The Politics of "Drive-Through Deliveries": Putting Early Postpartum Discharge on the Legislative Agenda

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When Jack L. Walker attempted to establish an innovation score to measure how quickly states adopted new programs, he used as a criterion "the total number of years which elapsed between the first and last recorded legislative enactment of a program" (Walker 1969, 882). He described how the growth of specialized organizations serving state government might expedite the adoption of new policies, noting that in the most recent period he studied (1930–66), the average time for all states to adopt a new policy had been reduced from 52.3 years in the period 1870–99 to 25.6 years, and the period for policy adoption in the first 20 states had fallen to 18.4 years, compared with 22.9 years in the earlier period. In its review of 1994 state legislation relevant to maternal and child health, the National Conference of State Legislatures identified over 600 new laws pertaining to women and children, including 125 statutory changes to insurance regulation in 42 states (Wright, King, and Perez 1995). Nowhere in the report is mention made of laws requiring insurers to provide minimum periods of hospitalization for new mothers and babies. Yet, by the end of 1995, beginning with Maryland on May 25th, five states had passed what are termed "early discharge" laws; at the close of 1996, 24 more states had adopted similar laws or

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regulations, and such laws were pending in four more states. The first 20 adoptions of state early discharge laws occurred well within 12 months of Maryland's action.

Comparable bills were also introduced in the U.S. House and Senate. The Senate bill, which had 52 cosponsors as diverse as Ted Kennedy and Jesse Helms and was actively supported by the Labor and Human Resources Committee Chair Nancy Kassebaum, received a favorable committee report and, on April 17, 1996, a 14–2 vote. The bill was revised over the summer of 1996, adopted as an amendment to an appropriations bill for the Departments of Veterans Affairs and Housing and Urban Development, and signed into law by President Clinton on September 26, 1996.

We will describe and analyze the process by which the issue of early discharge not only moved quickly onto the agenda of decision makers (Cobb and Elder 1983; Nelson 1984; Kingdon 1995), but also resulted in new state laws. Our major focus will be on the agenda-building process in state legislatures. In order to explain state agenda placement, we will examine the impact of published research (Brooks and Gagnon 1994), media attention (Erbring, Goldenberg, and Miller 1980), the gender of legislators (Thomas 1994), and interest group activity (Hunter, Wilson, and Brunk 1991) on the state legislative process. The early discharge debate also served as a powerful example of symbolic politics (Edelman 1967) and drew support for an essentially unfunded legislative mandate at a time when such laws were supposedly in disfavor. The underlying irony of this policy process is that there is little empirical evidence to support *either* those insurers who reduced the postpartum length of stay for mothers and babies *or* the new statutes that mandate minimum periods of insurance coverage (Braveman et al. 1995).

Our analysis covers legislative adoptions through the end of 1996 and is based on the following sources: a review of the clinical and programmatic literature on early discharge; analysis of the statutes, hearings, and supporting documents regarding the topic; and interviews with the pertinent legislators, staff, insurers, and lobbyists. We had planned to analyze the role of party and gender in voting patterns in the state legislatures, but, because the legislation has passed with nearly unanimous votes in each state, no voting patterns could be discerned. Examination of the party and gender of the sponsors in states where the legislation did pass, however, found a preponderance of either female (65 percent) or Democratic (67 percent) legislators as sponsors.

The Debate over Early Discharge

> Possible risks of early discharge remain of concern to many physicians, who feel that early signs of disease will be missed out of the hospital. On the other hand, the superiority of a longer hospitalization in facilitating improved outcomes has not been established, and arguments that continued hospitalization poses increased risk are equally tenable. In the absence of definitive medical data, current practices remain based upon clinical judgment, and economic considerations continue to emerge as directive forces behind the trend to discharge early. (Britton, Britton, and Beebe 1994, 294–5)

In the past quarter century, the average length of postpartum hospital stays in the United States has been halved, with the result that U.S. stays are now among the shortest in the developed world. In 1970, the average postpartum length of stay for vaginal births in the United States was 3.9 days; the comparable rate in 1993 was 2.0 days. Similarly, the average postpartum stay for cesarean births was 7.9 days in 1970 and 3.9 days in 1993 (Centers for Disease Control and Prevention 1995; U.S. Department of Health and Human Services 1996). These national averages mask considerable regional variation: one study found that 87.6 percent of 1994 postpartum stays in the West were one day or less, compared with 33.8 percent of that duration in the Northeast (Gazmararian and Koplan 1996). Decreasing lengths of postpartum stays also occurred within a context of general reduction in hospital stays in all countries for all diagnoses (Organization for Economic and Cooperative Development 1996). Shorter postpartum hospital stays are only part of the issue, as much of the debate centers on who (mothers? doctors? insurers?) will control the decision. The diversity of postpartum discharge patterns around the world and within the United States reflects disagreement over the definition of early discharge. In this article, we use the standard developed by the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP), which define "early discharge" as a stay of less than 48 hours for uncomplicated vaginal births and a stay of less than 96 hours for cesarean deliveries (American College of Obstetrics and Gynecology 1992, 105–8).

