of visits).

- 96% of Maine mothers report that they got as much well baby care for their child as they wanted during the early months of life.

* An exceptionally low number is no visits (unrelated to illness) for 3 to 4 month-olds, and fewer than two visits for 5 to 6 month-olds.

Note: All data presented apply to 3 to 6 month-old babies who were not hospitalized more than 7 nights at birth, who did not die, and whose amount of well baby care is known (n=2,899).

Footnotes 1,2: Citations are available upon request.

For further data on this topic, please contact:
the Office of Data, Research, and Vital Statistics, Bureau of Health
at 35 Anthony Avenue, State House Station 11, Augusta, Maine 04333-0011
The contact person(s) is: Judy Danna - 624-5445

For prevention information, please contact: Rachel Curtis at 287-3311

John R. McKernan, Jr.
Governor

Jane Sheehan
Commissioner

DS.FACTS2.FRP P6
PRA.005

OFFICE OF DATA, RESEARCH AND VITAL STATISTICS Number 7
FACT SHEET - PRAMS
8/1992

PREVALENCE OF BREASTFEEDING

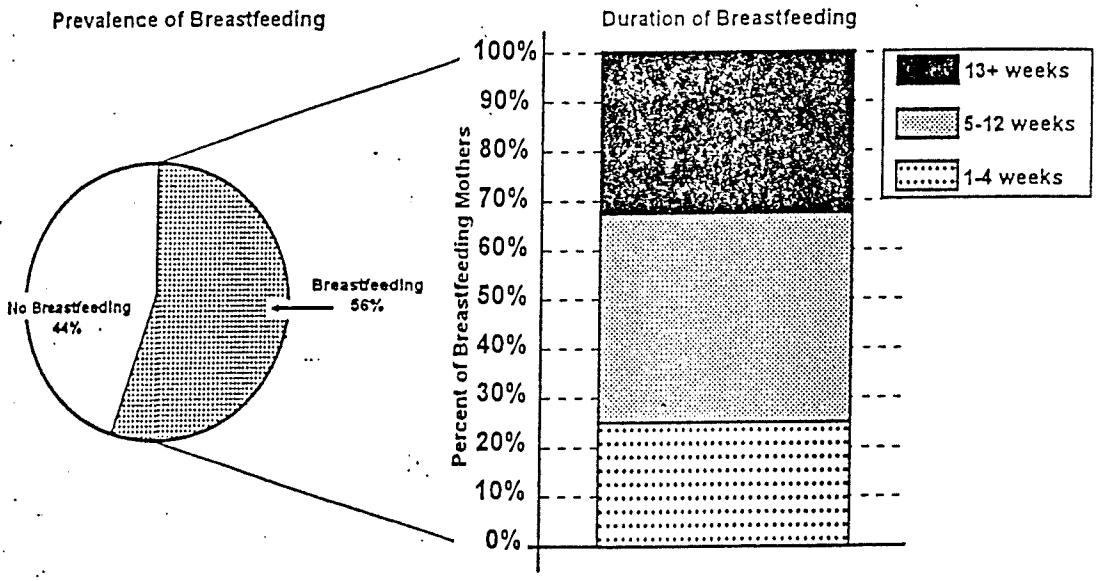
Data from the
MAINE PREGNANCY RISK ASSESSMENT MONITORING SYSTEM (PRAMS)
1988 - 1992

- One of the National Health Objectives for the Year 2000 is to increase the prevalence of breastfeeding in the first weeks after delivery to at least 75%.[1]

- 56% of Maine mothers breastfeed in the first weeks after delivery; this is true of 54% of mothers nationwide.[1]

- 26% of Maine breastfeeding mothers continue unsupplemented nursing less than 5 weeks; 42% do so for 5 to 12 weeks.

Prevalence and Duration of Unsupplemented Breastfeeding in Maine



- Breastmilk not only contains protective anti-infective agents, but meets the complete nutritional needs of the baby as well.[2]

Footnotes 1, 2: Citations available upon request.

