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Suzanne Seaman

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PUTTING THE BRAKES ON DRIVE-THROUGH DELIVERIES

A mother delivers a newborn baby. What image does this bring to mind? A hospital room filled with flowers, with mother and baby sharing a "leisurely week" recuperating at the hospital? Think again. The Center for Disease Control reports that the median length of stay for women who give birth vaginally decreased between 1970 and 1992 from 3.9 to 2.1 days, and for cesarean births from 7.8 to 4 days. This reflects a general decrease in the length of stay that has continued over the last two decades. Before the 1970's, postpartum hospital stays for vaginal births varied from four to five days, and between one to two weeks for cesarean deliveries. This trend has earned the infamous nickname "drive through deliveries."

The inclination toward earlier discharge began in the 1970's, and is attributed to consumer demands that childbirth be more family oriented. It should be noted that early discharge in the 1970's quite often "involved small, select groups of women who wanted to decrease the medical intervention[] surrounding childbirth." In addition, states in which health maintenance organizations or managed-care health plans dominated the health insurance industry shifted to earlier discharges in the 1980's. Postpartum hospital stays are targeted for reduction by the insurance industry because obstetrical delivery is the most frequent cause of hospitalization in the United States.

Fueled by the recent evidence of the effects

3. Id.
4. Id.
6. Id.
7. Id. at 12.
8. Id.
10. Boobman, supra note 5, at 10. U.S. Representative Robert Torricelli of New Jersey recently calculated that for the approximate 4 million births in the United States per
of early dismissal, the decrease in hospital stays has alarmed patients, doctors, and lawmakers, and resulted in legislation that would impose mandatory minimum hospital stays for newborns and mothers.\textsuperscript{11}

Treatable infant diseases are on the rise in the United States. On May 8, 1995, the American Pediatric Society ("APS") released a study that found an increase in the number of newborns readmitted to hospitals for jaundice over the last two years.\textsuperscript{12} Jaundice is caused by the buildup of a toxic yellow substance in the blood and tissue of a newborn.\textsuperscript{13} Jaundice occurs in approximately one third of all newborns, and it takes about seventy-two hours to reach its peak.\textsuperscript{14} Between 1972 and 1991, only one case of advanced infant jaundice was discovered in twenty-three hospitals surveyed by Dr. Augusto Sola, the author of the APS study.\textsuperscript{15} However, he found five advanced cases of jaundice occurring in just one San Francisco hospital between 1992 and 1994.\textsuperscript{16} Most of the infants were discharged from the hospital after twenty-four hours, but upon readmittance—due to the jaundice—they stayed between two and ten days.\textsuperscript{17}

This Comment examines the recent legislation concerning minimum hospital stays for newborns and mothers. First, this Comment reviews the traditional practice of physician-determined hospital stays and the modern approach toward managed care providers. Second, this Comment presents the latest legislative approach to confronting the issue of minimum hospital stays for newborns and mothers and argues that the legislation is a natural result of modern trends in health care in the United States. Also, this Comment explores the impact that federal legislation has on state legislation. Finally, this Comment concludes that the trend

\begin{itemize}
\item[12.] \textit{Maier, supra} note 9, at A21.
\item[13.] Prepared statement of Dr. Lillian R. Blackmon, former president of the Maryland Chapter of the American Academy of Pediatrics, in support of Maryland Senate Bill 677 (Feb. 28, 1995).
\item[14.] \textit{Id. See also 2 P. DENNER & D. K. STEVENSON, DISEASES OF THE FETUS AND NEWBORN} § 100.1.2, at 1454 (G.B. Reed et al. eds., 2d ed. 1995) (explaining that bilirubin levels frequently increase in the first few days of life, followed by a rapid decline).
\item[15.] \textit{Maier, supra} note 9, at A21. Dr. Sola is the director of neonatal clinical services at the University of California at San Francisco. \textit{Id.}
\item[16.] \textit{Id.}
\item[17.] \textit{Id.}
\end{itemize}
will continue appropriately in other states and most likely on the federal level.

I. PLANTING THE SEED FOR MINIMUM STAYS

A. Physician Alliance Results in Recommendations

Noting the trend toward early dismissal, "a consensus formed among obstetric care providers based on clinical experience that the optimal length of stay should be no less than forty-eight hours generally."18 As a result, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists joined together to publish their first recommendations for postpartum hospital stays in 1983, entitled "Guidelines for Perinatal Care" ("Guidelines").19 The Guidelines noted that patients who experienced uncomplicated deliveries usually were discharged forty-eight to seventy-two hours after birth20 and recommended that the patient should be discharged when "the physician is reasonably certain [that] there are no major postpartum complications."21 Initially, the Guidelines only addressed hospital stays for vaginal births.22

In 1988, the Guidelines23 incorporated postpartum hospital stays for cesarean births, recommending "96 hours . . . excluding the day of delivery."24 The most recent edition of the Guidelines25 maintains the same recommendation for a forty-eight hour stay following a vaginal birth with no complications, and ninety-six hours for cesarean deliveries.26 The current Guidelines, however, call for additional criteria to be met, such as a determination that the pregnancy, as well as the delivery, was uncomplicated.27 The alliance also recommends the collection of certain laboratory data for both the mother and infant, continuing medical care for the mother and child directed by a physician, and a demonstration that the

18. Senate Hearings, supra note 2, at 53 (testimony of Michael Mennuti, M.D.).
20. Id. at 89.
21. Id.
22. Senate Hearings, supra note 2, at 53 (testimony of Michael Mennuti, M.D.).
24. Id. at 100.
26. Id. at 107.
27. Id.
mother is ready to assume care for the infant.\textsuperscript{28} In essence, the policymaking decisions of dismissal times were left mostly in the hands of the practitioners. The one other significant group that has had a major influence, however, is the insurers.

\textbf{B. A History of Insurance Coverage in the United States}

Few Americans enjoyed health insurance early in this century. In 1940, for example, fewer than ten percent of Americans had access to health insurance coverage.\textsuperscript{29} After World War II, private health insurance began to take hold, most often utilizing the traditional fee-for-service arrangement.\textsuperscript{30} Today, Tennessee and Hawaii lead the nation with about ninety-four percent of their population covered by some form of health insurance.\textsuperscript{31}

Fee-for-service insurance still exists,\textsuperscript{32} but is often subject to measures designed to control costs, such as “utilization reviews.” These reviews assess the need for hospitalization or surgery, or specify certain procedures for testing diseases.\textsuperscript{33} Utilization review is an external evaluation by third-party payors or health care organizers that evaluate the appropriateness of treatment based on established clinical criteria.\textsuperscript{34} Such measures allow the insurer to keep its costs down, but also limit the treatment options of doctors and patients.