Underlying the debate over early discharge is the assumption that widespread hospitalization for birth and the postpartum period is desirable. This is a broadly held, but not universally accepted, belief (Campbell and MacFarlane 1994). For example, in Holland, home births account

for more than 30 percent of all births, and mothers who give birth in hospitals routinely return home within a day after parturition (Statistics Netherlands 1995). However, Dutch mothers are also visited regularly in their homes by the midwives who delivered their babies; a home health care worker attends to the mother in her home for up to eight hours a day for 10 days (Miller 1994). Home care in general, and specifically postpartum home visiting, is much more common in other developed countries than in the United States (Solloway and Budetti 1995); the United Kingdom, for example, provides up to 10 days' postpartum home visiting by a midwife. In its recent national reform of maternity practice, England established the following standards:

> As far as practicable, the length of time spent in a postnatal ward should be discussed and agreed between the woman, the midwife and other professionals as necessary. The midwife can help the woman to assess her readiness to return home and to prepare her for doing so. For some women, after the first few days at home, it will be enough to know that they can contact their midwife for advice or a visit if they are concerned about themselves or their babies. For others, the visits of a familiar midwife, and their GP, in the period up to 28 days after birth of their babies will be essential to build confidence in their own abilities. (Department of Health 1993, 32)

European countries also have had substantially more generous policies on maternity and family leave involving paid (at rates of 50 to 100 percent of salary) leaves of at least 12 weeks (Ierodiaconou 1986; Miller 1987). With little tradition of systematic postpartum home care, the U.S. average length of postpartum hospitalization for a vaginal birth (2.0 days) is nonetheless distinctly shorter than that of Australia (3.0), Great Britain (3.0), Sweden (4.0), Norway (4.5), or Japan (6.5) (U.S. Department of Health and Human Services 1996).

The Evolution of Early Discharge Practices

In the United States, debate over the timing of postpartum hospital discharge is hardly a new phenomenon. Guerriero (1943) described a New Orleans program that appeared (data only on mothers' health were presented) safely to minimize hospital crowding by reducing what was then the average stay of eight to ten days to one lasting between two and five days, with follow-up home visits by nurses. Nabors and Herndon

(1956) described a program at Parkland Hospital in Dallas, which, because of pressure for bed space, reduced the postpartum length of stay to 24 hours for more than half of the mothers delivered between 1950 and 1954. It also incorporated six home visits in the first postpartum week: three by a public health nurse and three by a senior medical student and nurse. They documented a rehospitalization rate of 1.6 percent for mothers, but, like Guerriero, failed to record readmission rates for neonates.

In 1951, the "Bradford Experiment" was established in England. It was an attempt to improve prenatal care by allocating more beds for early admission of very high-risk mothers. The only way to free enough beds was to discharge mothers who experienced no birth complications within 48 hours after birth; substantial follow-up home care was provided by domiciliary midwives. The researchers reported low maternal (0.4 percent) and infant (0.5 percent) hospital readmission rates, although 5.9 percent of mothers and 7.3 percent of babies needed medical care during the home visits (Theobald 1959). The Bradford model was cited as one basis for other early discharge programs in the 1950s (Hellman, Kohl, and Palmer 1962) and 1960s (College of General Practitioners 1966). Virtually all of these programs shared two characteristics:

1. They provided an intensive postpartum home-visiting program.
2. The development of the early discharge model was driven more by the need to free up bed space than a desire to explore an alternative model of home-based postpartum care.

From the late 1960s to the present, trends toward early discharge gained a new source of support: mothers who wanted less intervention and hospitalization in childbirth (Wertz and Wertz 1977). While national rates of out-of-hospital births remained fairly constant and low (around 1.0 percent) through this period (Declercq 1992), in some states, like California, rates of out-of-hospital births more than doubled in the 1970s (Eakins 1986). The development of alternative birth centers, in which mothers gave birth in a more homelike environment while in or near a hospital, may have also contributed to a shortened length of stay (Barton et al. 1980; Greulich et al. 1994). However, the number of births at the generally more independent freestanding birth centers remains less than 0.5 percent nationally (Ventura et al. 1996).

Is Early Discharge Safe?

The historical and cross-national comparisons do not, however, answer the question: is early discharge safe? Current research provides little comfort for either side in the debate over early discharge (MacDonald 1995). The clinical literature does not suppport the safety of this practice; however, the negative effects of early discharge have not been consistently and empirically documented either. Most studies of early discharge are flawed by a lack of appropriate comparison groups, limited outcome measures, and/or inadequate description of participation criteria and protocols, loss of subjects to follow-up, sample sizes too small to detect clinically significant effects on important outcomes, or the use of a population drawn under highly restrictive circumstances (Braveman et al. 1995). As a result of the inherent difficulty of interpreting the outcomes of these studies, both insurers who reduced stays and policy makers who wish to lengthen them may be basing their efforts on inadequate health outcome data. A constant theme among opponents of early discharge is that the impetus for this change did not arise from advocacy of an alternative model of home-based care, but, rather, was based on financial concerns of insurers, particularly managed care providers (Britton, Britton, and Beebe 1994).

Those opposed to early discharge focus on several problems. The major physiological concern is with the threat of hyperbilirubinemia (jaundice), which accounts for 85 percent of newborn readmissions in the first week (Catz et al. 1995). Since jaundice will generally not be apparent before the third or fourth day after birth, it is much less likely to be identified in babies sent home at 24 hours; if untreated, it can lead to serious brain damage (Maisels and Newman 1995). Ironically, keeping a mother and baby in the hospital for a second day increases the likelihood of discovering jaundice but still misses a critical period for identification of the problem. Early discharge has also made in-hospital breast-feeding support difficult because mothers frequently now leave the hospital before their milk has come in; improper nursing technique can lead to a premature discontinuation of breast-feeding, or mastitis, although there is no clear evidence linking early discharge to either outcome (Ryan et al. 1991; Braveman et al. 1995). Pediatricians are concerned that the opportunities for newborn screening are diminished by early discharge because some tests should be conducted during the second day after birth (Coody et al. 1993).

There is also a concern that early discharge can hamper efforts to identify and address postpartum depression in new mothers (Ugarriza 1992) or, at a minimum, allow mothers some time to rest in the hospital before returning home, although some would argue that rest is more likely to occur at home. Few published studies have examined mothers' attitudes toward early discharge; those that did so relied on small, unsystematic samples in different countries. A study from France found only 22 percent of mothers in favor of a proposed early discharge program, while an Italian study found 28 percent of mothers supportive (Romito and Zalateo 1992). In the United States, studies have suggested little dissatisfaction with early discharge, but, again, these relied on very small, unsystematic samples that were contextually distinct (Gjerdingen, Titus, and Tuggle 1988). In the political debates, discussed below, insurers cited the satisfaction (as measured by their internal market surveys) of mothers who participated in their early discharge programs, although the reliability of such data cannot be ascertained.

