

Assembly Bill No. 38

Passed the Assembly August 11, 1997

Chief Clerk of the Assembly

Passed the Senate August 4, 1997

Secretary of the Senate

This bill was received by the Governor this ____ day
of _____, 1997, at ____ o'clock __M.

Private Secretary of the Governor



CHAPTER ____

An act to add Section 1367.62 to the Health and Safety Code, and to add Section 10123.87 to the Insurance Code, relating to health coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 38, Figueroa. Health coverage: maternity benefits.

(1) Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Under existing law, a willful violation of any of these provisions is punishable as either a felony or a misdemeanor. Existing law also provides for the regulation of policies of disability insurance administered by the Insurance Commissioner.

Existing law requires that health care service plans and disability insurers provide coverage for certain benefits and services.

This bill would prohibit every health care service plan contract and certain disability insurance policies issued, amended, delivered, or renewed on or after the effective date of the bill, that provide maternity coverage, from restricting benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section, unless specified conditions are met.

The bill would further prohibit these contracts and policies from reducing or limiting the reimbursement of the attending provider for providing care to an individual enrollee or insured in accordance with the coverage requirements; providing monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee or insured in a manner inconsistent with the coverage requirements; denying a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements; providing monetary



payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements; restricting inpatient benefits for the 2nd day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay; and requiring the treating physician to obtain authorization from the health care service plan or insurer prior to prescribing any services covered by this provision. This bill would also require these contracts and policies to include notice of the coverage specified above in the plan's or the insurer's evidence of coverage for evidences of coverage issued on or after January 1, 1998, and to provide additional written notice of this coverage during the course of the enrollee's or insured's prenatal care.

Because a willful violation of the provisions applicable to health care service plans is a crime, this bill would impose a state-mandated local program.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

(3) This bill would also declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares both of the following:

(a) The length of a postdelivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the ability and confidence of the mother and the father to care for their newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate followup health care.



(b) The timing of the discharge of a mother and her newborn child from the hospital should be made by the treating physician in consultation with the mother.

SEC. 2. This act shall be known, and may be cited, as the “Newborns’ and Mothers’ Health Act of 1997.”

SEC. 3. Section 1367.62 is added to the Health and Safety Code, to read:

1367.62. (a) No health care service plan contract that is issued, amended, renewed, or delivered on or after the effective date of the act adding this section, that provides maternity coverage, shall do any of the following:

(1) Restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

(A) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

(B) The contract covers a postdischarge followup visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician office visit, or plan facility visit. The treating physician, in consultation with the mother, shall determine whether the postdischarge visit shall occur at home, the plan’s facility, or the treating physician’s office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.



(2) Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee in accordance with the coverage requirements.

(3) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee in a manner inconsistent with the coverage requirements.

(4) Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.

(5) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.

(6) Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.

(7) Require the treating physician to obtain authorization from the health care service plan prior to prescribing any services covered by this section.

(b) (1) Every health care service plan contract, except as specified in paragraph (2), shall include notice of the coverage specified in subdivision (a) in the plan's evidence of coverage for evidences of coverage issued on or after January 1, 1998, and shall provide additional written notice of this coverage during the course of the enrollee's prenatal care. The contract may require the treating physician or the enrollee's medical group to provide this additional written notice of coverage during the course of the enrollee's prenatal care.

(2) Health care service plans that negotiate and enter into a contract with professional providers to provide services at alternative rates of payment of the type described in Section 10133 of the Insurance Code shall notify subscribers of the coverage under subdivision (a) within 60 days of the effective date of this act. The plan shall provide additional written notice of the coverage specified in subdivision (a) during the course of prenatal care if both of the following conditions are met:



(A) The plan previously notified subscribers that hospital stays for delivery would be inconsistent with the requirement in subparagraph (A) of paragraph (1) of subdivision (a).

(B) The plan received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the enrollee is pregnant.

(c) Nothing in this section shall be construed to prohibit a plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

SEC. 4. Section 10123.87 is added to the Insurance Code, to read:

10123.87. (a) No individual or group policy of disability insurance that provides coverage for hospital, medical, and surgical benefits that is issued, amended, renewed, or delivered on or after the effective date of the act adding this section, that provides maternity coverage, shall do any of the following:

(1) Restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

(A) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

(B) The policy covers a postdischarge followup visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician



office visit, or a visit to a facility under contract with the insurer. The treating physician, in consultation with the mother, shall determine whether the postdischarge visit shall occur at home, the contracted facility, or the treating physician's office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.

(2) Reduce or limit the reimbursement of the attending provider for providing care to an individual insured in accordance with the coverage requirements.

(3) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual insured in a manner inconsistent with the coverage requirements.

(4) Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.

(5) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.

(6) Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.

(7) Require the treating physician to obtain authorization from the insurer prior to prescribing any services covered by this section.

(b) (1) Every individual or group policy of disability insurance that provides coverage for hospital, medical, and surgical benefits shall include notice of the coverage specified in subdivision (a) in the insurer's evidence of coverage or certificate of insurance for evidences of coverage or certificates of insurance issued on or after January 1, 1998.

(2) Every insurer that issues a policy of disability insurance under paragraph (1) shall notify policyholders of the coverage under subdivision (a) within 60 days of the effective date of this act. The insurer shall provide additional written notice of the coverage specified in



subdivision (a) during the course of prenatal care if both of the following conditions are met:

(A) The insurer previously notified policyholders that hospital stays for delivery would be inconsistent with the requirement in subparagraph (A) of paragraph (1) of subdivision (a).

(B) The insurer received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the insured is pregnant.

(c) Nothing in this section shall be construed to prohibit an insurer from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

SEC. 6. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the health of mothers and their newborns at the earliest possible time, it is necessary that this act take effect immediately.



Approved _____, 1997

Governor

