Approved: 2/13/96
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Dick Bond at 9:08 a.m. on February 12, 1996 in Room 529-S of the Capitol.

Members present were: Senator Clark, Senator Corbin, Senator Emert, Senator Lee, Senator Petty, Senator Praeger, Senator Steffes

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
June Kossover, Committee Secretary

Conferees appearing before the committee: William Grant, Kansas Banking Department
Senator Sandra Praeger
Tom Bell, Kansas Hospital Association
Jerry Slaughter, Kansas Medical Society
Kathleen Sebelius, Commissioner of Insurance
Dr. Ann Wigglesworth, Manhattan, KS
Karen Nelson, Overland Park, KS
Barbara McClaskey, Pittsburg, KS
Gail Kiefer
Dr. Steven Potsic, KDHE
Terri Roberts, Kansas State Nurses Association
Elizabeth Miller, Topeka, KS

Others attending: See attached list

William Grant, Kansas Banking Department, appeared before the committee to request introduction of legislation to require registration for mortgage brokers and companies. (Attachment #1) (Senator Steffes moved to introduce the legislation; Senator Praeger seconded the motion. The motion carried.

Senator Emert made a motion; seconded by Senator Praeger, to approve the minutes of the meeting of February 8 as submitted. The motion carried.

The chair opened the hearing on **SB 573**, requiring minimum inpatient care coverage following the birth of a child. Senator Praeger explained that the bill would required 48 hours of inpatient care following natural delivery and 96 hours following a birth by caesarean section. Senator Praeger also presented a balloon to amend the bill. (Attachment #2)

Tom Bell, Kansas Hospital Association, testified in support of this bill, stating that **SB 573** calls attention to the potential in some managed care arrangements for sacrificing quality to cost. (Attachment #3)

Jerry Slaughter, Kansas Medical Society, appeared as a proponent and pointed out another technical correction that should be made: on line 30, page 1, to strike "caesarean delivery," as it is duplicate language. (Attachment #4)

Insurance Commissioner Kathleen Sebelius appeared before the committee to urge passage of this legislation and to present the fiscal impact statement. (Attachment #5) In response to Senator Bond's question, Commissioner Sebelius replied that her office had received several complaints in regard to the issue of difficulties arising from shortened hospital stays following childbirth.

In response to Senator Emert's question, Senator Praeger replied that there are no studies which have determined the effect of shortened hospital stays, due to the difficulty of conducting comparative studies and the smallness of the sample size.

Ann Wigglesworth, M.D., an obstetrician from Manhattan, KS, testified in support of **SB 573**, giving case examples from her personal experience. (Attachment #6)

Karen Nelson, RN, testified as a proponent of this legislation; however, she suggested that it might be more cost effective to develop additional home care services instead of simply increasing the length of hospital stay. (Attachment #7)

Barbara McClaskey, Perinatal Association of Kansas, also supported **SB 573** and urged consideration of coverage for home health care. (Attachment #8)

Gail Kiefer provided a history of the difficulties her child experienced, resulting from too short a post-natal stay in the hospital. (Attachment #9)

Dr. Steven Potsic, Kansas Department of Health and Environment, testified that the KDHE supports having insurance coverage available for post delivery inpatient hospital stays of 48 hours for a normal delivery and 96 hours for a Caesarean section. (Attachment #10)

Terri Roberts, Kansas State Nurses Association, delivered testimony by proxy for Manya Schmidt, ARNP, on behalf of nurse midwives. (Attachment #11)

Elizabeth Miller, BSN, RN, gave a personal history of the difficulties experienced following the birth of her last child because of a shortened hospital stay. (Attachment #12)

There were no further conferees; the hearing was closed.

Senator Emert made a motion to amend **SB 573** as requested by Senator Praeger and the Kansas Medical Society. Senator Clark seconded the motion. The motion carried.

Following discussion regarding the need to add nurse midwives specifically, the committee elected not to further amend the bill since nurse midwives work under the direct supervision of physicians.

Senator Praeger made a motion to pass **SB 573** favorably as amended. Senator Petty seconded the motion. The motion carried. Senator Praeger will carry this bill on the Senate floor.

The committee adjourned at 9:58 a.m. The next meeting is scheduled for February 13, 1996.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/12/96

NAME	REPRESENTING
Kathy Peterson	Prudential Insurance
Liz Miller RN	self
Barb McCloskey	Perinatal Assoc. of Kansas
STEVE KENNEDY	CIGNA
Rob + Gail Kiefer	
BILL GRANT	STATE BANK COMMISSIONER
David Hanzlick	KS Dental Assn
Carol Ridgway	KS Ins Dept
Roger Tramble	KGC
Paul Garvin	KDHE
Steve Gobs	KDHE
Brad Smoot	BCBS
Margaret Zillinger	SRS
Meg Henson	KS Medical Society
Tom Wilder	Kansas Insurance Dept
Callie Denton	KS Ins. Dept
Anne Meyer MD	Self
Kathleen Sebelius	KID
CANDA Byrne	KSNA

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/12/96

NAME	REPRESENTING
Linda Odom	Asbury Co Leadership Ctr.
Melodie Hendrick	" "
Vicki Corbett	" " "

Section 1. For purposes of this act, unless otherwise clearly indicated by the context the following terms shall be defined as follows:

(a) "Commissioner" means the Kansas state bank commissioner.

(b) "Mortgage business" means engaging in, or holding out to the public as willing to engage in, for compensation or gain, or in the expectation of compensation or gain, directly or indirectly, the business of making, originating, servicing, soliciting, placing, negotiating, acquiring, selling, or arranging for others, or offering to solicit, place, negotiate, acquire, sell, or arrange for others, five or more mortgage loans in a calendar year

(c) "Mortgage loan" means a loan made to a natural person which is secured by a first mortgage or other similar instrument or document, and which creates a first lien on a one to four family dwelling, located in this state, occupied or intended to be occupied for residential purposes by the owner, including the renewal or refinancing of such a loan.