Although a number of factors are cited as potential problems associated with early discharge, there is little evidence clearly documenting the degree and extent to which those problems appear. Some studies have documented increases in infant readmission rates. For example, Lee et al. (1995), in their study of over 85,000 births at an Ontario hospital from 1987 to 1994, found higher readmission rates for jaundice and dehydration as postpartum stays were reduced. However, a review of U.S. national neonatal readmission rates from 1988 to 1993 finds an inconsistent pattern of readmission rates for jaundice and a steady and slightly downward trend for other conditions (infections, respiratory difficulties, feeding problems, and congenital anomalies) that might either be associated with early discharge or not initially detected because of a short length of stay (U.S. Department of Health and Human Services 1996). Likewise, a study of an Alabama early discharge program that included a home visit found the program to be both safe and cost-effective (Brumfield et al. 1996). In summary, there is no discernible trend to the research, and, in a comprehensive review of the literature, Braveman and colleagues either found no support for early discharge or uncovered no compelling evidence against it. They concluded:

> This review raises the general question of what constitutes sufficient evidence to justify changes in clinical practice. Early discharge of newborns and mothers affects virtually the entire medically low risk

> population at a highly vulnerable time of life, but has not been subjected to the same standards of scientific evidence for safety and efficacy required for the introduction of drugs or devices. . . . Furthermore, there is no clear evidence for the safety, efficacy and effectiveness of the hospital and posthospital practices that were previously standard. (Braveman et al. 1995, 724)

The Emergence of Early Discharge on the Political Agenda

Agenda-Building Models

A distinction has been drawn between three types of agenda-setting research (Rogers and Dearing 1988). *Public agenda-setting* research focuses on the relation between the media and public issue priorities, whereas *media agenda setting* analyzes the sources of media content. We have chosen to focus on the third category, *policy agenda setting*, and thereby to examine the ways in which issues are shaped as priorities of public policy makers. Cobb and Elder (1972) emphasized the importance of issues expanding from narrow interest groups to the general public, and they linked that process to the extent to which an issue has these characteristics: is ambiguously defined; is seen as socially significant; is seen as having a long-range impact; is seen as nontechnical; is defined as lacking a clear precedent; is linked to powerful symbols in society; and is portrayed as an emotional issue. Walker's study of agenda placement in the U.S. Senate suggested that three factors were critical to the advancement of an issue: it should affect a large number of people; there must be convincing and, preferably, graphic evidence that the problem is serious; and there should be an easily understood solution (Walker 1977, 431–2).

John Kingdon's agenda-building model, while criticized by some (Mucciaroni 1992), is the most popular current analysis of agenda building. It examines the interaction of three process "streams":

1. problem recognition
2. the formation and refining of policy proposals, often by "policy entrepreneurs"
3. the political mood of the times (Kingdon 1995, 92–3)

In Kingdon's model, problems may become recognized as meriting governmental attention in one of the following ways: the publication of

a regularly measured indicator (e.g., the annual publication of the proportion of births to unmarried mothers); the occurrence of a "focusing event," usually drawing widespread attention to an existing problem (e.g., a *Boston Globe* series, entitled "Birth in the Death Zone," stressed racial distinctions in infant mortality in Boston and led to several new policy initiatives) (King and McNamara 1990); or the generation of routine feedback (systematic and anecdotal) that highlights a problem in implementing an existing policy. Focusing events do not always have to garner widespread publicity: "Sometimes, subjects become prominent agenda items partly because important policy makers have personal experiences that bring the subject to their attention" (Kingdon 1995, 96). Kingdon, like Cobb and Elder, stressed the importance of symbolic politics in advancing agenda items. Central to agenda building are "policy entrepreneurs," who are characterized by their "willingness to invest their resources—time, energy, reputation, and sometimes money—in hope for a future return. That return might come in the form of policies of which they approve, satisfaction from participation, or even personal aggrandizement" (ibid., 122–3).

The early stages of the agenda process may involve a battle over the definition of a problem. The definition of a problem is not a fixed reality, but, rather, a dynamic social construct created by those advancing or opposing an issue. Rochefort and Cobb (1994) emphasized the importance of problem definition both to the advancement of an issue and to setting the guidelines for possible solutions. Thus, a problem's public definition is malleable, as "cultural values, interest group advocacy, scientific information, and professional advice all help to shape the content of problem definition" (ibid., 4). In this case, for example, the declining postpartum length of stay might be seen as testimony to the medical system's sensitivity to a mother's wishes to be home sooner, a reflection of the ability of medical technology to shorten unnecessary hospital stays, or, as it was ultimately viewed, an economic decision imposed on mothers and doctors by greedy insurers.

Is the rapid expansion and speedy adoption of the issue of early discharge unique? There is a noteworthy precedent for rapid expansion of a social issue (child abuse) documented by Nelson (1984), wherein all 50 states adopted child abuse reporting laws within a five-year period. The case of issue expansion in child abuse reporting laws has some parallels with early discharge, in that both involve family issues (including an active role for the Children's Bureau and its successor, the

Maternal and Child Health Bureau); the use of limited public expenditures; the advancement of the issues by "physician experts"; and the extent to which both could easily be publicized through tragic, emotional, and highly personal stories. Perhaps most important, both child abuse reporting laws and early discharge laws might be seen as politically safer alternatives to more fundamental changes: addressing the relation between poverty and child abuse or dealing with Medicaid coverage for pregnant women and children. However, there are some major differences, particularly in the credibility and resources of opponents. Nelson documents little public opposition to reporting laws and, although early discharge laws have advanced and passed with relative ease, there has been opposition from HMOs, insurers, home birth advocates, and professional groups (e.g., nurse-midwives), who questioned their empirical foundation.