For further data on this topic, please contact:
the Office of Data, Research, and Vital Statistics, Bureau of Health
at 35 Anthony Avenue, State House Station 11, Augusta, Maine 04333-0011
The contact.person(s) is: Judy Danna - 624-5445

For program information, please contact: Kathy Savoie at 287-3311

John R. McKernan, Jr.
Governor

DEPARTMENT OF HUMAN SERVICES

Jane Sheehan
Commissioner

DS:FACTS1.FRP P9
PRA.005
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OFFICE OF DATA, RESEARCH AND VITAL STATISTICS Number 12

FACT SHEET - PRAMS

Pregnancy Risk Assessment Monitoring System (PRAMS)

Q. 34. When you went in the hospital to have your baby, how many nights did you stay?

ONE Night

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	17.2	5.1	10.9	10.0	18.3	12.6
20+	10.0	11.0	13.4	13.8	16.0	12.8
All Ages	11.0	10.4	13.1	13.4	16.2	12.8

TWO Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	45.8	41.9	46.0	47.6	49.6	46.1
20+	44.6	46.5	43.9	47.6	43.7	45.3
All Ages	44.8	46.1	44.1	47.6	44.3	45.4

THREE Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	21.7	23.8	17.4	20.9	19.5	20.7
20+	25.4	20.6	22.5	21.8	22.5	22.5
All Ages	24.9	20.9	21.9	21.7	22.2	22.3

FOUR Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	8.4	12.9	12.7	13.5	4.2	10.2
20+	11.6	13.2	11.6	11.3	10.2	11.6
All Ages	11.2	13.2	11.7	11.5	9.6	11.5

FIVE - SEVEN Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	8.7	12.8	11.1	7.4	5.8	8.7
20+	6.5	7.5	7.0	4.7	5.9	6.5
All Ages	7.4	8.0	7.4	4.9	5.9	6.8

EIGHT or More Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	*	*	*	*	*	1.8
20+	0.8	1.2	1.8	0.8	1.7	1.3
All Ages	0.8	1.4	1.8	0.8	1.8	1.3

* Sample size less than 10.

Source of Data: Maine Pregnancy Risk Assessment Monitoring System
Prepared by: Maine Department of Human Services, Bureau of Health,
Office of Data, Research and Vital Statistics

Pregnancy Risk Assessment Monitoring System (PRAMS)

Q. 35. When your baby was born, how many nights did he or she stay in the hospital?

ONE Night

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	16.1	*	9.6	*	14.7	11.6
20+	9.7	10.8	14.7	14.1	16.0	13.0
All Ages	10.5	10.6	14.4	13.5	15.8	12.9

TWO Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	45.8	38.8	56.1	52.7	53.2	49.1
20+	43.9	48.5	46.7	50.5	48.2	47.6
All Ages	44.2	47.5	47.7	50.7	48.8	47.7

THREE Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	19.0	19.7	18.1	17.2	19.9	18.8
20+	24.8	18.7	19.6	18.5	18.6	20.1
All Ages	24.0	18.8	19.4	18.4	18.7	19.9

FOUR - SEVEN Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	13.7	25.2	12.8	17.7	7.4	15.7
20+	17.8	18.4	15.1	14.3	12.7	15.3
All Ages	17.2	19.1	14.9	14.6	12.1	15.7

EIGHT or More Nights

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	5.4	7.4	3.4	5.1	4.8	5.2
20+	3.9	3.7	3.7	2.6	4.5	3.7
All Ages	4.1	4.0	3.6	2.8	4.6	3.8

* Sample size less than 10.

Source of Data: Maine Pregnancy Risk Assessment Monitoring System
Prepared by: Maine Department of Human Services, Bureau of Health,
Office of Data, Research and Vital Statistics

Pregnancy Risk Assessment Monitoring System (PRAMS)

Q. 38. for how many weeks or months did you breastfeed your baby before feeding him or her any other milk, formula, or food?

I did not breastfeed.

AGE	1989	1990	1991	1992	1993	1989 -1993
<20	n/a	56.4	58.1	62.5	56.0	58.1
20+	n/a	45.8	43.1	38.1	36.6	40.7
All Ages	n/a	47.1	45.0	40.3	39.6	42.6

I breastfed < 1 week.