Since the mid-1970’s, health care in the United States has changed dramatically, from the traditional fee-for-service insurance programs to health maintenance organizations (“HMOs”) and preferred provider organizations (“PPOs”).\textsuperscript{35} HMOs receive insurance premiums from insureds at the start of the year in exchange for a promise to provide medical services throughout the year.\textsuperscript{36} There are two main types of

\begin{itemize}
  \item \textsuperscript{28} Id. at 108-09.
  \item \textsuperscript{29} Burton A. Weisbrod, \textit{The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care and Cost Containment}, 29 J. Econ. Lit. 523, 523 (1991).
  \item \textsuperscript{31} Steven Findlay, \textit{Getting Tough on Managed Care}, Bus. & Health, Dec., 1995, at 54. Tennessee has the highest number of insured residents: 94.2\% of Tennessee residents are covered by private insurance, Medicaid, Medicare, or military programs. \textit{Id.}
  \item \textsuperscript{32} Schwartz, \textit{supra} note 30, at 1362.
  \item \textsuperscript{34} John D. Blum, \textit{An Analysis of Legal Liability in Health Care Utilization Review and Case Management}, 26 Hous. L. Rev. 191, 192-93 (1989).
  \item \textsuperscript{35} Schwartz, \textit{supra} note 30, at 1362.
  \item \textsuperscript{36} \textit{Id.} at 1362-63.
\end{itemize}
HMOs: (1) the "staff model," where the HMO hires its own physicians as salaried employees, and (2) the independent physician association ("IPA") model, where the HMO contracts with many physicians in independent offices. PPOs are a network of area providers that agree to charge lower rates for their services in exchange for attracting a greater number of patients. HMOs and PPOs also practice cost containment measures such as utilization reviews and precertification requirements before admission to the hospital. Naturally, physicians are affected by this change in the American health care system.

One positive aspect of the fee-for-service plan is the financial incentive it creates for the development of new technology, thereby advancing available medical treatment. However, this can also lead to higher health care costs. In the fee-for-service model, doctors and patients often do not need to concern themselves with the cost of a particular course of medical treatment because a third party (the insurer) bears the immediate cost. Traditionally, physicians are not taught to concern themselves with the costs of medical care when evaluating a patient's health. Also, the treating physician makes treatment decisions based on her first-hand knowledge of the patient, rather than an off-site administrator making such decisions.

There are some drawbacks to fee-for-service plans. One such drawback is that doctors often conduct their own tests and procedures. Consequently, doctors may gain a financial benefit from ordering as many procedures as possible, including those that are not really necessary. In fact, according to one physician, "'[the incentives [are] to keep people in the hospital, to perform more tests and procedures, to increase costs.'"
Modern cost containment methods bring the impact of medical costs closer to home for physicians. For example, under HMOs, physicians often are paid on a capitation basis, they receive a fixed amount for each of their patients covered by the HMO. Therefore, any service the patient receives reduces the physician's net revenues. Another mechanism is withholding a portion of the physician's annual salary so that she receives it at the end of the year, only if costs are below a predetermined limit. PPOs employ similar means, such as reviewing its list of providers and removing any physicians whose tests and services take them outside of the desired financial range.

Utilization review provides substantial savings for managed care insurance companies. Utilization review usually occurs in three ways: preadmission, concurrent review, and retrospective review. Preadmission or precertification generally requires advance authorization for certain methods of treatment or hospitalization. Concurrent review generally manages the length of treatment, most often lengths of hospital stays. Retrospective review is a remedial measure that examines a physician's practices or particular methods of treatment for cost-effectiveness. In conjunction, the three methods provide ample opportunity for an insurance provider to oversee its services.

II. COST CONTAINMENT MEASURES: LIMITING HOSPITAL STAYS

Neither insurance system is perfect—"[t]he problem with . . . fee-for-service medicine [is] that the incentive [is] to do more. . . . [But] capitation['s] incentive is to do less." One cost-cutting measure is to limit the

46. Schwartz, supra note 30, at 1364-65. See also W. Pete Welch et al., Toward New Typologies for HMOs, 68 MILBANK Q. 221, 224-25 (1990).
47. Schwartz, supra note 30, at 1365.
48. Id.
49. W. Pete Welch et al., supra note 46, at 226-27.
52. Payne, supra note 40.
53. Id.
54. Id.
55. Id.
patient's stay following initial hospitalization. This can happen in a number of situations. For example, in Wickline v. State,57 the plaintiff underwent surgery on her leg and required hospitalization.58 The physician requested an additional hospital stay of eight days, but the insurance company only authorized four days, after which the patient was discharged.59

Over a period of several days after her release, the plaintiff's leg gave her extreme pain and turned a mottled color.60 She was ordered back to the hospital nine days after her release, at which time an above the knee amputation was performed due to excessive blood clotting.61 At a trial on the merits, the plaintiff won a jury verdict in her favor.62 On appeal, the California Court of Appeals for the Second District noted that "this case appear[ed] to be the first attempt to tie a health care payor into the medical malpractice causation chain and that it, therefore, deal[t] with issues of profound importance to the health care community and to the general public."63

In his opinion, Justice Rowen noted that "public and private payors have in recent years experimented with a variety of cost containment mechanisms."64 In particular, this case concerned the use of a prospective utilization review process that required authorization before medical care could be received. Although the attending physician requested additional time in the hospital, once the utilization review administrators (a nurse and a physician) returned the request and allowed only four days, no other request was made.65 The court found that the insurer was not negligent because the four-day discharge met the "pertinent standard of care," and that the ultimate decision to discharge is made by the physician.66

Notwithstanding the verdict in favor of the insurer, the Wickline court, in dicta, noted the potential risk of such cost containment measures. "[I]t is essential that [cost containment] not be permitted to corrupt medical judgment" and "patient[s] who require treatment and [are] harmed when

58. Id. at 812.
59. Id. at 813-14.
60. Id. at 816.
61. Id. at 816-17.
62. Id. at 811.
63. Id.
64. Id.
65. Id. at 815.
66. Id. at 819-20.
care which should have been provided is not provided should recover . . . from all those responsible . . . including, when appropriate, health care payors” and cost containment providers, in cases of unreasonable decision-making practices. In Wickline, none of the three hospital physicians made a second request for additional days. The court declined to impose liability on the insurer where “the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid ultimate responsibility for his patient’s care.”