Applying Agenda-Building Models to Early Discharge Laws

How well do the models of policy agenda building help explain the extremely rapid expansion of the issue of early postpartum discharge? Before examining the case studies of several states, we will consider, based on the criteria described above, the potential for this issue to move onto the agenda of policy makers. Early discharge as a political issue meets several of the standards described by Cobb and Elder for rapid issue expansion. As noted above, the issue was defined largely by advocates in a way that served their interests: greedy insurers were risking the health of mothers and of our most vulnerable and innocent population, babies. The widespread adoption of the phrase "*early* discharge" was a victory in itself for advocates because it described the problem in a way that suggested mothers and babies might have been sent home prematurely. Keeping the issue narrowly focused on postpartum discharge avoided more difficult choices about funding maternity care for the poor or the efficacy of hospitalized birth in general. With almost four million births annually in the United States (Ventura et al. 1996), the issue has considerable social significance, and it symbolized a much larger one: growing concern that access to quality health care is being limited by HMOs and insurers (Mechanic 1996). Because the issue addresses the health of infants, its potential long-term impact is sub-

stantial. Although the research literature on early discharge is anything but clear, the issue can easily be seen as nontechnical, a matter of "common sense," as its Senate sponsor, Bill Bradley, noted to a national television audience (*Nightline* 1995), while a physician representing a major HMO tried to describe the clinical research supporting his view. Agenda placement of the issue was also helped, echoing Walker's thesis, by having an apparently simple, clearly defined solution: an extra day in the hospital. Another alternative, increased home care, is not so easily defined (when and how often would visits occur? what training would home visitors have?) as a solution and may conflict with cultural predispositions toward privacy in the home. Early discharge also focuses on the fundamental rights of mothers (Annas 1995). The issue has enormous potential to elicit an emotional response from the public, as occured in the case of heavily reported testimony in New Jersey by parents whose baby's life might have been saved with more time in the hospital, or that of the Massachusetts mother whose early discharge might have contributed to her congestive heart failure. The testimony focused on the callous insurers who forced the parents to act against their self-interest, thereby identifying a clear villain. In light of such powerful anecdotal testimony, presentation of national neonatal hospital readmission rates had little impact.

Media coverage played a major role in this case of issue expansion, and the inability of clinical and public health research on early discharge to provide definitive answers only furthered the media's natural tendency to rely on easily personalized anecdotes. The issue was framed as involving mothers, babies, and doctors on one side and faceless insurance bureaucrats on the other, making it a natural for television. Media coverage increased, and *Nightline*, the *Phil Donahue Show*, and *Today* all focused on the issue. *Nightline* opened with the story of a mother "rushed" out of the hospital and a doctor recounting the instruction of her HMO employer: "If I didn't decrease the number of days my patients stayed, I would be out of the system" (*Nightline* 1995, 1). The debate segment featured Senator Bill Bradley and a representative of a major HMO, Dr. Roger Taylor, who talked past each other (while Senator Bradley referred to "common sense," Dr. Taylor touted the positive birth outcomes of HMO patients). The issue of Medicaid coverage was only raised in the final minutes, and when Dr. Taylor challenged Senator Bradley to improve Medicaid coverage for poor women, the Senator replied, "I'm all for that. I mean, in fact we've done that, except they changed Medicaid

and made it into a block grant. So that—that's—we can't do that now" (*Nightline* 1995, 4). Senator Bradley was technically correct about the status of Medicaid negotiations at that point, and he also suggested the political potential of the issue when he noted that an article on early discharge in *Good Housekeeping* included a small coupon to mail to his office as an indication of support for his proposal. His office received 65,000 cards and letters.

Did the expansion of this issue to the policy agenda come about because of the joining of the problem, policy, and political streams described by Kingdon? Despite the ambiguity of the clinical research literature, there was increasing recognition that early discharge was at least a concern, if not a medical problem. The research literature on early discharge developed slowly, in part because, without early discharge programs, there were few cases to study. Nonetheless, the pace of studies picked up rapidly in recent years. A comprehensive review (Braveman et al. 1995) of clinical trials of early discharge documented a total of nine studies prior to 1985 and 20 in the decade from 1985 to 1994. Editorials also began to appear in medical journals attacking early discharge, with titles like "Early Discharge—Early Trouble" (Eidelman 1992). Nelson noted, in her study of the expansion of child abuse as an agenda item, the importance of physicians who, "by virtue of their high status, had easy and early access to officials" (Nelson 1984, 14) and, as described below, physicians played a prominent role in this agenda process. There is little evidence to suggest that medical journal editorials had a direct impact on agenda placement, but they did increase the legitimacy of early discharge as a political issue before 1995. There does not appear to be any clear national focusing event that drew attention to the topic, although state legislative hearings and subsequent legislative debates received considerable local media coverage. However, Kingdon's suggestion about the impact of personal experience proved prophetic, as a number of legislators cited their own personal or family experiences with early discharge.

A community of policy specialists worked to advance this legislation, as the American Association of Pediatricians (AAP), the American College of Obstetrics and Gynecologists (ACOG), and the American Medical Association (AMA) all strongly supported laws on early discharge. The AAP and ACOG have jointly developed guidelines (American College of Obstetrics and Gynecology 1992) for postpartum discharge, and these have been incorporated into many state laws. One might assume

that the option of a mandated extra day in the hospital would have a special appeal to hospital interests because it would represent a way to improve occupancy rates; however, the solution is not so clear, and an unanticipated consequence of early discharge legislation has put some hospitals in a difficult position. In a number of cases, hospitals have significantly reshaped their maternity wings by constructing labor, delivery, recovery, and postpartum rooms (LDRPs), which are the only rooms a mother uses while in the hospital for maternity care. LDRPs are more expensive to construct and maintain than traditional hospital rooms, but with 24- to 48-hour stays, their occupancy turns over so often that they become economically feasible and also serve as a valuable marketing tool for hospitals. Doubling the length of stay has put great pressure on maternity areas to find space for all the mothers.