(d) "Person" means any individual, sole proprietorship, corporation, partnership, trust, association, joint venture, pool syndicate, unincorporated organization or other form of entity, however organized.

Section 2. The following are exempt from the registration requirements of this act.

(a) Any bank, bank holding company, savings bank, trust company, savings and loan association, credit union, or any other financial institution regulated by an agency of the United States or of any state;

(b) any entity directly or indirectly regulated by an agency of the United States or of Kansas which is a subsidiary or affiliate of any entity in subsection (a);

(c) any person who is registered with the Kansas securities commissioner as a loan broker pursuant to K.S.A. 50-1001 et seq. or who is licensed by the Kansas consumer credit commissioner as a supervised lender pursuant to K.S.A. 16a-2-301 et seq.; or

(d) the United States of America, the State of Kansas, any other state, or any agency or instrumentality of any governmental entity.

Section 3. On or after November 1, 1996, no person shall conduct mortgage business in Kansas unless registered with the Office of the State Bank Commissioner pursuant to this act.

Section 4. (a) Any person required to register pursuant to this act shall submit to the commissioner an application for registration on forms prescribed and provided by the commissioner. The application shall contain such information as the commissioner deems necessary to adequately identify:

(1) the location and nature of the business to be conducted;

(2) the identity, character, and qualifications of an individual applicant;

(3) the identity, character, and qualifications of the officers and directors of the entity, if the applicant is a partnership, corporation or other business entity;

(4) the name under which the applicant intends to conduct business; and

(5) such other information as the commissioner may require to evaluate the financial responsibility, character, qualifications and fitness of the applicant.

(b) Each application for registration shall be accompanied by a nonrefundable fee of no less than $100, which may be increased by rules and regulations pursuant to Section 8.

Senate 7/H 1
2/12/96
Attachment #1

(c) An application for registration shall be approved and a nonassignable certificate of registration shall be issued to the applicant by the commissioner provided:

(1) the commissioner has received the complete application and fee required by this section; and

(2) the commissioner determines the financial responsibility, character, qualifications, and fitness of the applicant warrants a belief that the business of the applicant will be conducted compentently, honestly, fairly, and within the purposes of this act.

Section 5. (a) A certificate of registration shall become effective as of the date specified on the face of the original certificate and is effective for one year. The registration shall be renewed annually by filing with the commissioner, at least 30 days prior to the expiration of the registration, a renewal application, containing such information as the commissioner may require, to determine the existence of material changes from the information contained in the applicant's original registration application or prior renewal applications.

(b) Each renewal application shall be accompanied by a nonrefundable fee to be established by rules and regulations pursuant to Section 8.

Section 6. If the commissioner notifies the applicant in writing that any application has been denied, or the commissioner fails to issue a certificate of registration within 60 days or grant a renewal within 30 days after a filed application is deemed complete by the commissioner, the applicant may make written request for an appeal on the issue of the applicant's registration or renewal qualifications. The commissioner shall conduct a hearing in accordance with the Kansas administrative procedure act.

Section 7. (a) The commissioner may deny, suspend or revoke the registration of a mortgage banker or mortgage broker if the commissioner finds:

(1) the applicant or registrant has repeatedly or willfully violated any section of this act or any rule or order lawfully made pursuant to this act;

(2) facts or conditions exist which would have justified the denial of the registration or renewal had these facts or conditions existed or been known to exist at the time the application for registration or renewal was made;

(3) the applicant or registrant has filed with the commissioner any document or statement containing any false representation of a material fact or failing to state a material fact; or

(4) the applicant or registrant has been convicted, within 10 years before the date of an application, renewal, or review, of any crime involving fraud, dishonesty, or deceit.

(b) The commissioner shall not revoke a registration until the registrant is provided written notice of the facts or conduct the commissioner believes to form the basis for the proposed revocation and of the registrant's right to request a hearing in accordance with the Kansas administrative procedure act.

Section 8. (a) Every certificate of registration shall be properly displayed in a prominent place within the registrant's place of business in a way that reasonably assures recognition by customers and members of the general public which enter the registrant's place of business.

(b) Prior to entering into any contract for the provision of services or prior to the registrant receiving any compensation or promise of compensation the registrant shall acquire from the customer a signed acknowledgment that contains only the following items:

(1) the name and address of the mortgage banker or mortgage broker,

(2) the name and position of the individual presenting the acknowledgment to the customer for signature,

(3) a statement in at least 10 point boldface letters which reads "**[name of the registrant] is a mortgage business registered with the Kansas Office of the State Bank Commissioner in accordance with the laws of the state of Kansas. This registration does not represent an endorsement or recommendation of the registrant's products or services by the Office of the State Bank Commissioner. As a consumer, you may submit a complaint or inquiry about this mortgage business by delivering a written statement to the Office of the State Bank Commissioner,700 Jackson, Suite 300, Topeka, Kansas 66603.**

(4) an original signature of the customer(s) and the date such signature(s) was attached.

Section 9. The commissioner may exercise the following powers:

(a) adopt such rules and regulations, in accordance with article 4 of chapter 77 of the Kansas Statutes Annotated, as shall be necessary to carry out the intent and purpose of this act,

(b) make investigations and examinations of the registrant's operations, books, and records as the commissioner deems necessary for:

(A) determining the adequacy or acceptability of any application for registration;

(B) pursuing a complaint or information which forms reasonable grounds for a belief that an investigation or examination is necessary or advisable for more complete protection of the interests of the public.

(c) charge reasonable costs of investigation or examination to be paid by the registrant under investigation or examination;

(d) order any registrant to cease any activity or practice which the commissioner determines to be deceptive, dishonest, violative of state or federal law, or unduly harmful to the interests of the public; and

(e) exchange any information regarding the administration of this act with any agency of the United States or any state which regulates the registrant or administers statutes, regulations, or programs related to mortgage loans.

Section 10. All fees collected by the commissioner pursuant to this act shall be subject to the provisions of K.S.A. 75-1308.

