1	SENATE BILL NO. 34
2	INTRODUCED BY NELSON
3	BY REQUEST OF THE STATE AUDITOR
4	
5	A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM
6	HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A
7	DELAYED EFFECTIVE DATE."
8	
9	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
10	
11	NEW SECTION. Section 1. Coverage for minimum hospital stay following childbirth. (1) For the
12	purposes of this section, "attending health care provider" means a person licensed under Title 37 who is
13	responsible for providing obstetrical and pediatric care to a mother and newborn infant.
14	(2) Each group or individual policy, certificate of disability insurance, subscriber contract,
15	membership contract, or health care services agreement that provides coverage for maternity services,
16	including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care
17	following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean
18.	section for a mother and newborn infant in a health care facility as defined in 50-5-101.
19	(3) A decision to shorten the length of inpatient stay to less than that provided under subsection
20	(2) must be made by the attending health care provider and the mother. A health benefit plan, as defined
21	in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise
22	provide financial disincentives to an attending health care provider in response to orders by the attending
23	health care provider for care consistent with the provisions of this section.
24	(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother
25	and newborn infant in the home may not be required to provide coverage of inpatient care under subsection
26	(2) unless the inpatient care is determined to be medically necessary by the attending health care provider.
27	(5) A health benefit plan must provide written notice, in a manner consistent with the provisions
28	of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.
2 9	
30	Section 2. Section 33-31-301, MCA, is amended to read:



1 "33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) Each 2 enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization 3 shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance 4 policy issued by an insurer or a contract issued by a health service corporation, whether by option or 5 otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

6 (2) A health maintenance organization may not issue or deliver an enrollment form, an evidence 7 of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this 8 state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved 9 enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain
 a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence
 of coverage must contain:

13 (a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate,
14 of:

15 (i) the health care services and the insurance or other benefits, if any, to which the enrollee is16 entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any
 deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may
be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if
 any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for
 resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

30



(c) clear disclosure of each provision that limits benefits or access to service in the exclusions,

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1 limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and 2 exceptions that must be disclosed include but are not limited to: 3 (i) emergency and urgent care; (ii) restrictions on the selection of primary or referral providers; 4 (iii) restrictions on changing providers during the contract period; 5 6 (iv) out-of-pocket costs, including copayments and deductibles; 7 (v) charges for missed appointments or other administrative sanctions; 8 (vi) restrictions on access to care if copayments or other charges are not paid; and (vii) any restrictions on coverage for dependents who do not reside in the service area. 9 (d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease 10 treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and 11 12 nervous and mental disorders; 13 (e) a provision requiring immediate accident and sickness coverage, from and after the moment of 14 birth, to each newborn infant of an enrollee or the enrollee's dependents; 15 (f) a provision providing coverage as required in [section 1]; 16 (f)(g) a provision requiring medical treatment and referral services to appropriate ancillary services 17 for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however: 18 19 (i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary 20 services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit 21 the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary 22 services for mental illness, alcoholism, or drug addiction; 23 (ii) if an enrollee chooses a provider other than the health maintenance organization provider for 24 treatment and referral services, the enrollee's designated provider shall limit treatment and services to the 25 scope of the referral in order to receive payment from the health maintenance organization; 26 (iii) the amount paid by the health maintenance organization to the enrollee's designated provider 27 may not exceed the amount paid by the health maintenance organization to one of its providers for 28 equivalent treatment or services; 29 (iv) the provisions of this subsection (3)(f) (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6; 30



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1 (g)(h) a provision as follows:
2 "Conformity With State Statutes: Any provision of this evidence of coverage that on its effective
3 date is in conflict with the statutes of the state in which the insured resides on that date is amended to
4 conform to the minimum requirements of those statutes."
5 (h)(i) a provision that the health maintenance organization shall issue, without evidence of
6 insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee,

7 dependents, or family members:

8 (i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members 9 covered under the evidence of coverage ceases because of termination of employment or termination of 10 membership in the class or classes eligible for coverage under the policy or because the employer 11 discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months
 preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group
 coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by
 the group contract from which the enrollee converts.