Early discharge laws did face opposition from some nursing groups, who took positions on this legislation according to whether or not they provided hospital or home care services. Kingdon's observation that policy entrepreneurs may search for problems to solve with their already prepared solutions would seem to apply here. For those (physicians and nurses) associated with hospital-based care, an extra day of hospitalization is a perfectly sensible policy, while those involved in home care see it as a waste of limited resources. As is often the case in health policy issues, self-interest and concern with patients' well-being were likely entangled.

Was the political mood appropriate for such an issue to emerge? The answer depends on timing and on the level of government being examined. Given the frequent criticism that President Clinton's health insurance reform would create too large a government role in health care, there should have been considerable opposition to this legislation, which draws state legislatures into determining the length of a postpartum stay. Early discharge legislation also established a potentially critical precedent. Will the same approach be used to determine a legislatively sanctioned postoperative length of stay for all surgical procedures? Such a debate has already begun concerning mastectomies (Ross 1996). In fact, new state laws generally do not mandate a certain length of stay; rather, they usually require insurers to pay for two to four days if the doctor and/or the mother think it is necessary (how that is determined varies by state); if a mother leaves earlier, she may be entitled to home care.

It is ironic that the timing of the passage of these laws, which are essentially unfunded state mandates, coincided with the Republican

Party's Contract with America, which advocated curtailed government involvement in the private sector and opposed unfunded mandates. How can this contradiction be explained? First, support for the "Republican Revolution" was neither unanimous nor monolithic, and, to an extent, a relatively small policy like early discharge legislation could slip by unnoticed. Second, the legislation did symbolize in a simple, direct way, growing public concern with managed care and with limits on patients' and doctors' rights. Third, in a time of severe budget constraints, an unfunded mandate on a private entity as disliked as insurers has a definite appeal to politicians. They are likely to receive fewer complaints in this instance than in cases of unfunded mandates targeting other levels of government, which result in opposition from governors and mayors. The issue also appears to be a largely middle- and upper-class women's issue, and one that female legislators, who represent a growing force in American state legislatures, played a crucial role in advancing (Thomas 1991; Reingold 1992; Kathlene 1994; Thomas 1994; Conway, Ahern, and Steuernagel 1995). As noted above, in 15 of the 23 states (65 percent) where successful early discharge legislation had a single sponsor, that sponsor was female. Therefore, both general public attitudes and the mood within legislative institutions were perhaps more receptive than they initially appeared.

The models of agenda building illuminate the context in which early discharge became a political issue. The potential for early discharge to emerge onto the agenda was considerable. We will now turn to specific examples from selected states to examine the sources of legislative interest in the issue and how it moved quickly to enactment.

Early Discharge in the States

Maryland was the first state to pass an early discharge law,[1] and the original impetus for enacting it came from the medical community. Specifically, ACOG and AAP representatives approached Senator Delores Kelley, the bill's sponsor, with concerns about their patients being discharged "too soon." The text of the bill was largely written by a lobbyist from AAP, and, unlike the language of future bills, the bill's provisions were flexible. Maryland's original law (it was revised in 1996)

[1]S.B. 677, chap. 502, § 19-1305.4.

applied only to HMOs and private utilization review agents, not Medicaid, had no provisions for implementation or oversight, and did not specify the exact number of hours that must be covered, but, rather, simply referred to the ACOG/AAP *Guidelines for Perinatal Care*. Senator Kelley's constituents did not approach her on the subject until *after* the bill had been announced, at which time they voiced their support.

Early evidence suggested that the new law had no impact on postpartum lengths of stay in the state, and the 1996 revision expanded and strengthened the provisions of the law (Watson 1996). Similarly, the states following Maryland have used progressively more sophisticated language and have significantly increased the scope of their bills. New Jersey, for example, set firm guidelines (the familiar 48-/96-hour standards) for length of stay, and a study of the impact of the law after six months found the average length of stay increasing by 29 percent for vaginal deliveries and by 18 percent for cesarean deliveries (Dato et al. 1996).

In Massachusetts, the nature of the final legislation contrasts sharply with that of Maryland, but its placement on the agenda underwent a similar chronology. The sponsor of the legislation, Senator Lois Pines, received a phone call in late May, 1995, from the director of OB/GYN at Brigham and Women's Hospital in Boston (which, with 8,727 births in 1994, is the busiest maternity care facility in the state), who complained about mothers being sent home early. Pines, married to a physician and long a supporter of women's issues, began exploring the matter with a group of physicians. A late-filed bill was very quickly written to ensure consideration during the 1995 session, was introduced on June 15th (Gordon 1995), and became the topic of a hearing on July 11th. The hearing lasted five hours and drew widespread attention from all Boston media outlets, particularly regarding the testimony of Maggie Mallory. Ms. Mallory described how, despite her request for a longer stay in the hospital after feeling weak subsequent to a cesarean birth, she was forced to leave the hospital after 48 hours. She was later diagnosed with congestive heart failure (Paige 1995). Also testifying on behalf of the bill were the president-elect of ACOG and the president of AAP (both Boston-based physicians). The bill was mildly opposed in public by insurance companies but was substantially revised after a meeting of representatives of various interest groups, including insurers. It was passed on November 13th and signed into law on November 21st by Governor William Weld.