Courts are ill-equipped to take utilization review into account in the context of retrospective review. Physicians often must keep their costs down to avoid a reduction in pay or being purged from the list of providers. Thus, physicians must balance the benefits of further treatment for their patients against the costs associated with such treatments and how those costs are reflected on the physician in retrospective review.

Shortly after Wickline, a similar case arose in California. In Wilson v. Blue Cross of Southern California, a patient was hospitalized due to severe depression, drug dependency, and anorexia. Shortly after his release, the patient committed suicide and his family brought a wrongful death action against their son’s insurer, Blue Cross, and in particular, its utilization review provider. The trial court granted summary judgment in favor of the defendants on the ground that the plaintiffs did not have a valid claim. On appeal, the appellate court reversed and remanded.

The victim’s physician sought to have the patient hospitalized for four weeks. However, Blue Cross declined to pay for more than ten days, and the victim’s family could not afford to pay for the hospitalization. The decision to deny coverage in this case again was a result of a utilization review process. The appellate court held that upon remand, no public policy immunizes utilization review contractors from liability for its decisions. The case went to trial, but the plaintiff settled with the utilization review provider, and no legal result was reached. This is not the

67. Id. at 820.
68. Id. at 819.
70. Id. at 878, 880.
71. Id. at 885.
72. Id. at 877-78.
73. Id.
74. Id. at 884.
75. See Milt Freudenheim, When Treatment and Costs Collide, N.Y. TIMES, Apr. 28, 1992, at D2.
only type of case concerning hospital discharges. As parents seek additional days of hospitalization for the mother and newborn infant, the potential for additional suits against utilization review providers arises.

Recently, the parents of a New York infant filed a ten million dollar suit against their insurer, U.S. Healthcare, and the hospital where the child was born. The infant was discharged from the hospital twenty-four hours after his birth, but on his second day at home, his parents said his breathing became labored and his skin "looked blotchy." Upon readmission, doctors discovered that the infant had a serious heart defect and he died as a result. The boy's mother charged, "On my son's death certificate, it should read - 'Cause of Death: Lack of Insurance Coverage'... We feel devastated by our loss and bitter toward a senseless policy that failed our son miserably." The parents believe that their son's defect would have been detected sooner if their insurance plan provided for maternity stays of three or more days, as the plan did two years earlier. The outcome of the claim remains open, as no trial date or settlement is set.

When interviewed by The New York Times about the case, Dr. Nancy Bridges, a pediatric cardiologist at Philadelphia's Children's Hospital, said "serious heart problems like [this infant's] afflict about one or two children in every 1,000 births." She noted that babies should not be kept unnecessarily in the hospital, "[b]ut if a child like this were in the hospital for a little longer, [the heart problem] likely would have been caught." Three physicians contacted by Newsday stated that the symptoms of the condition that this infant suffered from "are difficult to see on the first day [of life], but are often picked up on the second or third day."

The news media is full of accounts of similar incidents. In fact, even

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76. Thomas Maier, Symptoms of Danger Slow to Show, Newsday, June 12, 1995, at A5, A20.
77. Id. at A20.
78. Id. at A5, A20.
79. Id. The infant's problem was hypoplastic left heart syndrome, an underdevelopment of the heart's left ventricle. About 50% of children with this defect survive after surgery, according to pediatric heart specialists at another New York hospital. Id.
80. Id.
81. Id. Another specialist noted, however, that "[i]t's difficult to say whether the 24-hour discharge delayed diagnosis in [the infant's] case, or whether a delay in diagnosis led to his death." Id.
82. Id.
83. See e.g., Robert L. Jackson, Baby's Death Focuses Senators on Question of Hospital Stays, L.A. Times, Sept. 13, 1995, at A5; Julie Miller, Mother and Newborn: How Long in
First Lady Hillary Rodham Clinton wrote in her syndicated column about her experience during childbirth. She recounted her difficulty in learning to breastfeed and the nurses’ instructions that helped her during her stay in the hospital after a cesarean section. Her article included stories of several other women who experienced difficulties in obtaining insurance approval for additional days in the hospital, and the death of one child as a result of a treatable infection. Recent studies are beginning to confirm these anecdotal accounts.

Specifically, Dartmouth Medical School conducted research to determine if the early dismissals increased the risk of hospital readmission and visits to the emergency room within the first two weeks of life for infants who were discharged after less than forty-eight hours in the hospital. This study revealed that the risk of readmission increased by fifty percent, and the risk of an emergency room visit increased by seventy percent.

Another study published in *Pediatrics* found that the Guidelines for Perinatal Care remains the standard for early infant discharge, but that the available information is limited. The study noted that only three previous randomized studies “provide information regarding the medical safety of early discharge.” Those studies contained varying discharge times, a relatively small numbers of infants, and differing follow-up periods that made comparison difficult. Acknowledging that “the superiority of a longer hospitalization . . . has not been established,” the researchers recommended that in the absence of definitive medical data, the decision to discharge apparently healthy term newborns should be left to the practitioner, based upon her first-hand knowledge of the medical, social, and economic aspects of each case.

There are several treatable diseases in newborns that call for this level

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85. *Id.*
86. *Id.*
88. *Id.*
90. *Id.* at 293.
91. *Id.*
92. *Id.*
of caution. First, jaundice, the buildup of toxins within a newborn, is a relatively common occurrence. When left untreated, jaundice advances to kernicterus, which can lead to permanent brain damage or death. A second complication is dehydration, which may seem relatively harmless, but can have serious consequences. Dehydration usually results when the baby and mother have difficulty in adapting to breast feeding. This can lead to insufficient milk syndrome, where a child eventually can become mentally impaired and suffer neurological damage. A third disease that can be treated effectively with an early diagnosis is phenylketonuria ("PKU"). PKU is genetic and occurs because of a hereditary absence of the enzyme necessary to break down an amino acid, phenylalanine. The test to determine whether PKU is present is most reliable when given twenty-four hours after the infant's first feeding. PKU can be treated with a low-protein diet that prevents the severe brain damage associated with an untreated case. In fact, a recent survey conducted by Children's Hospital of Philadelphia found that the widespread practice of discharging infants twenty-four hours after vaginal delivery increased the number of infants at risk for PKU.