17 (i)(j) a provision that clearly describes the amount of money an enrollee shall pay to the health
 18 maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage
 in a separate document if the separate document is filed with and approved by the commissioner and issued
 to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.



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1 (c) If a health maintenance organization requires payment of a specific fee to provide coverage of 2 a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain 3 a provision that requires notification to the health maintenance organization, within 31 days after the date 4 of birth, of the birth of an infant and payment of the required fee.

5 (6) A health maintenance organization may not use a schedule of charges for enrollee coverage for 6 health care services or an amendment to a schedule of charges before it files a copy of the schedule of 7 charges or the amendment to it with the commissioner. A health maintenance organization may evidence 8 a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The 9 charges in the schedule must be established in accordance with actuarial principles for various categories 10 of enrollees, except that charges applicable to an enrollee may not be individually determined based on the 11 status of the enrollee's health.

12 (7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) 13 through (5) are met. A health maintenance organization may not issue a form before the commissioner 14 approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the 15 notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a 16 hearing within 30 days after receipt of a written request by the filer.

17 (8) The commissioner may require a health maintenance organization to submit any relevant
18 information considered necessary in determining whether to approve or disapprove a filing made pursuant
19 to this section."

20

21 <u>NEW SECTION.</u> Section 3. Coverage for minimum hospital stay following childbirth. (1) For the 22 purposes of this section, "attending health care provider" means a person licensed under Title 37 who is 23 responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) Each disability insurance plan or group disability insurance plan that is delivered, issued for
delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage
for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of
inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by
cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection
(2) must be made by the attending health care provider and the mother. A health services corporation may



- 5 -

not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

4

4 (4) A membership contract that provides coverage for postdelivery care that is provided to a 5 mother and newborn infant in the home may not be required to provide coverage of inpatient hospital care 6 under subsection (2) unless the inpatient hospital care is determined to be medically necessary by the 7 attending health care provider.

8 (5) A health service corporation must provide written notice, in a manner consistent with the 9 provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subscribers regarding the 10 coverage required by this section.

11

12 <u>NEW SECTION.</u> Section 4. Codification instruction. (1) [Section 1] is intended to be codified as 13 an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to 14 [section 1].

15 (2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and 16 the provisions of Title 33, chapter 30, part 10, apply to [section 3].

17

18 <u>NEW SECTION.</u> Section 5. Effective date. [This act] is effective January 1, 1998.

19

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0034, as revised

DESCRIPTION OF PROPOSED LEGISLATION:

An act requiring insurance coverage for a minimum hospital stay following childbirth.

ASSUMPTIONS:

State Auditor's Office:

- 1. There are approximately 750 health care policies that will be amended. It is estimated that one-half of these policies will be updated with an endorsement at \$10 per endorsement, and that the other half of these policies will be rewritten at \$25 per policy. This will be a one-time fee and one-time revenue to the general fund in fiscal year 1998 estimated to be \$13,125.
- The State Auditor's Office will process these endorsements and rewritten policies through payment of an estimated 200 hours of staff overtime estimated at a cost of \$5,428.
- 3. Complaints to the State Auditor's Policyholders Service Bureau may increase due to noncompliance of this bill by health insurance providers. This possible increase in complaints will be absorbed by existing staff.

Department of Public Health and Human Services (DPHHS):