The Massachusetts law, consciously built on the experience of earlier states, was broader than previous state enactments, as it provided coverage for women under Medicaid, all state employee plans and all private insurers, HMOs, and managed care plans. Massachusetts was also the first state to address the ERISA (the Employee Retirement Income Security act of 1974) issue. Because ERISA, a federal law, prohibits states from enacting mandated benefit laws for self-insured employers, states have little control over employers' ERISA plans. This constraint is a significant problem, as some estimates find that over half of all employees work for companies that are fully or partially self-insured (Sullivan and Rice 1990; Mariner 1992). In an attempt to cover as many women as possible, Senator Pines added a hospital mandate to the legislation. This provision required that "no hospital licensed pursuant to this section shall permit early discharge, defined as less than forty-eight hours for a vaginal delivery and ninety-six hours for a cesarean delivery except in accordance with rules and regulations established by the Department of Public Health (DPH)."[2] The safety net this bill intended to create for women insured under ERISA plans is not as stable as it would appear. Hospitals could not discharge women early except in accordance with the DPH rules, but they could charge the mothers for the extra time in the facility. The hospital provision guarantees access to, but not coverage of, 48/96 hours of inpatient care for women in an ERISA plan. The ERISA "loophole" quickly became an issue in a number of states and increased the call for national legislation. The federal legislation, which does not go into effect until January 1, 1998, does address this problem, requiring ERISA plans to meet the 48/96 standards.

Legislative sponsors from the initial adopters and all six New England states were interviewed to address three questions related to agenda building:

1. What was the impetus for their involvement with the legislation?
2. Why propose the new law at this time?
3. What was the cause of the rapid placement on legislative agendas?

Responses to these questions were strikingly similar. All of the legislators became involved either because of their desire to shift control over

[2] *Massachusetts General Laws*, chap. 218 (1996).

medical decisions from insurers back to women and their providers and/or their fear of possibly negative health consequences from early discharge. The general consensus was that legislative action was necessary because insurers would not have acted on their own. One senator suggested, "This legislation will force the insurance companies to rethink their policies." Their comments mirror those put forth by ACOG, one of the major backers of the federal legislation, which stated in its August 1995 newsletter, "For now, legislation appears to be the only way to force insurers to recognize the needs of patients and the clear consensus of physicians on the issue of postpartum hospital stays" (American College of Obstetrics and Gynecology 1995). These parallel arguments are not surprising because representatives of the state chapters of ACOG, and of AAP, have been actively promoting this legislation on both the state and the federal level.

The common thread running through the legislators' answers to questions about why they felt compelled to enact legislation at this time confirmed Kingdon's observation about the impact of a personal experience. For example, all six New England state legislative sponsors were women and mothers who strongly believed that a woman should have the option of recuperating in the hospital. Three are nurses, one is a social worker, one has a daughter whose baby died, and one is the wife of a physician. All participants cited the "horror stories" in the media as a major impetus behind their action, while the three nurses referred to their professional hospital experiences. In one case, the sponsor stated that she had originally heard about early discharge legislation from a more formal source of communication, the magazine of the National Conference of State Legislatures.

Even the sponsors were surprised at the speed of agenda placement and adoption of the legislation. One remarked, "It simply had become the new mantra that everyone picked up on." Public awareness and understanding of the issue, as propelled by the media stories, seem to have played a significant role in the state legislative process; one sponsor included in her definition of public awareness a heightened sense of "the huge salaries the CEO's of managed care companies make." The public popularity of the legislation may also be a reflection of the general decline of trust in medical institutions, particularly managed care and for-profit medicine (Mechanic 1996). The fact that physicians' groups were supporting legislation that did not benefit them, either financially or professionally, in contrast, for example, to debates over malpractice

reform, enhanced their credibility, and the alliance between physicians and patients only further isolated insurers.

By the end of 1996, 28 states (see Appendix and figure 1) had passed legislation mandating insurance coverage for postpartum hospital stays, one other (New Mexico) had adopted comparable insurance regulations, and three more (Arizona, Colorado, and Michigan) had voluntary agreements with insurers. The details of the laws vary from state to state, but most follow AAP/ACOG guidelines, mandating coverage for 48 hours of inpatient care following a vaginal birth and 96 hours following a cesarean. Ten states rejected the legislation; in three states and the District of Columbia legislation was still pending; and in seven states early discharge legislation was never introduced. This activity has occurred within 19 months of the passage of the first state early discharge law.

Figure 1 illustrates a clear regional pattern to the adoption of the legislation; most of the states that adopted new laws were in the eastern half of the country. All states east of the Mississippi had the issue on their legislative calendars by the end of 1996, and three-fourths had adopted an early discharge law. Five of the 13 states west of Texas had not even introduced the legislation, and only three had new laws or regulations. It is therefore in the western region of the country, where postpartum lengths of stay are currently shortest, that legislative actions to lengthen stays are least successful. This distinction may reflect wider acceptance of the policy in that region or the desire of states in the East and the Midwest to prevent further growth of the systems already adopted in the South and the West.

Despite considerable evidence that low-income women are disproportionately at risk for bad health outcomes, and a national debate over Medicaid cuts that might further limit their access to care, concerns about Medicaid mothers did not appear to have been a major part of the drive to pass early discharge laws. Only in eight out of the 23 states for which we have data on Medicaid coverage do the new laws clearly apply to women on Medicaid: Alabama, Georgia, Kentucky, Massachusetts, Missouri, Oklahoma, Tennessee, and Virginia. It is, rather, the voices of insured middle-class women that have been loudest in this debate. Politicians have found this group and their children "telegenic and sympathetic" in a way that allows this issue to serve as a surrogate for more pervasive problems with market-driven medicine (Annas 1995).