Because follow-up visits for retesting within the first month of life are required only in thirteen states, many early discharge infants are not properly screened. Simple infections can affect both the mother and infant. Early dismissal may mean that these and other problems are...

94. Boodman, supra note 5.
95. Boodman, supra note 5, at 12.
96. Id.
97. Senate Hearings, supra note 2, at 56-57 (testimony of Palma E. Formica, M.D. of the AMA).
98. Joan Beck, Babies Will Point Out the Failures of Cheap Health Care, CHI. TRIB., Oct. 22, 1995, at 21. PKU is a genetic disease, inherited from the parents' recessive genes, and adjusting the baby's diet can avoid the severe brain damage that will follow without treatment. THOMAS L. STEDMAN, STEDMAN'S MEDICAL DICTIONARY 1348 (26th ed. 1995).
100. Beck, supra note 98.
101. Horvath, 704 S.W.2d at 868. See also Beck, supra note 98.
103. Id.
104. Testimony of Ruth Manchester, Health Issues Chair of the Maryland Chapter of the American Association of University Women, in front of the Maryland House, for HB
not discovered in time or cannot effectively be diagnosed.\footnote{Boodman, supra note 5, at 12.}

One other complication is that family structure in American society is different now than it was earlier in this century. Traditionally, families created a network for new parents, whereas "'today, the mother is usually working and needs to get back to her job.'\footnote{Miller, supra note 83, at 1 (quoting Dr. Michael R. Tesoro, Assistant Director of Obstetrics and Gynecology at St. Francis Hospital and Medical Center in Hartford, Conn.).} Adequate home health care and an individualized assessment of a family may fulfill the needs of a family with a newborn. The benefits of tailored home health care were demonstrated recently by a study of low birth weight infants. A Canadian study of low birth weight infants found that earlier discharge of infants was feasible.\footnote{Oscar G. Casiro, M.D. et al., Earlier Discharge With Community-Based Intervention for Low Birth Weight Infants: A Randomized Trial, 92 PEDIATRICS 128 (1993).} Low birth weight infants, however, normally are not dismissed within forty-eight or ninety-six hours. Rather, these infants usually are kept in the hospital until they reach a certain weight. In the Canadian study, dismissal of low birth weight infants occurred when infants met certain readiness criteria, rather than reaching a certain weight.\footnote{Id. at 129. It should be noted that Canada has a nationwide, publicly funded healthcare system. Id.}

What made this project successful was the individualized follow-up care each family received, including teaching and support services, as well as telephone or home visits of thirty to sixty minutes, during which the nurse assessed the health of the infant and the social structure and physical environment of the family.\footnote{Id.} The nurse could be contacted by the family twenty-four hours a day, seven days a week, while experienced homemakers provided additional support and training.\footnote{Id.} Families participated in assessing their needs for home nursing and trained commu-

\footnote{Mothers can experience infections at the point of incision for episiotomies or cesarean sections and infants experience infections of the cord. Id.}

\footnote{"Jaundice doesn't start to happen until the second or third day of life, and dehydration never happens until after two to five days . . . ." Certain infections and serious heart defects also do not show up during the first 24 hours and may occur after babies go home. Early discharges also mean that babies are being sent home before certain tests can be performed, such as the screening for . . . phenylketonuria (PKU). Id. (quoting Dr. Augusto Sola, Chief of Neonatal Clinical Services at the University of California, San Francisco).}

\footnote{Miller, supra note 83, at 1 (quoting Dr. Michael R. Tesoro, Assistant Director of Obstetrics and Gynecology at St. Francis Hospital and Medical Center in Hartford, Conn.).}

\footnote{Oscar G. Casiro, M.D. et al., Earlier Discharge With Community-Based Intervention for Low Birth Weight Infants: A Randomized Trial, 92 PEDIATRICS 128 (1993).}

\footnote{Id. at 129. It should be noted that Canada has a nationwide, publicly funded healthcare system. Id.}

\footnote{Id.}
The researchers concluded that the individualized community-based program for low birth weight infants was cost-effective.\textsuperscript{112}

III. Lawmakers Take A Stand

Spurred by anecdotal accounts and urged by physicians, lawmakers on the state level have taken swift action; already several states have enacted legislation that requires mandatory minimum hospital stays for newborns and mothers. Currently, just under half of the states have passed legislation that mandates minimum stays, either by the number of hours per stay or mandating that the Guideline criteria be followed.\textsuperscript{113} Similar legislation is pending in several other states.\textsuperscript{114} Maryland was one of the first states to enact such legislation.\textsuperscript{115} Maryland Senator Delores G. Kelley testified that:

\begin{quote}
[D]ischarge decisions are often based solely upon economic and insurance considerations, instead of upon clinical criteria established by the American Academy of Pediatrics and by the American College of Obstetricians and Gynecologists [Guidelines for Perinatal Care]. Hospital discharges which are too early, also prevent adequate newborn-screening for certain hereditary disorders which if unrecognized and untreated for more than two weeks can lead to severe mental retardation of the infant.\textsuperscript{116}
\end{quote}