- 4. The effective date of this bill will be January 1, 1998.
- 5. The state Medicaid program covers approximately 4,000 deliveries per year.
- 6. In fiscal year 1998, Medicaid will cover only 2,000 births due to the effective date of bill.
- 7. It is estimated that 10 percent of the delivery claims, 200 in fiscal year 1998 and 400 in fiscal year 1999, will include one extra hospital day.
- 8. Both the mother and child will stay an extra day. Therefore, the estimated number of covered days will be twice the number of claims estimated in assumption 7 (200 x 2 = 400 in fiscal year 1998 and 400 x 2 = 800 in fiscal year 1999).
- 9. The FMAP rates used for Medicaid funding are 29.83 percent general fund in fiscal year 1998 and 28.88 percent general fund in fiscal year 1999.
- 10. It is assumed that the average cost per day to Medicaid is \$500. The total estimated cost to Medicaid is \$200,000 (400 x \$500, with \$59,660 of that cost as general fund) in fiscal year 1998 and \$400,000 (800 x \$500, with \$115,520 of that cost as general fund) in fiscal 1999. This cost will be a responsibility of the department due to the passage of federal legislation, and is not shown as a cost to this proposed legislation. This additional cost will be reflected in the Medicaid estimates for the department.

FISCAL IMPACT:

	FY98	FY99
<u>State Auditor's O</u> ffice Expenditures:	Difference	Difference
Personal Services	5,428	0
<u>Funding:</u> General Fund (01)	5,428	0
<u>Revenues:</u> Policy endorsements (01)	13,125	. 0
<u>Net Impact on Fund Balance:</u> (Revenue General fund (01)	ninus expense) 7,697	0

DAVE LEWIS, BUDGET DIRECTOR

LINDA NELSON, PRIMARY SPONSOR Fiscal Note for <u>SB0034</u>, as revised

5B 3

Office of Budget and Program Planning

1	SENATE BILL NO. 34
2	INTRODUCED BY NELSON
3	BY REQUEST OF THE STATE AUDITOR
4	
5	A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM
6	HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A
7	DELAYED EFFECTIVE DATE."
8	
9	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
10	
11 -	NEW SECTION. Section 1. Coverage for minimum hospital stay following childbirth. (1) For the
12	purposes of this section, "attending health care provider" means a person licensed under Title 37 who is
13	responsible for providing obstetrical and pediatric care to a mother and newborn infant.
14	(2) Each group or individual policy, certificate of disability insurance, subscriber contract,
15	membership contract, or health care services agreement that provides coverage for maternity services,
16	including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care
17	following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean
18	section for a mother and newborn infant in a health care facility as defined in 50-5-101.
19	(3) A decision to shorten the length of inpatient stay to less than that provided under subsection
20	(2) must be made by the attending health care provider and the mother. A health benefit plan, as defined
21	in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise
22	provide financial disincentives to an attending health care provider in response to orders by the attending
23	health care provider for care consistent with the provisions of this section.
24	(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother
25	and newborn infant in the home may not be required to provide coverage of inpatient care under subsection
26	(2) unless the inpatient care is determined to be medically necessary by the attending health care provider.
27	(5) A health benefit plan must provide written notice, in a manner consistent with the provisions
28	of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.
29	
30	Section 2. Section 33-31-301, MCA, is amended to read:

- 1 -

1 "33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) Each 2 enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization 3 shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance 4 policy issued by an insurer or a contract issued by a health service corporation, whether by option or 5 otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

6 (2) A health maintenance organization may not issue or deliver an enrollment form, an evidence 7 of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this 8 state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved 9 enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain
 a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence
 of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate,
of:

15 (i) the health care services and the insurance or other benefits, if any, to which the enrollee is16 entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any
 deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services maybe obtained;

21 (iv) the total amount of payment for health care services and the indemnity or service benefits, if

any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for
 resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

30



(c) clear disclosure of each provision that limits benefits or access to service in the exclusions,

1 limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and 2 exceptions that must be disclosed include but are not limited to: 3 (i) emergency and urgent care; 4 (ii) restrictions on the selection of primary or referral providers; 5 (iii) restrictions on changing providers during the contract period; 6 (iv) out-of-pocket costs, including copayments and deductibles; 7 (v) charges for missed appointments or other administrative sanctions; 8 (vi) restrictions on access to care if copayments or other charges are not paid; and 9 (vii) any restrictions on coverage for dependents who do not reside in the service area. 10 (d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and 11 12 nervous and mental disorders; 13 (e) a provision requiring immediate accident and sickness coverage, from and after the moment of 14 birth, to each newborn infant of an enrollee or the enrollee's dependents; 15 (f) a provision providing coverage as required in [section 1]; 16 (f)(g) a provision requiring medical treatment and referral services to appropriate ancillary services 17 for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and 18 coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary
 services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit
 the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary
 services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for
 treatment and referral services, the enrollee's designated provider shall limit treatment and services to the
 scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider
 may not exceed the amount paid by the health maintenance organization to one of its providers for
 equivalent treatment or services;