Beyond the question of agenda placement, the evolution of state legislation is an interesting study in communication among state policy

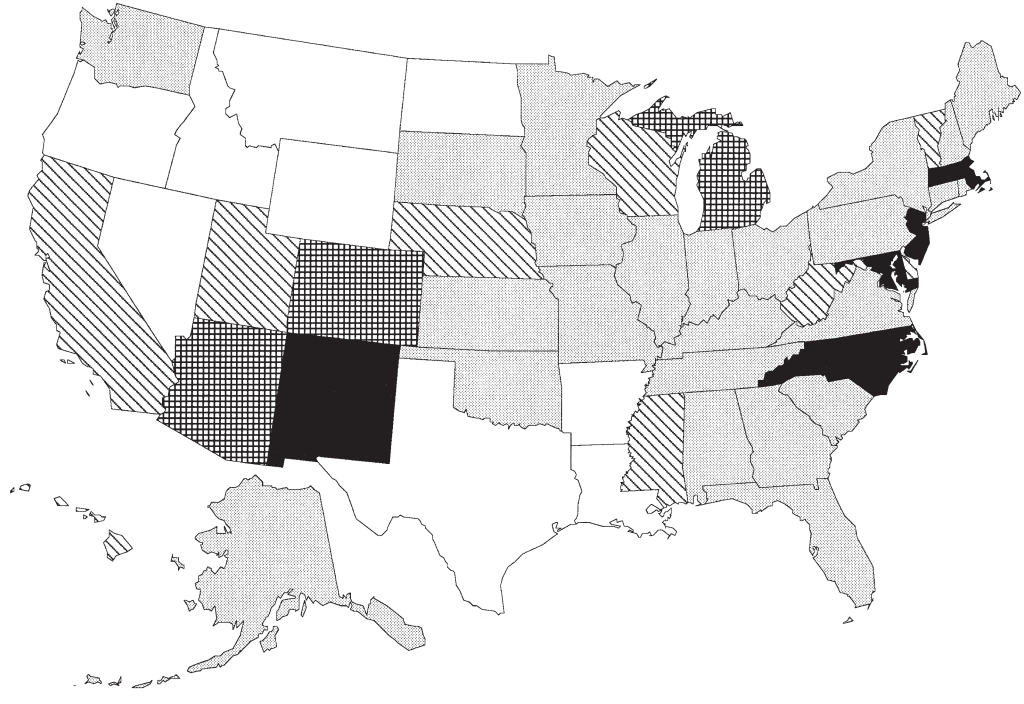

FIG. 1. Status of early discharge laws, December 31, 1996. *Sources*: National Conference of State Legislatures and American College of Obstetrics and Gynecology. ☐ no action; ▨ bill considered but not enacted, 1996; ▦ voluntary agreement; ▩ bill/regulation, 1996; ■ bill/regulation, 1995.

makers. Many learned of the legislation from the actions of earlier adopters. Interstate communication was particularly important in policy formation, as states strengthened their pending legislation based on the experiences and mistakes of the states that had earlier passed a law. There was a distinct evolution in the comprehensiveness of the language of the bills as policy makers became more sensitive to the demands of various interest groups. Walker (1969) was correct in predicting that the growth in the number of groups serving to facilitate communication between legislators would speed adoption of new legislation. Obviously, the increasing speed of communication, on web pages and over fax networks, has also expedited this process.

Discussion

Why did this issue move at such a brisk pace onto state legislative agendas and, in the case of 29 states, become a law or a regulation within the span of 17 months? The success of the legislation was due to a variety of factors that may characterize the immediate future of health policy making in the United States. Early discharge laws involved incremental changes to an existing policy, a simple solution to a problem whose health consequences are unclear, and limited government expenditures. However, these laws were symbolically powerful, reflecting dissatisfaction with insurance companies, institutions disliked almost as much as are elected officials. The legislation united physicians and consumers in common cause, attracted widespread, very positive media coverage, and had powerful appeal to a swing constituency, middle-class female voters ("soccer moms"), in an election year. In contrast, neither the Congress nor the two-thirds of the states that passed early discharge laws included Medicaid coverage in their legislation, ignoring the same poor mothers and babies who were so much a subject of policy debates in 1996. Ironically, at a time when legislators have enormous access to policy-relevant information sources, the research literature could not provide clear support for either side of the issue, so anecdotes and personal experience dominated the debates over the issue. A brief review of each of these factors may suggest lessons that can be learned from early discharge policy development in the states.

The legislation was incremental and simple. It was an incremental response to a health policy problem, reflecting the desire of policy makers

to avoid large, comprehensive health reforms in the wake of the failure to pass the Clinton plan. Consumers could also easily relate to the problem through direct or indirect personal experience with maternity care or with HMOs in general. For the public, the solution to the problem was profoundly simple: more free days in the hospital. Compare a description of this legislation to any attempt to explain the meaning of changes in Medicare funding, and the political appeal of an early discharge law is evident.

The legislation was nonpartisan and appeared to be politically uncontroversial because it called for limited governmental expenditures. Early discharge laws are basically unfunded mandates. Only insurers and hospitals were directly affected financially, and states that did not specifically include Medicaid coverage incurred little direct expense. When we asked bill sponsors whether they viewed these laws as unfunded mandates, they generally avoided using that charged phrase and referred to the insurers' ability to pay and to the fact that consumers are simply getting something they have already paid for. Nonetheless, the fact that the laws did not involve public expenditures meant that legislators who might dislike the substance of the legislation could not hide behind familiar arguments about budget constraints. The legislation's political appeal meant that insurers and HMOs opposing the legislation usually did so at the policy formation stage, seeking to influence legislative language rather than prevent agenda placement or adoption. The failure of the legislation to make further headway in western states may, however, be a function of insurers' ability in those states to keep the issue off the agenda.