Senate 7-4
2/12/96
Attachment #2

Session of 1996

SENATE BILL No. 573

By Senators Praeger and Bond, Burke, Clark, Corbin, Emert, Hardenburger, Harrington, Hensley, Jordan, Kerr, Langworthy, Lawrence, Lee, Morris, Oleen, Papay, Petty, Ramirez, Ranson, Reynolds, Salisbury, Steffes and Walker

1-31

AN ACT concerning accident and sickness insurance; requiring coverage for minimum inpatient care following birth of child; amending K.S.A. 40-2,103 and 40-1909 and K.S.A. 1995 Supp. 40-19c09 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) As used in this section:

(1) "Health plan" means any insurer or corporation which issues individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity-type contracts issued by a profit or nonprofit corporation and all contracts issued by health maintenance organizations organized or authorized to transact business in this state;

(2) "attending physician" means the person licensed to practice medicine and surgery who is ~~attending~~ responsible for the care to the mother or newborn.

(b) Any health plan which provides coverage for maternity services, including benefits for child birth, shall provide coverage for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a caesarean delivery or delivery by caesarean section for a mother and newly born child in a medical care facility.

(c) Any decision to shorten the length of inpatient stay to less than that provided under subsection (b) shall be made by the attending physician ~~after conferring with the mother~~. No health plan may ~~provide financial incentives, to any attending physician to encourage a length of stay of less than that provided for in subsection (b), nor may any health plan~~ , penalize terminate the service of or otherwise provide financial disincentives in response to any attending physician who orders care consistent with the provisions of this section.

(d) Notwithstanding the provisions of subsection (b), any health plan which provides coverage for postdelivery care provided to a mother and newly born child in the home, shall not be required to provide coverage of inpatient care under subsection (b), unless such inpatient care is de-

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

Memorandum

To: Senate Committee on Financial Institutions and Insurance
From: Kansas Hospital Association
Re: Senate Bill 573
Date: February 12, 1996

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of SB 573. This proposal requires any health plan which provides coverage for maternity services to allow for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a caesarean delivery. It also states that any decision to shorten that period of time can only be made by the attending physician after conferring with the mother.

In recent months, several states have taken action to discourage what is commonly called "drive through deliveries." This term refers to the practice of insurance companies putting pressure on health care providers to discharge a mother and newborn baby shortly after delivery, specifically within 24 hours of delivery. These states have generally enacted laws to require insurers to pay for at least 48 hours hospitalization following delivery.

Data released by the Centers for Disease Control and Prevention in May 1995 disclosed that the average length of stay for all hospital deliveries in 1970 was 4.1 days; by 1992 the average had decreased to 2.6 days. (These figures include births with complications.) The following chart depicts a similar trend in Kansas.

Trends in Average Length of Stay (Kansas)

	1990	1994
All Hospitalizations	6.0 Days	5.1 Days
Hospitalizations for Patients < 65 Yrs of Age	5.2 Days	4.2 Days
Normal Deliveries (DRG 373)	2.0 Days	1.6 Days

Senate 7/4
2/12/96
Attachment #3

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

Some attribute the decrease in obstetric and newborn length of stay to intensified efforts by insurers, particularly health maintenance organizations (HMOs) and managed care plans, to reduce health care costs by imposing strict limits on childbirth payment or by offering incentives to patients to leave early. Others credit the steady decline in maternity stays to improved hospital efficiency and appropriate outpatient management. Still others point to consumer demand for increased family participation in the birth process, increased involvement of fathers in caring for their newborns, and better prenatal education. Finally, as the previous chart indicates, a general overall trend has had at least some impact. Obviously the forces behind the trend toward early discharge are complex and various--economic, social, medical and psychological.

The point is not that all mothers should stay 48 or 72 hours in the hospital after giving birth. The point is, rather, that the tug-of-war between what is medically appropriate for each patient and what is financially feasible should be predicated upon sound clinical guidelines applied by a physician and informed patients who understand the conditions of both their body and their insurance policy. In other words, the discharge decision is one to be made between the informed patient and her physician; not by the insurer or, for that matter, the legislature.

We are supportive of SB 573 because it calls attention to the potential in some managed care arrangements for sacrificing quality to cost. It also recognizes, however, that this decision is best reached by the responsible physician utilizing appropriate medical standards.

Thank you for your consideration of our comments.

7141
2/12/96
3-2

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 12, 1996

TO: Senate Financial Institutions and Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 573; concerning minimum inpatient maternity benefits

The Kansas Medical Society appreciates the opportunity to appear today in support of SB 573. This legislation would mandate all indemnity and HMO health insurers to provide inpatient hospital benefits of at least 48 hours for vaginal deliveries, and 96 hours for deliveries by caesarian section.

Ideally, legislation such as this should be unnecessary if all health insurers merely provided that level of coverage which is deemed to be medically necessary in the professional judgment of the patient's physician. A good medical management system involving sound utilization review should be adequate to assure that only medically necessary care is provided. Unfortunately, the reality of the marketplace is that sometimes physicians are pressured to provide discharge patients quickly in order to reduce costs. This bill is intended to address that potential as it relates to maternity care by making sure that new mothers and their children receive adequate inpatient care.

The bill has some important features such as the language in subsection (c) on lines 32-39, which provides that insurers cannot use inducements, threats or penalties as a tool to get physicians to discharge mothers and their newborns early. The language in the bill relating to the penalty provision reads a little awkwardly, but we understand some amendments to clarify the section are being offered.

A minor technical amendment also needs to be made on line 30, by striking "caesarean delivery or", since the language immediately following that phrase adequately deals with the situation.

We support SB 573 in general, and believe it can be made better by the amendments referenced above. Thank you for giving our comments your consideration.