(iv) the provisions of this subsection (3)(f) (3)(g) do not apply to services for mental illness provided
 under the Montana medicaid program as established in Title 53, chapter 6;



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(g)(h) a provision as follows: 1 2 "Conformity With State Statutes: Any provision of this evidence of coverage that on its effective 3 date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes." 4 5 (h)(i) a provision that the health maintenance organization shall issue, without evidence of 6 insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, 7 dependents, or family members: 8 (i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members 9 covered under the evidence of coverage ceases because of termination of employment or termination of 10 membership in the class or classes eligible for coverage under the policy or because the employer 11 discontinues the business or the coverage; 12 (ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months 13 preceding the termination of group coverage; and 14 (iii) if the enrollee applied for continuing coverage within 31 days after the termination of group 15 coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by 16 the group contract from which the enrollee converts. 17 (ii) a provision that clearly describes the amount of money an enrollee shall pay to the health 18 maintenance organization to be covered for basic health care services. 19 (4) A health maintenance organization may amend an enrollment form or an evidence of coverage 20 in a separate document if the separate document is filed with and approved by the commissioner and issued 21 to the enrollee. 22 (5) (a) A health maintenance organization shall provide the same coverage for newborn infants. 23 required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be 24 no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce

benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is
 consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this
state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and
sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the
moment of birth.



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1 (c) If a health maintenance organization requires payment of a specific fee to provide coverage of 2 a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain 3 a provision that requires notification to the health maintenance organization, within 31 days after the date 4 of birth, of the birth of an infant and payment of the required fee.

5 (6) A health maintenance organization may not use a schedule of charges for enrollee coverage for 6 health care services or an amendment to a schedule of charges before it files a copy of the schedule of 7 charges or the amendment to it with the commissioner. A health maintenance organization may evidence 8 a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The 9 charges in the schedule must be established in accordance with actuarial principles for various categories 10 of enrollees, except that charges applicable to an enrollee may not be individually determined based on the 11 status of the enrollee's health.

12 (7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) 13 through (5) are met. A health maintenance organization may not issue a form before the commissioner 14 approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the 15 notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a 16 hearing within 30 days after receipt of a written request by the filer.

17 (8) The commissioner may require a health maintenance organization to submit any relevant
 18 information considered necessary in determining whether to approve or disapprove a filing made pursuant
 19 to this section."

20

21 <u>NEW SECTION.</u> Section 3. Coverage for minimum hospital stay following childbirth. (1) For the 22 purposes of this section, "attending health care provider" means a person licensed under Title 37 who is 23 responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) Each disability insurance plan or group disability insurance plan that is delivered, issued for
delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage
for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of
inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by
cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection
(2) must be made by the attending health care provider and the mother. A health services corporation may



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not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

4 (4) A membership contract that provides coverage for postdelivery care that is provided to a 5 mother and newborn infant in the home may not be required to provide coverage of inpatient hospital care 6 under subsection (2) unless the inpatient hospital care is determined to be medically necessary by the 7 attending health care provider.

8 (5) A health service corporation must provide written notice, in a manner consistent with the 9 provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subscribers regarding the 10 coverage required by this section.

11

12 <u>NEW SECTION.</u> Section 4. Codification instruction. (1) [Section 1] is intended to be codified as 13 an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to 14 [section 1].

15 (2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and 16 the provisions of Title 33, chapter 30, part 10, apply to [section 3].

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18. <u>NEW SECTION</u>, Section 5. Effective date. [This act] is effective January 1, 1998.