The Maryland chapter of the American Academy of Pediatrics found that there is "no data to substantiate that all of the mothers and babies can successfully leave with very early discharges" and that "Maryland's rate of insufficient milk feedings [which lead to physical and mental complications for the infant] . . . has gone from 5\% in 1989, to 30\% in 1993."\textsuperscript{117} The Maryland bill requires insurance companies to assist parents in selecting a primary care physician for their newborn, and provide

\begin{itemize}
\item[\textsuperscript{111}] Id. at 128.
\item[\textsuperscript{112}] Id.
\item[\textsuperscript{113}] Those states are: Alaska, Florida, Georgia, Indiana, Kentucky, Maine, Maryland, Massachusetts, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, and South Dakota.
\item[\textsuperscript{114}] Diane West, Maternity Stay Issue Won't Be Getting Early Discharge, NAT'L UNDERRITER, Jan. 1, 1996, at 4.
\item[\textsuperscript{115}] 1995 MD S.B. 677, Enacted May 25, 1995.
\item[\textsuperscript{116}] Testimony of Senator Delores G. Kelley before the Maryland Senate Finance Committee hearing on the Mother's and Infants Health Security Act, S.B. 677 (March 9, 1995).
\item[\textsuperscript{117}] Prepared testimony of the Maryland Chapter of the American Academy of Pediat-
those parents with information on postpartum home visits before the date of delivery. The bill also utilizes the Guidelines for Perinatal Care in establishing minimum stays of forty-eight hours for vaginal births and ninety-six hours for cesarean births. The bill has an "opt-out" clause, however, allowing for the authorization of shorter stays if the newborn meets the criteria for medical stability as stated in the Guidelines, and if the utilizations review agent "authorizes a sufficient number of postpartum home visits" or an HMO "authorizes for the mother and child an initial postpartum home visit which include[s] the collection of an adequate sample for the hereditary and metabolic newborn screening, when indicated."

The New Jersey and North Carolina legislatures also used the Guidelines for Perinatal Care when they enacted laws regarding minimum hospital stays, and provided an "opt-out" clause for "a hospital service corporation contract that provides post-delivery care to a mother and her newly born child in the home." In other words, an insurer may send a mother and newborn home, after a vaginal delivery, before forty-eight hours, provided there is a home visit.

New Jersey lawmakers heard testimony from one man whose niece lost her child to a treatable infection after she was dismissed from the hospital within twenty-four hours. Her insurance carrier provided for a home visit from a health care provider, but the family did not receive a visit. The nurse was supposed to visit the family on the second day but never arrived. When the family asked why the nurse had not visited, they discovered that the nurse did not know the child was born.

In the case of the Jones family, a home-care nurse came to the family's home three days after their son was born. The nurse informed Mrs. Jones "that Bryan had mild jaundice and a weak grasp with his fingers, but was otherwise fine." Later that day, Bryan's breathing and color alarmed his mother and she called her pediatrician and brought him to the hospital. Essentially, the Jones family received the services pro-

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118. S.B. 677, 2d Sess., Maryland (Mar. 9, 1995).
119. Id.
120. Id.
122. Id. (testimony of Dominick A. Ruggiero, Jr.).
123. Maier, supra note 76.
124. Id.
125. Id.
vided for in the “opt-out” clauses of the new legislation, which is some indication that this measure may not be a sufficient precaution to protect the health of a mother and her newborn. If a nurse visits too soon after an infant’s release, it may be too early to diagnose problems such as PKU. Jaundice may go untreated for too long, however, if a nurse does not visit early enough.

Similar legislation is pending in several states such as Wisconsin, Pennsylvania, Illinois, Kansas, Georgia, and New Hampshire. New York state should pass legislation by the end of February 1996. However, in California and Rhode Island, similar legislation failed to come to a vote, effectively ending the measure from the previous session, although the legislation is still pending. Ironically, Kaiser Permanente began sending mothers and newborns home as early as eight hours after delivery at one of their Los Angeles facilities.

Not surprisingly, this issue reached the federal level shortly after it gained popularity in the states. Former Senators Nancy Kassebaum and Bill Bradley were co-sponsors of The New Borns’ and Mothers’ Health Protection Act of 1995. The language of the bill is nearly identical to the measures passed in Maryland and New Jersey. Senator Bradley testified before the Senate Committee on Labor and Human Resources that the recent accounts of mothers and newborns being discharged quickly from hospitals are not isolated incidents, and when they are looked at together “these tales show a consistent pattern of mothers and newborns being denied the care they need.” Senator Bradley noted that although several states passed or are considering passing simi-
lar laws, a federal law still is necessary. Explaining his view on the need for federal legislation, Senator Bradley testified:

[T]hese states are finding that they are powerless to protect thousands of their mothers. Specifically, if a woman is covered through a self-insured plan, if her health insurer is headquartered in another state, or if she crosses state lines to receive her health care, then she is not protected by her state's law prohibiting drive-through deliveries.

Senator Bradley's testimony has proven to be accurate. Women are discovering that the new laws are not applicable to their insurance plan and are surprised that they are not covered by the law under their particular health plan. Even insurers who are giving their patients the "gift" of an extra day in the hospital are sending the bill to the doctors.

President Clinton agreed with Senators Bradley and Kassebaum, citing the need for such a bill in his acceptance speech at the Democratic National Convention, and in his State of the Union Address. The bill was signed into law on September 26, 1996.

131. See Devon P. Groves, ERISA Waivers and State Health Care Reform, 28 COLUM. L. & SOC. PROBS. 609, 616 n.37 ("Self-insured employee benefit plans are those in which the funds for coverage are collected and saved up by the employer, thus negating the need to pay premiums to an outside insurer."); William J. Kilberg & Paul D. Inman, Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514, 62 TEX. L. REV. 1313, 1315 n.7 (1984) ("Employee benefit plans and insurance companies often look alike, because both seek to provide groups of persons with financial protection against defined risks in defined ways.").

132. Senate Hearings, supra note 2, at 52 (testimony of Senator Bradley). Senator Bradley characterized this problem as "gaping loopholes." Id. See infra text accompanying notes 147-62 for a discussion on how the gaping holes in state legislation are a result of ERISA.


134. Id.

135. See President William J. Clinton, Address at the Democratic National Convention, (Sept. 4, 1996) (transcript available in LEXIS, Nexis Library, U.S. Newswire File); President William J. Clinton, State of the Union Address (Feb. 4, 1997) (transcript available in LEXIS, Nexis Library, Federal News Service File). While approving the measure to stop "drive-through deliveries," President Clinton went on to say that new measures were needed to end the practice of sending women home just hours after a mastectomy. Id. Physicians, legislators, and others who are opposed to mandating minimum stays for procedures may be concerned over a suggestion that other procedures merit consideration. See infra text accompanying notes 141-42.