Senate 7/4
2/12/96
Attachment #4

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions
and Insurance Committee

From: Kathleen Sebelius, Commissioner
of Insurance

Re: S.B. 573 (Hospital Stays After Delivery of Newborns)

Date: February 12, 1996

I would like to thank the Committee for the opportunity to testify in favor of S.B. 573 which would require health insurers and health maintenance organizations to provide coverage for minimum hospital stays for mothers and newly born infants after delivery. The legislation requires coverage for 48 hours of hospitalization after a vaginal delivery and 96 hours in the case of a cesarean section. The mother and child could go home early if authorized by the attending physician. The bill also allows insurers to have programs for early discharge if followed up by a home health visit.

The Kansas Insurance Department conducted a survey of the top 12 writers of health insurance in this state on the average reimbursement for hospitalization after delivery. The information gathered by the Department indicates that the average reimbursement rates by health insurance companies and health maintenance organizations is between 1.3 and 1.9 days of hospitalization after a normal delivery and between 3.1 days and 3.3 days after a cesarean section. Several of the health maintenance organizations and preferred provider organizations which responded to the survey reported 24 hour hospitalization plans.

Senate H+I
2/12/96

420 SW 9th Street
Topeka, Kansas 66612-1678

913 296-3071
Fax 913 296-2283

☎ Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

Attachment # 5

The provisions of Senate Bill 573 are similar to legislation introduced in the Kansas House of Representatives as well as a bill sponsored on the federal level by Senator Nancy Landon Kassebaum of Kansas. In introducing her bill, Senator Kassebaum made the following statement which I believe puts this issue in the proper perspective:

> I have consistently advocated and supported reforms to control health care inflation and have generally resisted government micromanagement of the private health care market. We cannot, however, allow our zeal to control health spending outweigh the need to protect the most vulnerable and fragile in our society. . . . Shorter hospital stays for newborns and mothers may be appropriate in some circumstances. But, in the absence of strong medical evidence, I believe we must err on the side of caution and allow decisions about the length of stay to be made by patients, their families and their doctors.

I would also note that legislation of this type has been introduced or approved in at least 15 other states.

I want to emphasize that this bill addresses a health care issue and not just a matter of insurance laws. A recent article in the New England Journal of Medicine discussed the necessity for hospitalization of a mother and infant after delivery. The authors noted that studies show readmissions for post-delivery problems are related to the length of the hospital stay after birth. As stated by the Journal, "early discharge has particular implications for breast-feeding and for the diagnosis of jaundice, sepsis, and other conditions in newborns." The article also indicated that symptoms of neonatal disorders may not be evident in the first 24 hours of life. There are valid medical reasons for setting minimum standards for hospitalization of mothers and infants after birth.

These criteria are one of the reasons that the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics in their published Guidelines for Perinatal Care recommend a 48-hour stay after a vaginal delivery and a 96-hour stay after a cesarean section if there are no complications. The American Academy of Pediatrics also issued a policy statement that sets forth similar standards for discharge after delivery.

7141 2/12/96
5-2

I believe Senate Bill 573 will provide important protections for mothers and newly born infants. The bill leaves the decision when patients should be discharged after delivery up to the attending physician--who is in a better position than the insurer to decide whether a mother and child should be sent home from the hospital early. I urge this Committee to favorably approve S.B. 573.

7141 2/12/96

5-3

FISCAL IMPACT OF SB573

February 5, 1996

Narrative Summary:

The impact of mandating stays for delivery after the birth of a child is mixed.

For companies with health policies that make maternity available upon request, claims are currently being processed for stays based on the discretion of the physician. Therefore the length of stay for maternity is not restricted. Based on this practice the premiums for the optional maternity rider would not increase. If premiums increased, it would be based solely upon the increased costs associated with normal maternity claims.

Conversely true is Mutual of Omaha who offers a maternity rider for coverage also. They report that additional stays would increase the cost of the maternity rider by 35%. This the overall increase with cesarean and normal delivery expenses for the maternity rider would be 22%.

One company, Blue Cross and Blue Shield of Kansas City interpreted the bill to mandate coverage to policies of all individuals, thus increasing premiums $9-$10 per person per month. In their group market, most of their employees have maternity coverage so the premium impact would be $1-$1.50. Mutual of Omaha reported an increase of 2% spread across both male and female rates for c-sections are considered a complication of pregnancy.

The effect of mandating length of stays will have an effect for the PPO's and HMO's reporting. Premiums would increase. The Principal Financial Group approximates a $12.50 per member increase for the PPO's and a significant increase for their HMO insureds at 19% for normal deliveries and 36% for cesarean stays.

The follow-up visit seems to be the biggest area of concern for all companies surveyed except for Mutual of Omaha which already provides this benefit. If it is a provision they currently do not provide, companies reported an approximated increase in premium, while others stated that it would be too difficult to assess its effect at this time. As the survey illustrates for example, BlueCross BlueShield of Kansas predicts a $.05 increase per contract month.

In summary, indemnity companies report a mixed report that mandating stays would result in premium increases in regard to mandating stays of 48/96 hours. For many, the effect of the cost of the follow-up visit for these companies could not be assessed at this time. For HMO's and PPO's, there would be an overall increase in premiums for insureds when mandating the length of stays.

7141
2/12/96
5-4

Summary of company responses:

Coverage for normal maternity benefits are excluded in American Family Insurance Group current health policies in Kansas. However, as required by Kansas law, benefits for normal maternity are made available by rider. The adjudication process for normal maternity claims under this optional rider is based on the discretion of the attending physician in conference with the mother, and therefore does not restrict length of stay. Based on this practice, the premiums would not increase due to the passage of this bill. Future premium increases would be based solely on the increased costs associated with normal maternity claims.

BlueCross and BlueShield of Kansas stated that generally across the board would not be effected by the mandated periods for stay, but would be effected if the follow-up visit was implemented at early dismissal. The premium increase would be $.05 per contract per month.

Kaiser Permanente included suggested changes to HB 2738 and did not directly respond to the impact of the bill unless language was modified in the bill that would directly effect coverage by their HMO.

Principal's cost would increase for mandated stays for HMO/PPO contracts by $12.50 per covered member. Indemnity contracts would not be effected by mandated length of stay. The costs estimate of the mandated follow-up visit after early dismissal is not available.