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-END-

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1	SENATE BILL NO. 34
2	INTRODUCED BY NELSON
3	BY REQUEST OF THE STATE AUDITOR
4	
5	A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM
6	HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A
7	DELAYED EFFECTIVE DATE."
8	
9	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
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11	NEW SECTION. Section 1. Coverage for minimum hospital stay following childbirth. (1) For the
12	purposes of this section, "attending health care provider" means a person licensed under Title 37 who is
13	responsible for providing obstetrical and pediatric care to a mother and newborn infant.
14	(2) Each group or individual policy, certificate of disability insurance, subscriber contract,
15	membership contract, or health care services agreement that provides coverage for maternity services,
16	including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care
17	following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean
18	section for a mother and newborn infant in a health care facility as defined in 50-5-101.
19	(3) A decision to shorten the length of inpatient stay to less than that provided under subsection
20	(2) must be made by the attending health care provider and the mother. A health benefit plan, as defined
21	in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise
22	provide financial disincentives to an attending health care provider in response to orders by the attending
23	health care provider for care consistent with the provisions of this section.
24	(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother
25	and newborn infant in the home may not be required to provide coverage of inpatient care under subsection
26	(2) unless the inpatient care is determined to be medically necessary by the attending health care provider.
27	(5) A health benefit plan, AS DEFINED IN 33-22-243, must provide written notice, in a manner
28	consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the
29	coverage required by this section.
30	



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Section 2. Section 33-31-301, MCA, is amended to read:

2 "33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) Each 3 enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization 4 shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance 5 policy issued by an insurer or a contract issued by a health service corporation, whether by option or 6 otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

7 (2) A health maintenance organization may not issue or deliver an enrollment form, an evidence 8 of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this 9 state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved 10 enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain
 a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence
 of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate,
of:

16 (i) the health care services and the insurance or other benefits, if any, to which the enrollee is
17 entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any
 deductible or copayment feature;

20 (iii) the location at which and the manner in which information is available as to how services may
21 be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if
any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for
 resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.



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1	(c) clear disclosure of each provision that limits benefits or access to service in the exclusions,
2	limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and
3	exceptions that must be disclosed include but are not limited to:
4	(i) emergency and urgent care;
5	(ii) restrictions on the selection of primary or referral providers;
6	(iii) restrictions on changing providers during the contract period;
7	(iv) out-of-pocket costs, including copayments and deductibles;
8	(v) charges for missed appointments or other administrative sanctions;
9	(vi) restrictions on access to care if copayments or other charges are not paid; and
× 10	(vii) any restrictions on coverage for dependents who do not reside in the service area.
11	(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease
12	treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and
13	nervous and mental disorders;
14	(e) a provision requiring immediate accident and sickness coverage, from and after the moment of
15	birth, to each newborn infant of an enrollee or the enrollee's dependents;
16	(f) a provision providing coverage as required in [section 1];
17	(f)(g) a provision requiring medical treatment and referral services to appropriate ancillary services
18	for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and
19	coverage provided in Title 33, chapter 22, part 7; however:
20	(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary
21	services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit
22	the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary
23	services for mental illness, alcoholism, or drug addiction;
24	(ii) if an enrollee chooses a provider other than the health maintenance organization provider for
25	treatment and referral services, the enrollee's designated provider shall limit treatment and services to the
26	scope of the referral in order to receive payment from the health maintenance organization;
27	(iii) the amount paid by the health maintenance organization to the enrollee's designated provider
28	may not exceed the amount paid by the health maintenance organization to one of its providers for
29	equivalent treatment or services;
30	(iv) the provisions of this subsection (3)(f) (3)(g) do not apply to services for mental illness provided



1 under the Montana medicaid program as established in Title 53, chapter 6;

2 (g)(h) a provision as follows:

3 "Conformity With State Statutes: Any provision of this evidence of coverage that on its effective 4 date is in conflict with the statutes of the state in which the insured resides on that date is amended to 5 conform to the minimum requirements of those statutes."