AGE	1989	1990	1991	1992	1993	1989 -1993
<20	n/a	*	*	*	11.2	9.6
20+	n/a	4.5	4.6	3.7	4.7	4.4
All Ages	n/a	4.8	5.0	4.5	5.4	5.0

I'm still breastfeeding and have started some formula or food too.

AGE	1989	1990	1991	1992	1993	1989 -1993
<20	n/a	*	*	*	*	6.7
20+	n/a	17.9	21.4	23.0	22.8	21.5
All Ages	n/a	17.2	19.7	21.8	20.5	20.0

I'm still breastfeeding and haven't fed m y baby any other milk, formula or food yet.

AGE	1989	1990	1991	1992	1993	1989 -1993
<20	n/a	*	*	*	*	*
20+	n/a	16.6	11.4	7.6	3.8	9.3
All Ages	n/a	15.0	10.5	7.1	3.4	8.6

* Sample size less than 10.

Source of Data: Maine Pregnancy Risk Assessment Monitoring System
Prepared by: Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics

Pregnancy Risk Assessment Monitoring System (PRAMS)

Of the mothers who did not breastfeed...

Q. 39 Did any of these things stop you from breastfeeding?

a. I didn't want to.

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	n/a	48.1	48.9	35.9	52.1	46.9
20+	n/a	48.6	41.9	37.7	36.9	45.1
All Ages	n/a	48.5	42.9	37.5	39.0	45.3

b. I was planning to go to work or school.

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	26.3	24.3	22.9	26.8	19.0	23
20+	25.0	19.5	23.7	23.0	23.7	22.9
All Ages	25.2	20.2	23.6	23.4	23.0	22.9

c. I tried, but my baby didn't breastfeed well.

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	n/a	10.3	16.9	21.4	18.2	16.6
20+	n/a	15.8	12.7	13.5	12.6	12.4
All Ages	n/a	15.0	13.3	14.4	13.4	12.9

d. My baby was not with me.

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	n/a	*	1.7	3.8	3.4	2.5
20+	n/a	2.2	1.1	2.2	1.4	1.7
All Ages	n/a	2.0	1.2	2.4	1.6	1.8

e. I think it's better for my baby to be bottle fed.

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	12.1	15.0	15.5	8.3	*	11.9
20+	9.2	7.3	5.7	4.9	5.1	6.2
All Ages	9.8	8.4	7.2	5.3	5.5	6.9

f. I was taking medicine.

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	n/a	*	*	2.1	*	3.9
20+	n/a	5.0	5.3	5.7	4.6	5.2
All Ages	n/a	4.7	5.9	5.3	4.1	5.0

g. I felt it was the right time to stop.

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	n/a	*	*	*	*	6.9
20+	n/a	6.6	7.3	12.6	4.6	9.3
All Ages	n/a	6.5	7.1	12.4	4.1	9.0

h. Other reason.

AGE	1989	1990	1991	1992	1993	1989 - 1993
<20	11.0	26.4	18.1	16.7	28.4	22.5
20+	20.7	21.7	24.3	24.3	28.5	24.0
All Ages	19.0	22.3	23.4	23.5	28.5	23.8

* Sample size less than 10.

Source of Data: Maine Pregnancy Risk Assessment Monitoring System

Prepared by: Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics

Pregnancy Risk Assessment Monitoring System (PRAMS)

Q. 40 In the week after you went home from the hospital, did you see a doctor or nurse for yourself?

AGES	1989	1990	1991	1992	1993	1989 - 1993
<20	35.4	21.4	22.0	19.6	22.5	24.3
20+	27.3	20.3	17.8	15.5	20.5	21.1
All Ages	28.4	20.4	18.3	19.2	20.7	21.5

Q.41 Why did you see a doctor or nurse?