Prudential estimates the fiscal impact would be an increase of approximately 1-1.5% of premium. In terms of dollar amount per insured, this would be in the range of $1 to $2.50 per insured per month.

Blue Cross and Blue Shield of Kansas City reported without time to evaluate the full effect of the proposed legislation, felt there were two components they could report on. One is that a significant block of their business has selected plans without maternity coverage. HB 2738 would effectively mandate this coverage, increasing our premiums in the range of 10% or roughly $9-10 per person per month. The second component is the group market in which most of the employees have maternity coverage. The 48/96 hour requirement would add approximately 1% to the cost or $1-$1.50

Mutual of Omaha estimates a 22% overall increase in premiums. Mandated stays for cesarean would be an increase of both male and females due to C-sections considered a complication of pregnancy. Mandating stays would increase on the maternity rider by 35%.

7H 2/12/96

FISCAL IMPACT OF SB573

COMPANY	Premium Impact/ Mandated Stays	Premium Impact/ Follow-up visit
American Family Insurance Group	none	premium increases would be solely based on the increased costs associated with normal maternity claims
BlueCross BlueShield of Kansas	none	mandated follow-up visit $160,000 per year or $.05 per contract per month, less than 0.1% of our current premium
Kaiser Permanente	did not assess the cost effect of the bill need amendments made to the language important to HMO's	already provided
The Principal Financial Group	HMO premium impact would be substantial, 19% for normal delivery stay; 36% for cesarean. $12.50yr per/member PPO No impact on indemnity policies	unable at this time to determine how this would effect premiums charged
The Prudential Insurance Company of America and Subsidiaries	would impact all policies 1%-1.5% of premium=$1 to $2.50 per insured per month	this is a broad based estimate but their Medical Plan expects to report a premium of $63 to $64 million for Kansas. The impact of the proposed bill would be $0.75 to $1.0 million.
Blue Cross and Blue Shield of Kansas	Individual policies $9-$10 per person per month: Group 1% or $1-$1.50	Did not address specifically the impact of the follow-up visit.
Mutual of Omaha Insurance Company	With C-section, 2% increase for males and females. For mandated stays, 35% increase=overall 22%.	No impact, already provided.

7141 2/12/96

5-6

An example of the possible effects on premium rates from the increase of maternity age to 48/96. These estimates are only.

Case characteristics:

Major Medical Policy
$1,000 deductible
$2,500 Out-of-Pocket
80% Coinsurance
Female
Age Less Than or Equal to 29

Current rates without a maternity rider: $1041.34 per year

Current rates with a maternity rider: $2,549.52 per year

48/96 rates without a maternity rider: $1,062.19 per year

Up to a 2% increase spread across both males and females due to C-sections as a complication to pregnancy.

48/96 rates with a maternity rider: *$3,098.30 per year

*Up to an additional 35% increase on the maternity rider itself.

Thus, in the example, an overall 22% increase was realized by the insured with the maternity rider.

Concerning the extent to which the expansion of coverage for one-follow-up visit after early dismissal would increase or decrease the premium charged, the current, common practice of Mutual of Omaha is to allow one home health care visit within one week of discharge. Therefore, there is no anticipation of any significant increase or decrease to rates.

AAA 2/12/96

Testimony to Senate Financial Institutions and Insurance Committee, Feb. 10, 1996.
Anne Wigglesworth, M.D., F.A.C.O.G., 1133 College Ave., Manhattan, KS 66502.

Ladies and gentlemen of the committee, my name is Anne Wigglesworth. I've been an obstetrician for 20 years, and now practice in Manhattan. I was offered an opportunity to testify today in support of S.B. 573, which would mandate that insurors pay for hospital care for new mothers for 48 hours after normal deliveries and for 96 hours after delivery by cesarean section. People with some political clout--mostly women, as a matter of fact--are calling the public's attention to the fact that more and more payors for health care decline to pay for hospitalization beyond 24 hours for vaginal births, or 48 hours for Cesarean sections. They justify this by insisting that there is no "medical necessity" for longer hospitalization, and by declining to reimburse the hosptals for the extra days. This permits situations such as the following:

--The16 year old single SRS client who came in at10 p.m. Monday, gave birth to her first child in the small hours of Tuesday morning, and had to go home Wednesday, to a marginal home about which no one really knew anything.

--The 34 year old married mother of breastfeeding twins whose insurance company refused to pay for more than 24 hours postbirth because she delivered vaginally. It took four months of letters and phone calls between her physicians and the insurance provider before an obstetrician reviewed the case and a second day was allowed.

--The Cesarean section mother who developed an incisional infection on third postbirth day. Because the causative organism was anaerobic, the infection did not show up sooner. Some women come from many miles away to Kansas hospitals; after discharge it is hard to monitor them over distance. It seems counterproductive to ask them to "drop by" thirty miles to the office to be checked if a problem, which could have been detected in the hospital on the third postop day, has developed at home.

So it is true that there is a problem, but S.B.573 addresses only part of it. This bill does not address the fact that growing numbers of women are giving birth without adequate preparation, household stability, or resources to manage their own care or that of a newborn. I'm talking not only about the unmarried teen, but also about the 22--year-old couple with minimum-wage jobs and no family nearby, and the 32-year old divorced woman with 2 children at home whose "fiance" has disappeared. Support systems and prebirth education for parenting, selfcare, nutrition, breastfeeding, and return to work are sparse; both in terms of examples women can see around them, and in terms of adequately funded programs.

The irrational parental leave and maternity policies of American employers are a joke everywhere else in the world. Women, having had to fight to stay in jobs such as school teaching after the pregnancy begins to show, now find that they are expected to work fulltime and even overtime until delivery, or risk loss of benefits. Businesses and institutions who employ women often don't have any flexibility in scheduling, or any place where an employee (pregnant or not) can rest at breaks.