6 (h)(i) a provision that the health maintenance organization shall issue, without evidence of
7 insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee,
8 dependents, or family members:

9 (i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members 10 covered under the evidence of coverage ceases because of termination of employment or termination of 11 membership in the class or classes eligible for coverage under the policy or because the employer 12 discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months
preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group
coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by
the group contract from which the enrollee converts.

18 (i)(i) a provision that clearly describes the amount of money an enrollee shall pay to the health
 19 maintenance organization to be covered for basic health care services.

20 (4) A health maintenance organization may amend an enrollment form or an evidence of coverage
21 in a separate document if the separate document is filed with and approved by the commissioner and issued
22 to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this
 state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and
 sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the



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1 moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of
a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain
a provision that requires notification to the health maintenance organization, within 31 days after the date
of birth, of the birth of an infant and payment of the required fee.

6 (6) A health maintenance organization may not use a schedule of charges for enrollee coverage for 7 health care services or an amendment to a schedule of charges before it files a copy of the schedule of 8 charges or the amendment to it with the commissioner. A health maintenance organization may evidence 9 a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The 10 charges in the schedule must be established in accordance with actuarial principles for various categories 11 of enrollees, except that charges applicable to an enrollee may not be individually determined based on the 12 status of the enrollee's health.

13 (7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) 14 through (5) are met. A health maintenance organization may not issue a form before the commissioner 15 approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the 16 notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a 17 hearing within 30 days after receipt of a written request by the filer.

(8) The commissioner may require a health maintenance organization to submit any relevant
 information considered necessary in determining whether to approve or disapprove a filing made pursuant
 to this section."

21

<u>NEW SECTION.</u> Scotion 3. Coverage for minimum hospital stay following childbirth. (1) For the
 purposes of this section, "attending health care provider" means a person licensed under Title 37 who is
 responsible for providing obstetrical and podiatric care to a mother and newborn infant.

25 (2) Each disability insurance plan or group disability insurance plan that is delivered, issued for
 26 delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage
 27 for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of
 28 inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by
 29 cesarean section for a mother and newborn infant in a health care facility as defined in 50 5-101.

30



(3) A decision to shorten the length of inpatient stay to loss than that provided under subsection

1 (2) must be made by the attending health care provider and the mother. A health services corporation may 2 not terminate the service of an attending health care provider or penalize or otherwise provide financial 3 disincentives to an attending health care provider in response to orders by the attending health care 4 provider for care consistent with the provisions of this section. 5 (4) A membership contract that provides coverage for postdelivery care that is provided to a 6 mother and newborn infant in the home may not be required to provide coverage of inpatient hospital care 7 under subsection (2) unless the inpatient-hospital care is determined to be medically necessary by the 8 attending health care provider. 9 (5) A health service corporation must provide written notice, in a manner consistent with the 10 provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subseribers regarding the 11 eoverage required by this section. 12 13 NEW SECTION. Section 3. Codification instruction. (1) [Section 1] is intended to be codified as 14 an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to 15 [section 1]. 16 (2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and 17 the provisions of Title 33, chapter 30, part 10, apply to [section 3]. 18 19 NEW SECTION. Section 4. Effective date. [This act] is effective January 1, 1998. 20 -END-

Legislative Services Division

1	SENATE BILL NO. 34
2	INTRODUCED BY NELSON
3	BY REQUEST OF THE STATE AUDITOR
4	
5	A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM
6	HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A
7	DELAYED EFFECTIVE DATE."
. 8	

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

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THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO THIRD READING COPY (BLUE) FOR COMPLETE TEXT.