Vaginal Bleeding

AGES	1989	1990	1991	1992	1993	1989 - 1993
<20	*	*	*	*	*	3.5
20+	5.5	7.2	3.7	8.2	6.6	6.2
All Ages	5.9	6.6	3.3	7.7	5.9	5.9

Fever or Infection

AGES	1989	1990	1991	1992	1993	1989 - 1993
<20	*	*	*	*	*	13.3
20+	4.4	13.7	20.2	17.8	10.9	12.7
All Ages	5.4	15.4	19.3	16.7	10.8	12.8

Other Reason

AGES	1989	1990	1991	1992	1993	1989 - 1993
<20	37.5	32.1	*	*	*	60.4
20+	36.6	52.7	77.2	75.0	76.9	61.4
All Ages	36.7	50.4	78.4	76.4	78.3	61.3

* Sample size less than 10.

Source of Data: Maine Pregnancy Risk Assessment Monitoring System
Prepared by: Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics

APPENDIX E

Misc. Articles

blems and ways to cope with them. Plans for as well as instructions to follow in the event of :ion, should be discussed.

ions

:nt should be informed of normal postpartum :es in the lochial pattern that she should expect : range of activities that she may reasonably ›reasts, perineum, and bladder; dietary needs, :eeding; the recommended amount of exercise; observations that she should report to the elevation, chills, leg pains, or increased vaginal convalescence based on the type of delivery itients should be counseled to avoid abdominal ve abnormal bleeding or signs of infection or rged. It is helpful to reinforce oral discussion

on should be fully reviewed and implemented. :ed adequately during the immediate postpar- contraindications, however, oral contraceptive livery. Breast-feeding mothers may start using eir milk flow is established. Patients for whom ves is contraindicated or patients who prefer ption, such as foam and condoms, should be se other methods.
is may be resumed after delivery is controver- coitus may cause vaginal laceration and pain. infection are minimal after approximately 2 time, the uterus has involuted markedly, and ix have begun to reepithelialize. Thereafter, d on the patient's desire and comfort, and after been resolved. Sexual difficulties are common ildbirth. Scarring at the episiotomy site may comfort during intercourse for 1–3 months. In gina is often atrophic, and lubrication during unsatisfactory. Furthermore, the demands of s ability to find the time previously allocated

e, arrangements should be made for postpar- n, and specific instructions should be conveyed

to the mother. The following points should be reviewed with the mother or, preferably, with both parents:

- Condition of the neonate
- Immediate needs of the neonate (eg, feeding methods and environmental supports)
- Roles of the obstetrician, pediatrician, and other members of the health care team concerned with the continuous medical care of the mother and neonate
- Availability of support systems, including psychosocial support
- Instructions to follow in the event of a complication or emergency
- Feeding techniques; skin care, including cord care; temperature assessment and measurement with the thermometer; and assessment of neonatal well-being and recognition of illness
- Reasonable expectations for the future
- Importance of maintaining immunization begun with initial dose of hepatitis B vaccine

When no complications are present, the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean birth, excluding the day of delivery. When the mother is discharged early, especially within 24 hours of delivery, certain criteria should be met:

- The mother should have had an uncomplicated vaginal delivery following a normal antepartum course and should have been observed after delivery for a sufficient time to ensure that her condition is stable. Pertinent laboratory data, including a postpartum determination of hemoglobin or hematocrit level and, if not previously obtained, ABO blood group and Rh typing, should have been obtained. If indicated, the appropriate amount of RhIg should have been administered.
- Family members or other support person(s) should be available to the mother for the first few days following discharge.
- The mother should be aware of possible complications and should have been instructed to notify the appropriate practitioner, as necessary.
- Procedures for readmission of obstetric patients should be consistent with hospital policy, as well as local and state regulations.

The medical and nursing staff need to be sensitive to potential problems associated with early discharge and to develop mechanisms to address patient questions that arise after discharge.