It has always been true that there is minimal to no third-party health-care reimbursement for preventative measures or education. Only acute care is paid for. So there is no incentive for hospitals, doctors, or county agencies to provide more than a rudimentary prebirth evaluation or postbirth homevisiting program, or to add new services as hospital days are cut.

Senate FI&I
2/12/96
Attachment #6

Hospitals have only one level of postbirth care--acute. So women must be in the hospital or at home after childbirth; though hospitals staff for "acuity," there is still no rational acuity level for new mothers beyond the first 24 hours. Much of the care given to these women in the hospital may not address fever, shock, hemorrhage, or wound healing. But it does address the less quantifiable needs of fatigue, anxiety, maternal-infant bonding, and the culture shock experienced by parents from every social stratum when a two-person household suddenly grows to three. Yet what cannot be quantified should not have to be paid for, in the cost-conscious, no-frills, managed-care environment we now occupy.

By reducing this very complex series of social problems to a matter of mandating 48 hours in the hospital for every postbirth mother, I believe (on my more charitable days) that the well-intentioned sponsors of this bill are missing the point. On my less charitable days, I think that there is a nationwide bandwagon which politicians (of all shades) want to board, and which rolls over many of the underlying and more complex issues. I think that the wider problems should be addressed as well, but they are certainly not as amenable to easy solutions.

Are these really problems which health insurors can solve by paying for an extra day? Should it not rather be the business of the state's leaders to insist that we fund preventative and supportive health care, programs aimed at deglamorizing early sexual activity, and ways to give girls hope that there is a role for them in life outside that of concubine? Insisting that insurance companies pay for a certain minumum of days in hospital will not help this. But it will almost certainly result in raising of premiums for people who carry maternity coverage, whether they choose to stay an extra day or not. I've been dealing with health insurors for years, and I know they can adduce convincing numbers to support almost any position.

Let me ask each of you, ladies and gentlemen, how long was your mother in the hospital after you were born? And what did she think about that?

Now, having made my points, I must say that, on the whole, I support this bill and hope it will be passed. I think that acknowledging that new mothers and their infants have many "soft" but important needs may be a first step toward solving some of the problems I have mentioned. But I would ask that our state and national legislators who are truly interested in improving the care of mothers at childbirth, and of the infants born to them, should look at the wider, more difficult issues and not just at this one, which is currently so popular. This is too important to be the issue du jour today, and forgotten tomorrow as you congratulate yourselves on the bill's passage. Thank you for your attention.

7141 2/12/96

6-2

SHAWNEE MISSION MEDICAL CENTER

Shawnee Mission Home Care

February 12, 1996

To The Honorable Members of the Senate Financial Institutions and Insurance Committee,

I appreciate the opportunity to provide communication regarding maternity hospital stays and the Senate Bill No. 573.

I have been involved in maternal/child nursing for over seventeen years. During that time, I have seen the length of postdelivery hospitalization change several times. It is obviously difficult to determine just how long the postpartum mother/infant couple should remain in the hospital. If the main objective of the Bill is to assist health care providers in determining the optimal method of providing care to newly delivered mothers and infants, factors beyond the hospital stay must be considered.

At Shawnee Mission Medical Center (SMMC), a comprehensive maternity program was implemented approximately 2 years ago. Prenatal and postpartum components were added to the existing inpatient maternity service. Prenatally, the patient has contact with a prenatal coordinator which enables discussion of expectations, concerns, and prenatal class options. Following hospital discharge, the mother/infant couple receives postpartum follow up care in the comfort of their home by Shawnee Mission Home Care's (SMHC) maternal/child staff. The success of this program is demonstrated by the following summary of 1995 data:

- 0.3% neonatal readmission rate to SMMC (the national data suggest an acceptable readmission rate of 3% among similar populations).
- 86% of postpartum mother/infant couples are dismissed by their physicians within 48 hours after delivery.
- 87% of mother/infant couples dismissed within 48 hours after delivery receive follow up care at home by SMHC.
- 39% of mothers and infants seen by SMHC have a secondary diagnosis (diagnosis in addition to well mother or well baby).
- Average number of SMHC visits per mother/infant couple: 2
- SMHC services provided in a wide geographic area in Kansas and Missouri.
- Greater than 95% patient satisfaction rate with SMHC program.
- Greater than 98% of the patients seen by SMHC would recommend the program.
- Physician satisfaction with SMHC program.

Senate 7/14
2/12/96
Attachment #7

7314 Antioch ▪ Shawnee Mission, Kansas 66204 ▪ (913) 676-2163

The maternal/child program at SMMC was developed as a collaborative effort between SMHC and the maternity staff and physicians of SMMC. The goal of the program is to provide quality clinical follow up to reduce the length of hospital stay for the well postpartum mother/infant couple. From its inception, high standards for quality of service and clinical outcomes were established. The maternal/child home care Registered Nurse (R.N.) staff was selected based on experience and skill in caring for postpartum mothers and infants. Each R.N. had expertise in preventing, detecting, and managing postpartum and neonatal complications. Through this highly skilled team, the program's goals have been attained and unnecessary hospital readmissions have been avoided.

In addition to meeting clinical outcomes, the program has demonstrated high patient satisfaction. The patients have provided supportive feedback through surveys and comments (enclosed) Patients frequently comment that they did not realize what to expect prior to the visit, but after the visit they realized just how much more beneficial it was to receive information and assistance related to infant care and safety at home as opposed to in the hospital.

The hospital environment may facilitate communication between patient and physician and provide a sense of security among patients and their families. However, hospital stays are costly. In addition, many postpartum complications will not be prevented or detected within a 48 hour hospital stay. Infant problems such as hyperbilirubenemia, dehydration, and some heart defects typically do not appear until after the infant is 3-5 days old. The home care nurse is in the position to recognize and effectively manage these and other problems by providing skilled nursing care during the first postpartum week and beyond that time if necessary.

To achieve the goal of providing higher quality maternity care to mothers and infants, the focus should be on developing additional competent home care services instead of on increasing the length of hospital stay. These services should be made available to all postpartum mothers and infants.