A. The Potential for Other Similar Legislation

As Wickline137 and Wilson138 demonstrate, early discharge occurs in other settings besides postpartum stays. In her testimony before the Senate, Dr. Palma E. Formica, a member of the American Medical Association's Board of Trustees, stated that the American Medical Association ("AMA") is often most in opposition to "congressional intervention into a physician's clinical decision making."139 The AMA is supporting this legislation because it specifically is in the "postpartum context."140

Other physicians also have expressed concern over this type of legislation.141 One physician criticized that mandating longer stays for particular procedures does not make sense, "'[o]nce you start with that, where do you stop? Total hip replacements and knees? What about prostates? There's no end to it.'"142 Some commentators have even characterized this issue as "the '90s version of politicians kissing babies."143 Still others have urged legislators to wait before passing such legislation, arguing that further research is necessary.144

B. ERISA's Impact on State Legislation

1. ERISA in General

Insurance legislation by the state is affected by the Employee Retirement Income Security Act of 1974 ("ERISA").145 Because of particular ERISA provisions, insurance companies not located in a state with minimum hospital stay legislation, as well as self-insured employers, do not have to comply with those state laws.146 The first provision of ERISA is a

139. Senate Hearings, supra note 2 (testimony of Palma E. Formica, M.D., AMA, Board of Trustees).
140. Id.
144. Dunstan McNichol, HMOs Stop 48-Hour Care Plan, RECORD, Mar. 24, 1995, at A3 (Trenton, N.J.). Leah Ziskin, assistant commissioner of the New Jersey Department of Health, urged lawmakers to postpone enactment of their bill until the department finished compiling information about births in the state. Id.
146. Senate Hearings, supra note 2 (testimony of Senator Bill Bradley).
broadly interpreted "preemption clause" that reaches "any and all State laws insofar as they . . . relate to any employee benefit plan." ERISA contains a large amount of substantive regulation of employee pension plans, but minimal regulation of health plans. Therefore, the statute preempts without providing much in the way of guidance. ERISA was enacted in order to protect employees from the abuse and misuse of employee health and retirement funds experienced as a result of unscrupulous business practices, questionable administration, and weak financing. Therefore, the reach of ERISA is necessarily broad in order to cover employee benefit plans nationwide and to provide for uniformity.

The next provision, the "savings clause," at first glance seems to give states the right to regulate all insurance. There is a catch—an employer must purchase an insurance contract to fall within the reach of the state. As a member of an insured plan, the employer directly purchases health care coverage from an insurance company and pays a premium for the coverage. A self-funded plan is out of the state's reach because no insurance contract is purchased; instead, the employer sets money aside in a plan to pay employee claims as they arise. Finally, the "deemer clause" generally prevents states from labeling employee benefit plans

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147. Section 1144(a) of ERISA provides:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.


149. Id. at 3-4.


151. Schmidt, supra note 148, at 4. See also Patricia A. Butler, J.D., National Governors' Ass'n, Roadblock to Reform: ERISA Implications for State Health Care Initiatives 3 (1994) (noting that Congress prohibited state regulation even though federal law was silent, and there would be no direct inconsistency in order to maintain uniformity).

152. Section 1144(b)(2)(A) reads, in pertinent part, "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

153. Schmidt, supra note 148, at 5.

154. Id. See also Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985) (noting the difference between insured and uninsured plans).

as insurance plans in order to attempt regulation. This clause clarifies the limits of the "savings clause."

The broad reach of ERISA has become clear to mothers in states with minimum hospital stay legislation. For example, after passing minimum hospital stay legislation, some New Jersey residents were surprised to learn that they were not protected. After giving birth, one New Jersey resident spent the afternoon on the phone in an effort to stay one more day in the hospital. Her employer was self-insured, however, so it was not covered by the New Jersey law. Some self-insured employers, not covered by the legislation, have chosen nonetheless to abide by it in an effort to show their support for employee welfare.

Congress intended ERISA's preemption to be read broadly. Indeed, Senator Bradley's testimony before the Senate acknowledged that state laws concerning minimum stays for mothers and newborns would fall directly under ERISA. New Jersey already has experienced difficulties in enforcement of its law due to out-of-state insurers or those who fall under ERISA.

2. ERISA in the Context of Claims Against a Utilization Review Provider

One recent case illustrates the effects ERISA has over a plaintiff's claims of negligence against utilization review administrators in the context of a denial of a hospital stay. In Corcoran v. United Health Care, the United States Court of Appeals for the Fifth Circuit held that ERISA preempted the parents' medical malpractice claim against the provider of utilization review services.

welfare benefit plans shall not "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance" in order for a state to attempt legislation).

156. Schmidt, supra note 148, at 5.
158. Id. In addition, state statutes do not extend to insurance policies written outside of the state, so the many employees who commute to New York or Philadelphia from New Jersey are not covered by the New Jersey law through their employer's plans. Id.
159. Id. (Johnson & Johnson chose to comply with the New Jersey legislation).
160. Schmidt, supra note 148, at 4. See also HCA Health Serv. of Va. v. Metropolitan Life Ins. Co., 957 F.2d 120, 125 (4th Cir. 1992) (Tilley, J., concurring, a preemption inquiry under ERISA is made by first analyzing the elements of the state law claim to determine if it "relates to" a specific pension or welfare benefit plan provision).
161. Senate Hearings, supra note 2, at 7 (testimony of Senator Bill Bradley).
162. Preston, supra note 133, at 30 (The New Jersey law, as well as other state laws, has loopholes.).
Plaintiff, Florence B. Corcoran, became pregnant early in 1989. In July, her obstetrician, Dr. Jason Collins, recommended that she have complete bed rest for the remainder of her pregnancy. When Corcoran applied to her employer for temporary disability benefits, she was denied. Dr. Collins wrote to the employer's medical consultant, explaining that Corcoran was in a category of high risk pregnancy. Although the medical consultant received a second opinion from another obstetrician who suggested the "company would be at a considerable risk denying her doctor's recommendation," the benefits again were denied.

In early October, as Ms. Corcoran's delivery date neared, Dr. Collins sought pre-certification from United HealthCare, Inc., the utilization review contractor. Corcoran's hospitalization was denied, but she was offered ten hours per day of home nursing care. On October 25, without a nurse on duty, Corcoran's fetus went into distress and died. The Corcorans filed a wrongful death action in Louisiana state court, alleging that their unborn child died as a result of various acts of negligence committed by Blue Cross and United HealthCare. The defendants removed the action to federal court on diversity grounds and alleged that the action was preempted by ERISA. The district court granted summary judgment in favor of the defendant.