Early Infant Discharge and Follow-up

The nursery stay is planned to allow the identification of early problems and to reinforce instructions in preparation for the infant's care at home. Complications often are not predictable by prenatal and intrapartum events. Because many neonatal problems do not become apparent until several days after birth, there is an element of medical risk in early neonatal discharge. Although most problems are manifest during the first 6 hours, data suggest that readmissions may be more common when early (by 48 hours) or very early (by 24 hours) discharge programs are instituted. With these observations in mind, the following criteria for early infant discharge are recommended:

- The course of antepartum, intrapartum, and postpartum care, for both mother and fetus, should be without complications.
- Maternal readiness to assume independent responsibility for her newborn should be assured by demonstration of skills and abilities such as feeding techniques, skin and cord care, measurement of temperature with a thermometer, and ability to assess infant well-being and recognize common neonatal illnesses. Family members who will care for the child should attend prenatal childbirth education or infant care classes, in which problems of the first days after birth are discussed.
- The infant should be delivered at term, be of appropriate birth weight, and found normal by examination.
- The infant should be able to maintain thermal homeostasis as well as suck and swallow normally.
- A physician-directed source of continuing medical care for both mother and baby should be identified and arrangements made for the baby to be examined within 48 hours of discharge.
- Laboratory data should be reviewed to include:
  - —Maternal testing for syphilis and hepatitis B surface antigen
  - —Cord or infant blood type and direct Coombs test (if the mother is Rho(D) negative, or is type O, or if screening has not been performed for maternal antibodies)

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Follow-up

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—Hemoglobin or hematocrit and blood glucose determinations as clinically indicated

—Screening tests required by law

- Initial hepatitis B vaccine should be administered.

At the initial follow-up visit, within 48 hours of discharge, the following assessments of the infant should be made:

- Evaluation of condition by history and physical examination to include evidences of adequate nutrition and hydration, normal stool pattern, degree of jaundice, quality of mother–infant interaction, and details of infant behavior
- Review of laboratory data obtained before discharge
- Screening tests for PKU, hypothyroidism, and other metabolic disorders, as indicated by state law and clinical judgment
- Planning for health maintenance, to include arrangements for emergency services, preventive care and immunizations, periodic evaluations, and necessary screening

High-Risk Infants

Each hospital should develop guidelines for the discharge of high-risk infants that may include the following criteria:

- The infant should be physiologically stable and should be able to maintain body temperature without cold stress when the amount of clothing worn and the room temperature are appropriate.
- The infant should be able to tolerate oral feeding by breast or bottle. If the infant's clinical condition precludes normal nipple feeding, the parents or other care providers should be instructed in an alternative feeding program.
- The infant should be gaining weight steadily at the time of discharge.
- The infant should be free of apnea prior to discharge or be receiving appropriate treatment.
- The physician or discharge planner should have confirmed parental competence (eg, ability to administer medications).
- The home situation should be considered appropriate.

Many common illnesses aren't noticed for days

By The Associated Press

The American Academy of Pediatrics says many potentially dangerous, yet easily treated conditions don't show up in newborns for a few days after birth:

✓ **Jaundice.** Yellow skin can mean the liver isn't functioning properly yet. A common condition, it usually clears up quickly. But other, more serious problems can cause jaundice, and if unchecked can result in seizures, retardation or hearing loss.

✓ **Dehydration.** This can occur if the baby is mimicking breast-feeding but not actually drawing milk, and can damage the kidneys, other organs and the central nervous system. Signs include dry or wrinkled skin, a sunken area at the top of the head, and the newborn wetting fewer than six diapers a day.

✓ **Infections.** With an immature immune system, newborns are vulnerable to viral, bacterial and fungus infections. Untreated, they can damage the brain and organs; some infections are up to 50 percent fatal.

✓ **Metabolism disorders.** Most states require testing for a number of these disorders, which generally can't be detected until the mother is producing enough milk for the baby's digestive system to operate normally.

Other relatively common symptoms sometimes indicate serious problems:

✓ **Fever.** Can indicate infection.

✓ **Vomiting.** Can indicate gastrointestinal obstruction or incompatibility with infant formula.

✓ **Failure to urinate.** Can mean kidney or bladder problems, or dehydration.

✓ **Bloody stools or no bowel movements.** Likely indicates a gastrointestinal blockage.

✓ **Listlessness.** Can indicate infection, or problems with the heart or other organs.

✓ **Sleeping through feedings.** Can indicate infection or a metabolism problem.

New mothers, too, can develop serious problems if discharged too soon, including infections or excessive bleeding after episiotomies, Caesarean sections or other surgeries. Also, exhaustion from a difficult delivery can leave the mother unable to properly care for her newborn.

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