If health care resources are going to continue to be limited, we have a cost effective model incorporating both high quality and excellent patient satisfaction. This model can be duplicated for use in another health care delivery systems.

If I can provide additional information or be of assistance in developing standards for maternal/child home care please contact me at (913) 676-2163.

Respectfully Submitted,

Karen B. Nelson

Karen B. Nelson, R.N., B.S.N.
Maternal/Child Clinical Manager

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2/12/96
7-2

PERINATAL ASSOCIATION OF KANSAS

Senator Dick Bond, Chairperson
Senate Financial Institutions and Insurance Committee
Kansas Statehouse Room 128-S
Topeka, KS 66612

February 9, 1996

Dear Senator Bond:

I am writing in support of Senate Bill No. 573. I currently serve as president of the Perinatal Association of Kansas which is a multidisciplinary organization of professionals interested in the health and well-being of pregnant women, newborns, and their families. My support of this bill is also based on over 15 years experience as a registered nurse in the hospital care of mothers and newborns. Currently I am involved in the provision of obstetric care with nursing students as an assistant professor in the Department of Nursing at Pittsburg State University.

I am very supportive of the content of this bill as it provides insurance coverage for 48 hours following a vaginal delivery and 96 hours following a cesarean delivery based on a cooperative decision between the mother and the health care provider. Research has shown that immediately post-delivery a mother is not always ready to learn and able to absorb the knowledge necessary to provide care for her newborn and herself. In addition to having adequate time for education, it is necessary for the caregivers to have sufficient time to assess for complications, such as infections, feeding problems, certain congenital heart defects, and hyperbilirubinemia. Some of these complications may not be significantly apparent at 24 hours post-delivery. If dismissed prior to 48 hours after delivery, the mother may not have absorbed or understood the information needed to provide optimal care of her newborn and to be able to recognize symptoms appropriately early to prevent development of more serious problems.

Although this bill addresses a very important issue in the well-being of new mothers and newborns, the bill could be strengthened if it included insurance coverage for home health follow-up by a professional licensed nurse in the cases of early discharge or as deemed necessary by the health care provider and parent. Another provision that would benefit the well-being of mothers and newborns would be to include insurance coverage for prenatal and parenting education. Education on pregnancy, infant care and development, and parenting may have significant impact on the pregnancy outcome, maternal health during and after the pregnancy, and infant health and well-being.

Thank-you for your time. I sincerely appreciate your efforts in improving the health and well-being of mothers and newborns.

Respectfully submitted,
Barbara McClaskey
Barbara McClaskey
President, Perinatal Association of Kansas
Assistant Professor, Department of Nursing
Pittsburg State University
Pittsburg, KS 66762

Senate FI&I
2/12/96
Attachment #8

On July 2, 1995 my husband and I went to the hospital to have our first child. Baylie Kristine Kiefer was born at 11:08 p.m. It was considered a normal delivery and birth. Since Baylie was born before 12:00 p.m. July 2nd was considered our night in the hospital. We were released at 5:00 p.m. on July 3, 1995. A mere 18 hours after delivery.

My husband and I were very excited to bring home our new baby. We were a little nervous about caring for her, but had several family members available to help. We had reservations about leaving the hospital so early. We were concerned about my physical condition not the well being of the baby. We assumed that since everything was considered normal we would be fine. We did not think that we would be released if there was a possibility that something was going to happen to Baylie.

The first night at home went well. My husband and I thought that nothing could go wrong now. It was not until 10:00 a.m. on July 4, 1995 that our near death tragedy occurred. I had taken a shower and was getting ready for the day when I went to Baylie's bassinet to check on her. When I looked in the bassinet I found Baylie laying on her side with her back arched, her head thrown back, her eyes and mouth open, and her arms and legs stiff. I called for my husband and I picked her up. She was not breathing. I told my husband to call 911 and I started giving her back blows. She appeared to be choking. Her mouth then closed and I had to pry it open. The local First Response Team and the police arrived within minutes. By that time Baylie was trying to cough and was turning blue. They took her and continued the back blows. Amniotic fluid started to drain from her mouth. They used a nasal aspirator to suction the fluid and gave

Senate 7/4
2/12/96
Attachment #9

her oxygen. By the time the ambulance arrived Baylie was getting her color back and was still trying to cough up the fluid.

We were transported back to the hospital by ambulance. Baylie tried to cough up more fluid in the emergency room, where they suctioned more fluid from her. She was admitted to the hospital for the night. She was put through several tests and monitored. All the tests and monitoring showed that she was a healthy baby that had choked on amniotic fluid that she was trying to cough up.

My husband and I feel fortunate that this happened while we were awake. It really scares us that this could have happened during the night. Had we been sleeping we would not have a happy healthy baby with us today. We are also grateful for the quick professional response of our local emergency personal. They saved the life of our most precious possession.

Had we stayed in the hospital 48 hours we would not have had our near death experience. Had we been in the hospital the nurses could have suctioned her immediately. Baylie's experience cost our insurance company more than if they would have allowed us to stay 48 hours. I feel that Senate Bill 573 would have prevented this from happening. Please vote for this bill and save the life of a newborn.

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2/12/96
9-2

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

Testimony presented to

Senate Financial Institutions and Insurance

by

The Kansas Department of Health and Environment

Senate Bill 573

The trend of shortening the length of hospital stays from three days (vaginal births) and 5-6 days (Caesarean section) in the mid-1980's to stays of 24 hours or less for vaginal births in 1996 has become a serious medical concern. It is recognized that the driving force behind this trend is the need to contain escalating health care costs. However, these shortened stays can have adverse effects on the well-being of the mother, newborn and their family. Shortened hospital stays may not allow sufficient time for necessary maternal and newborn observation and education.