The legislation was politically symbolic, capturing the frustration of consumers and physicians with HMOs. The laws represent one of the few victories physicians have had in their recent dealings with managed care organizations, and all those interviewed emphasized the significant role played by physicians' organizations. The legislation also fit physicians' medical model of hospital-based care. There was little discussion in these debates about the actual content of the postpartum care to be provided during those mandated longer hospital stays. This point was effectively raised in the testimony of the American College of Nurse-Midwives (ACNM) before the U.S. Senate on federal early discharge legislation. The problem, they argued, was not early discharge, but the nature of maternity care in general:

> Since nurse-midwives were among the first supporters of early discharge for selected patients with adequate and appropriate mechanisms for follow-up, we know that the problem is *not* timing of discharge. The problem is—what is the patient's condition at discharge and what services are available once a mother arrives home with a newborn baby. It is our position that the current debate and the proposed solution do not address the real problem. *Piecemeal, fear driven solutions are politically attractive and may appear to do no harm. But there is significant risk involved if the problem is not well defined, if solutions do not have a scientific basis, and if passage of legislation gives the impression that the problem has been corrected* (emphasis in original). (U.S. Congress 1995, 72)

The kind of personal anecdotes that dominated this debate also serves the need of both the media and advocates for emotional stories. When there are no clear research findings to put these personal stories in a larger context, and there is no concerted public campaign opposing the legislation, the power of these stories is magnified. The state legislatures' hearings regularly resulted in substantial media coverage focusing on two facts: the declining length of postpartum stays in general and the story of a tragic outcome to illustrate the dangers of this trend. The legislation also appealed to the political constituency seen as swing voters in critical elections in 1996: middle-class, suburban women. The speed of agenda placement was also expedited by female legislators, who constituted two-thirds of the sponsors of bills on this topic.

Systematic research played a limited role in a policy process dominated by personal anecdotes. A reliance on personal experience is hardly a new factor in legislative decision making (Kingdon 1973), but in an era where so many conscious efforts have been made to improve decision making by increasing the information resources of legislators, it is disappointing to see systematic research exerting so little influence. Two factors were critical: First, as noted, the research literature did not produce consistent results in a single direction. Second, the debate reflected a public consensus that longer hospital stays produce better health, leading to the conclusion that an extra day is a positive step. It appears that many of the usual sources of legislative information were used: staff, administrative agencies, and interest groups (Sabatier and Whiteman 1985). However, in the absence of definitive research and with respected interest groups like ACOG and AAP advocating a specific and simple plan that was not self-serving, powerful momentum for the legislation developed.

In light of major battles over balanced budgets and Medicare and Medicaid cuts, early discharge laws can be seen as relatively insignificant legislation. However, the laws thus far passed set some important precedents that may have a much more profound impact on health policy than is currently imagined. Enabling states to alter ERISA provisions is one obvious impact that might have resulted in a precedent-setting court test, had the federal law, which specifically included ERISA plans, not been passed. However, of greater importance in the future may be the degree to which this legislation signals a growing legislative interest in limiting insurers' control over clinical decision making. Insurers are not likely to be as willing to concede future government intrusions into their policies and can use their lack of public opposition to early discharge as an example of their willingness to be reasonable.

Was the passage of early discharge legislation the forerunner of an outpouring of incremental, largely symbolic health legislation targeted at key constituencies? In an era when political debate concerning education policy focuses on school uniforms and communication policy emphasizes V-chips, symbolic political responses are clearly not limited to health policy. As budget cuts further limit the "discretionary agenda" (Walker 1977), legislators may be inclined to turn to regulatory activities and unfunded mandates to prove their commitment to their constituents. With future health policy making likely to be dominated by debates over how much to cut Medicare and Medicaid, legislators will no doubt seek further instances where low cost (financially and politically) actions can be taken against unpopular institutions (i.e., insurers, tobacco companies) to reassure constituents symbolically that they are concerned about their interests.

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Appendix

Status of State Legislation as of December 31, 1996

State	Status
Alabama	*Enacted 5/20/96*
Alaska	*Enacted 5/31/96*
Arizona	Bill died 2/16/96; voluntary agreement with insurers
Arkansas	No action
California	Passed senate/pending house, failed in committee
Colorado	Withdrawn based on agreement with insurers
Connecticut	*Enacted 5/24/96*
Delaware	Pending; resolution approved 6/30/96
District of Columbia	Pending; in committee hearing 4/17/96
Florida	*Enacted 5/22/96*
Georgia	*Enacted 4/2/96*
Hawaii	Bills died 4/11/96
Idaho	No action
Illinois	*Enacted 7/17/96*
Indiana	*Enacted 3/6/96*

State	Status
Iowa	*Enacted 5/30/96*
Kansas	*Enacted 4/2/96*
Kentucky	*Enacted 3/23/96*
Louisiana	No action
Maine	*Enacted 4/5/96*
Maryland	*Enacted 5/25/95; revision 5/14/96*
Massachusetts	*Enacted 11/21/95*
Michigan	Pending in House Insurance Committee; voluntary agreement with insurers
Minnesota	*Enacted 3/20/96*
Mississippi	Bill died 2/6/96
Missouri	*Enacted 6/28/96*
Montana	No action
Nebraska	Bills died 4/18/96
Nevada	No action
New Hampshire	*Enacted 5/13/96*
New Jersey	*Enacted 6/28/95; revisions 2/26/96*
New Mexico	*Regulations issued 11/30/95*
New York	*Enacted 4/15/96*
North Carolina	*Enacted 7/29/95*
North Dakota	No action
Ohio	*Enacted 7/18/96*
Oklahoma	*Enacted 5/14/96*
Oregon	No action
Pennsylvania	*Enacted 7/2/96*
Rhode Island	*Enacted 8/6/96*
South Carolina	*Enacted 5/20/96*
South Dakota	*Enacted 3/14/96*
Tennessee	*Enacted 5/13/96; regulations issued 2/21/96*
Texas	No action
Utah	Passed senate; bill died 2/29/96
Vermont	Bill died 2/23/96
Virginia	*Enacted 3/8/96*
Washington	*Enacted 3/29/96*
West Virginia	Passed senate; bill died in house 3/9/96
Wisconsin	Bill died 5/9/96
Wyoming	No action

Sources: Adapted from data provided by the Maternal and Child Health Office, National Conference of State Legislatures, and ACOG State Government Relations Committee.

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