The Corcorans filed a motion for reconsideration, arguing that under ERISA's civil enforcement mechanism, compensatory damages were still available to them. The Corcorans claimed that equitable relief was available under ERISA for violations of an ERISA plan or the terms of its agreement. The district court found that equitable relief under ERISA referred only to the recovery of medical expenses covered by the

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164. Id. at 1322.
165. Id.
166. Id.
167. Id.
168. Id. at 1332.
169. Id. at 1324.
170. Id.
171. Id.
172. Id.
173. Corcoran, 965 F.2d at 1331, 1324-25.
174. Id. at 1325.
177. Id.
plan, not to compensatory or consequential damages for emotional distress.\textsuperscript{178} The district court entered a final judgment in favor of the defendants, and the Corcorans appealed.\textsuperscript{179}

The Court of Appeals for the Fifth Circuit found that Louisiana courts had not yet decided whether utilization review agents were incorporated under Louisiana wrongful death statutes, noting "[t]he potential for imposing liability on these entities is only beginning to be explored, with only one state explicitly permitting a suit based on a utilization review company's allegedly negligent decision about medical care to go forward."\textsuperscript{180} The court then reviewed the question of ERISA preemption.

The court asserted that it is the intent of Congress that dictates whether ERISA preempts state law.\textsuperscript{181} Commenting on the principle of ERISA preemption, the court stated that "[i]t is by now well-established that the 'deliberately expansive' language of this clause ... is a signal that it is to be construed extremely broadly."\textsuperscript{182} In deciding whether the plaintiffs had a valid cause of action, the court stated that "the generally applicable negligence-based causes of action may have an effect on an ERISA-governed plan ... The pre-emption question devolves into an assessment of the significance of these effects."\textsuperscript{183} Noting that United HealthCare did give medical advice, the court nevertheless found that such medical decisions were in the "context of making a determination about the availability of benefits under the plan," and, therefore, such decisions are preempted by ERISA.\textsuperscript{184}

As for the Corcorans' claim that they should be awarded extracontractual damages, the claim was denied\textsuperscript{185} because the court assumed that plan beneficiaries may sue under a section of ERISA that provides for such damages, but only as to remedies for contract actions.\textsuperscript{186} Even assuming a contractual relationship existed between the Corcorans and United HealthCare, at most the plan promised to act in accordance with

\begin{thebibliography}{99}
\bibitem{178} Id.
\bibitem{179} \textit{Corcoran v. United Healthcare, Inc.}, 965 F.2d 1321, 1322 (5th Cir. 1992).
\bibitem{180} \textit{Corcoran}, 965 F.2d at 1327 (citing Wilson v. Blue Cross of S. Cal., 222 Cal. App. 3d 660 (1990)).
\bibitem{181} \textit{See} 4 \textit{JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW § 9.1 (1991).}
\bibitem{182} \textit{Corcoran}, 965 F.2d at 1327 (citing \textit{Pilot Life Ins. Co. v. Dedeaux}, 481 U.S. 41 (1987)).
\bibitem{183} \textit{Id.} at 1329.
\bibitem{184} \textit{Id.} at 1331.
\bibitem{185} \textit{Id.} at 1338.
\bibitem{186} \textit{Id.} at 1338.
\end{thebibliography}
accepted standards of medical care.\textsuperscript{187}

The court remarked that its decision, while true to the law, left the plaintiffs with no remedy.\textsuperscript{188} The court stated three reasons for its discomfort.\textsuperscript{189} First, an “important check” on the utilization review process is eliminated by failing to factor the cost of poor decision making into utilization review companies’ decisions.\textsuperscript{190} Second, a system that compensated beneficiaries who charge that treatment was based on poor decisions would balance the interests of obtaining quality medical care with those of cost-saving.\textsuperscript{191} Third, utilization review providers such as United HealthCare did not exist when Congress passed ERISA.\textsuperscript{192}

Even with the knowledge that plan beneficiaries are left without a remedy, the language of ERISA has not been updated and the courts can continue to reach the same results. The Supreme Court recently let stand, without comment, a lower court ruling that ERISA prevented a California mother from suing her insurer for wrongful death in state court due to the denial of an “experimental” bone marrow treatment for cancer.\textsuperscript{193} The plaintiff’s attorney compared the barring of punitive and compensatory damages by ERISA to “‘a license to kill with impunity.’”\textsuperscript{194}

3. 	extit{Interpreting ERISA in the United States Supreme Court}

In 	extit{Shaw v. Delta Airlines},\textsuperscript{195} the Supreme Court determined the mean-

\textsuperscript{187} Id. at 1337. The Supreme Court later held that ERISA ordinarily does not authorize suits for compensatory or punitive damages. See Mertens v. Hewitt Associates, 113 S. Ct. 2063, 2068 (1993).

\textsuperscript{188} Corcoran, 965 F.2d at 1338.

\textsuperscript{189} Id.

\textsuperscript{190} Id.

\textsuperscript{191} Id.

\textsuperscript{192} Id. See also Butler, supra note 151, at 20 (describing the fact that patients may sue their providers in a traditional state court claim, but are left in uncharted water when attempting to resolve disputes regarding managed care, particularly utilization review).

\textsuperscript{193} Comer v. Kaiser Found. Health Plan, Inc., 45 F.3d 435 (9th Cir. 1994) cert. denied, 115 S.Ct. 1963 (1995). Billie J. Comer argued that ERISA should not apply because she was not bringing suit as a plan beneficiary, but as a survivor entitled to compensation. Id. She also argued that ERISA was inapplicable because she was not suing her employer, AT&T, but the insurer. Id. The court held that the insurer’s agreement was an “integral part of AT&T’s group medical plan,” therefore the agreement “relates to an employee benefit plan” and is preempted by ERISA. Id.

\textsuperscript{194} Michael A. Hiltzik, 	extit{Supreme Court Won’t Allow State Suit in Death Case}, L.A. Times, May 16, 1995, at D3. The same type of case may be made against an insurer who is not covered by ERISA. State plaintiffs are provided a remedy while similarly situated federal plaintiffs are barred from bringing suit. Id.