Adequate time for medical observation is difficult at best with a brief hospital stay. Observations should include such issues as infant feeding, urination, development of jaundice, responsiveness to external stimuli, etc. In addition, social and health risk factors are often difficult to access especially when there are concerns for necessary parental follow-through and the family environment. It is important that the care for mothers and infants should be tailored to their health care needs. Given the need to observe and recognize important risk factors, the decision about when it is safe and appropriate for a mother and infant to leave the hospital is one that should consider multiple factors, including any requirements for further follow-up assessment and care. We need decisions based upon sound clinical judgment if we want all of our children to have a healthy start in life. Obviously, the outcomes we wish to achieve are healthy babies and mothers.

Integrating the newborn into the family unit is a complex process with unique implications for the mother, newborn and family members. This process involves recovery from childbirth and assuming responsibility for the newborn's care. The newborn also faces a critical period of adaption. Thus, discussion on length of stay also gives us the opportunity to highlight the need for proper discharge planning and education.

The Kansas Department of Health and Environment supports having insurance coverage available for in-patient hospital stays of 48 hours for a vaginal delivery and 96 hours for a Caesarian Section post delivery. KDHE supports removing the potential for incentives to encourage

Senate FI+I
2/12/96
Attachment #10

Office of the Director of Health
900 SW Jackson, Rm 665, Topeka, KS 66612-1290

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early (premature) discharge or disincentives for early discharge. KDHE also supports inclusion of coverage for one possible post-discharge home follow-up visit within 48 hours of discharge if discharge occurs prior to the above inpatient stays.

Testimony presented by: Steven R. Potsic, M.D., M.P.H.
Director of Health
Kansas Department of Health and Environment
February 12, 1996

7141
2/12/96
10-2

KANSAS STATE NURSES ASSOCIATION

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the Voice of Nursing in Kansas

Betty Smith-Campbell, M.N., R.N., ARNP
President

Terri Roberts, J.D., R.N.
Executive Director

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February 12, 1996

S.B. 573 MATERNITY BENEFITS FOR HEALTH INSURANCE POLICY HOLDERS

Drive through deliveries

Chairman Bond and members of the Senate Financial Institutions and Insurance Committee, my name is Manya Schmidt ARNP, CNM and I am a certified Nurse Midwife here today representing the Kansas State Nurses Association and the Kansas Chapter of the American College of Nurse Midwives. Thank you for this opportunity to address you and speak to S.B. 573.

Timing of appropriate discharge after delivery of mothers and babies is indeed a recognized factor in the immediate postpartum health and well-being of the new family. Hospital readmissions following delivery are directly related to length of hospital stay and prenatal care and education. This bill provides the assurance to new mothers that the length of hospitalization following delivery will be determined by their health status. This is not occurring presently, as many plans outline a maximum hospital stay for "uncomplicated vaginal deliveries".

Senate 7/+1
2/12/96
Attachment #11

One of the current issues confronting the providers of health care are closer and careful scrutiny of billing records and payment. Medical records must accurately reflect the care provided and by whom the care is provided. As a certified nurse midwife I provide full scope maternity care. This includes prenatal, labor and delivery, and postpartum care. I currently deliver babies at both Topeka hospitals and I have colleagues who also deliver babies in Topeka and Kansas City area hospitals. I am responsible for making the decision regarding discharge and writing the dismissal order. This bill provides for a definition of "attending physician" on line 25-26, page one. At this time certified nurse midwives are not recognized in this bill and we would ask that serious consideration be given to expanding the definition to insure that certified nurse midwives are included as those recognized to attend mothers and newborns. If not included in this bill, we believe patients of certified nurse midwives may not be afforded the same benefits as outlined in this bill.

I have attached several documents regarding certified nurse midwifery care and references to the Kansas Nurse Practice Act.

Manya P. Schmidt, CNM

Thank you.

Manya Schmidt CNM, ARNP
Certified Nurse Midwife
(913) 235-0202

Senate 7/41
2/12/96
11-2

V. Elizabeth Miller, BSN, RN
131 Fillmore
Topeka, Kansas, 66606

Dear Honorable Senators: 12Feb96

I am speaking to you from the heart as a professional nurse and mother to consider SB573. I pray that SB573 will be passed for the following reasons.

I have been a professional nurse for 15 years. I am advocating with full voice monitoring the interium period of mother and neonate in that the majority of cases is without complication. The first 24-48 hours post-partum is critical in a neonate's life. In utero, fetal circulation channel's blood flow to functioning organ's and largely avoids the lung fields. At the time of birth an opening between the 2 atria of the heart closes forcing blood to be routed into the right ventricular, a fetal vessel between the pulmonary artery and aorta collapses to send blood into the lungs. This in itself, is an anatomical miracle. Additional risks of the term neonate are infection, low bloodsugar, hypothermia, and jaundice which by itself left untreated can lead to brain damage. At best, the neonate is a collection of new immature and independent body systems trying to survive.

As a professional nurse, I made educated choices during my last delivery. I chose to be discharged at 8 hours as my pregnancy and delivery were without complication After returning home my daughter had a brief cyanotic episode at 10 hours of age. I discounted this at first as anxiety on my part but with 2 more episodes a pediatrician was involved and she was admitted at age 15 hours to a neonatal intensive care unit. Her initial symtomology was

Senate 7/41
2/12/96
Attachment #12

very vague. My own nursing assessments did not reveal any other neonatal abmormalities. In other words she was perfectly normal in all ways. In NICU she was closely monnitored for heart and lung problems in which she had none. She was labeled a "Germ Baby" or medically known as Sepsis Neonatorum. The diagnostic tests and aggessive treatment available for her were hospital based and not home based. This incidence occurs in 1-10 cases per 1,000 live births. The mortality rates for neonatal sepsis range from 10 to 40 per cent and increase to to 15-50 per cent from meningeal involvement.

I quote form the late Dr. Ed Saylor, "Liz, If you had waited any longer Shannon's prognosis would have been grim, you did well by acting so quickly!" As a nurse and mother I strongly advocate SB573. Educated choices do not guarantee cost saving or life.

Sincerely,

V. Elizabeth Miller BSN RN

V. Elizabeth Miller, BSN, RN

7141
2/12/96
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