\textsuperscript{195} 463 U.S. 85 (1983).
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ing of ERISA's "relate to" language in its preemption clause. Using a plain meaning approach and the legislative history of ERISA, the Court determined that a state law relates to a plan "if it has a connection with or reference to such a plan."\textsuperscript{196}

In \textit{Shaw}, two New York state statutes prohibited discrimination on the basis of pregnancy in employee benefit plans, and required employers to give sick leave benefits to employees who took leave because of pregnancy.\textsuperscript{197} The defendant Delta Airlines' employee benefit package did not provide leave for pregnancy. First, the Court determined that the anti-discrimination statute was invalid to the extent that it prohibited practices that are permissible under Title VII.\textsuperscript{198} Second, the pregnancy leave statute was preempted by ERISA in the case of multiple-benefit plans maintained under the ERISA statute, but remained valid for plans maintained solely under state insurance laws.\textsuperscript{199} Just as the pregnancy leave statute was preempted by ERISA, so too the minimum hospital stay legislation will fall.

A more recent decision by the Supreme Court puts the scope of ERISA's preemption language in a new, and possibly limited light. \textit{New York Blue Cross v. Travelers Insurance Co.},\textsuperscript{200} involved a New York statute that required hospitals to collect surcharges from commercial insurers, but not from patients covered by a Blue Cross/Blue Shield plan, and provided surcharges for HMOs according to the number of medicaid recipients each enrolled.\textsuperscript{201}

The United States District Court for the Southern District of New York, in \textit{Travelers Insurance Co. v. Cuomo}, held for the plaintiff commercial insurers, finding that, at least indirectly, the surcharges could increase the plan costs.\textsuperscript{202} The court concluded that this effect "was enough to trigger pre-emption" and the surcharges could not be upheld under the

\textsuperscript{196} \textit{Id.} at 96-97. \textit{See also} Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138-42 (1990) (finding that state law may be preempted even though it does not address specific subjects covered by ERISA).

\textsuperscript{197} \textit{Shaw}, 463 U.S. at 88.

\textsuperscript{198} \textit{Id.} at 103-04.

\textsuperscript{199} \textit{Id.} at 108.

\textsuperscript{200} 115 S. Ct. 1671 (1995).

\textsuperscript{201} \textit{Travelers}, 115 S. Ct. at 1673 (citing N.Y. \textsc{Pub. Health Law} § 2807-c (McKinney 1993)).

savings clause as regulating insurance.\textsuperscript{203} The Second Circuit affirmed the blanket rule that ERISA's preemption clause has a broad reach and will preempt any state law that relates to employee benefit plans.\textsuperscript{204}

The Supreme Court found that the surcharges make the Blue Cross/Blue Shield plans more attractive to insurance buyers, including ERISA plans.\textsuperscript{205} The appeal generated by the surcharges created an "indirect economic effect," however, that "does not bind plan administrators."\textsuperscript{206} The surcharges simply reflect an additional cost in the plan and still permit uniform administration.\textsuperscript{207} As a result, the level of indirect economic effect generated by the New York statute does not fall in the face of ERISA's preemption clause.\textsuperscript{208}

Statutes that mandate certain policy benefits such as minimum hospital stays, however, have a more direct effect on ERISA plans. In \textit{Metropolitan Life Insurance Co. v. Massachusetts},\textsuperscript{209} the Court recognized that state insurance laws requiring minimal mental health care benefits directly affected employee welfare benefit plans.\textsuperscript{210} Insurance policies purchased by employers are subject to extensive state regulation, and a subclass of that regulation is mandated benefit laws that require an insurer to cover specific illnesses or procedures.\textsuperscript{211}

The appellant insurance companies argued that "traditional laws" directly regulating the insurer or that regulate the way the insurance contracts are sold are saved from preemption by the savings clause, but that substantive regulations are preempted by ERISA.\textsuperscript{212} The Court disagreed because this would make the savings clause surplus language.\textsuperscript{213} The law therefore was applicable to insurance plans and sustainable under the savings clause.\textsuperscript{214} The Court stated that it was aware that its holding created a distinction between insured and uninsured (self-insured) plans that left the former open to indirect regulation while the latter are not. But as the statute is written, this is the distinction Congress

\textsuperscript{203} \textit{Travelers Ins. Co.}, 813 F. Supp. at 1003-08.
\textsuperscript{204} \textit{Travelers Ins. Co. v. Cuomo}, 14 F.3d 708, 718 (2d Cir. 1993) (citations omitted).
\textsuperscript{205} \textit{Travelers}, 115 S. Ct. at 1679.
\textsuperscript{206} \textit{Id.}
\textsuperscript{207} \textit{Id.}
\textsuperscript{208} \textit{Id.} at 1683.
\textsuperscript{209} 471 U.S. 724 (1985).
\textsuperscript{210} \textit{Id.} at 732.
\textsuperscript{211} \textit{Id.} at 727-28.
\textsuperscript{212} \textit{Id.} at 741.
\textsuperscript{213} \textit{Id.}
\textsuperscript{214} \textit{Id.} at 744.
has created.\textsuperscript{215}

Clearly, requiring insurers to provide for mandatory minimum hospital stays is a substantive regulation that directly effects insurance plans. \textit{Metropolitan Life} spoke squarely on this issue. The mandatory minimum hospital stays for infants and mothers will apply to employee benefit plans that purchase insurance but not to self-insured plans.

### IV. Conclusion

As long as the existing state and proposed federal legislation mirror one another, families are guaranteed uniform protection. If one state decides to make its laws stricter than the federal mandate, however, the problem of ERISA preemption leaves little room for effective state laws. A federal law mandating minimum hospital stays would prevent an ERISA plan from avoiding compliance with similar laws within a state. Once a plan complies with the standards, however, there is still no available remedy for any beneficiary injured as a result of cost containment measures such as utilization review.

Congress and the states cannot continue to set mandatory hospital stays for individual medical procedures. The sheer volume of medical procedures and resulting inflexibility makes this approach impractical. Therefore, ERISA must be updated to reflect the changes in American health care. Utilization review procedures must be accounted for in the context of ERISA preemption. Moreover, unless follow-up visits are followed rigorously by insurance companies and strictly enforced by the states, such visits are ineffective. Procedures must be established to ensure that infants are receiving the follow-up care they require; plan beneficiaries deserve a remedy.

\textit{Suzanne Seaman}

\textsuperscript{215} \textit{Id.} at 747.