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 in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section. (4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider. (5) A health benefit plan, AS DEFINED IN 33-22-243, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section. 	19	(3) A decision to shorten the length of inpatient stay to less than that provided under subsection
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 health care provider for care consistent with the provisions of this section. (4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider. (5) A health benefit plan, <u>AS DEFINED IN 33-22-243</u>, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section. 	21	in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise
 (4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider. (5) A health benefit plan, <u>AS DEFINED IN 33-22-243</u>, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section. 	22	provide financial disincentives to an attending health care provider in response to orders by the attending
 and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider. (5) A health benefit plan, <u>AS DEFINED IN 33-22-243</u>, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section. 	23	health care provider for care consistent with the provisions of this section.
 (2) unless the inpatient care is determined to be medically necessary by the attending health care provider. (5) A health benefit plan, <u>AS DEFINED IN 33-22-243</u>, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section. 	24	(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother
 (5) A health benefit plan, <u>AS DEFINED IN 33-22-243</u>, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section. 	25	and newborn infant in the home may not be required to provide coverage of inpatient care under subsection
consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.	26	(2) unless the inpatient care is determined to be medically necessary by the attending health care provider.
29 coverage required by this section.	27	(5) A health benefit plan, AS DEFINED IN 33-22-243, must provide written notice, in a manner
• • •	28	consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the
30	29	coverage required by this section.
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Section 2. Section 33-31-301, MCA, is amended to read:

2 "33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) Each 3 enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization 4 shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance 5 policy issued by an insurer or a contract issued by a health service corporation, whether by option or 6 otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

7 (2) A health maintenance organization may not issue or deliver an enrollment form, an evidence 8 of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this 9 state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved 10 enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain
 a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence
 of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate,
of:

16 (i) the health care services and the insurance or other benefits, if any, to which the enrollee is17 entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any
 deductible or copayment feature;

20 (iii) the location at which and the manner in which information is available as to how services may
21 be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if
any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for
 resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.



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1 (c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and 2 3 exceptions that must be disclosed include but are not limited to: 4 (i) emergency and urgent care; 5 (ii) restrictions on the selection of primary or referral providers; (iii) restrictions on changing providers during the contract period; 6 (iv) out-of-pocket costs, including copayments and deductibles; 7 (v) charges for missed appointments or other administrative sanctions; 8 9 (vi) restrictions on access to care if copayments or other charges are not paid; and (vii) any restrictions on coverage for dependents who do not reside in the service area. · 10 11 (d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and 12 nervous and mental disorders; 13 14 (e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents; 15 16 (f) a provision providing coverage as required in [section 1]; 17 (f) a provision requiring medical treatment and referral services to appropriate ancillary services 18 for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and 19 coverage provided in Title 33, chapter 22, part 7; however: 20 (i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary 21 services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit 22 the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary 23 services for mental illness, alcoholism, or drug addiction; 24 (ii) if an enrollee chooses a provider other than the health maintenance organization provider for 25 treatment and referral services, the enrollee's designated provider shall limit treatment and services to the 26 scope of the referral in order to receive payment from the health maintenance organization; 27 (iii) the amount paid by the health maintenance organization to the enrollee's designated provider 28 may not exceed the amount paid by the health maintenance organization to one of its providers for

29 equivalent treatment or services;

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(iv) the provisions of this subsection (3)(f) (3)(g) do not apply to services for mental illness provided



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1 under the Montana medicaid program as established in Title 53, chapter 6;

2 (g)(h) a provision as follows:

3 "Conformity With State Statutes: Any provision of this evidence of coverage that on its effective
4 date is in conflict with the statutes of the state in which the insured resides on that date is amended to
5 conform to the minimum requirements of those statutes."

(h)(i) a provision that the health maintenance organization shall issue, without evidence of
 insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee,
 dependents, or family members:

9 (i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members 10 covered under the evidence of coverage ceases because of termination of employment or termination of 11 membership in the class or classes eligible for coverage under the policy or because the employer 12 discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months
 preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group
coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by
the group contract from which the enrollee converts.

18 (i)(i) a provision that clearly describes the amount of money an enrollee shall pay to the health
 19 maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage
 in a separate document if the separate document is filed with and approved by the commissioner and issued
 to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this
state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and
sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the



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1 moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of
a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain
a provision that requires notification to the health maintenance organization, within 31 days after the date
of birth, of the birth of an infant and payment of the required fee.

6 (6) A health maintenance organization may not use a schedule of charges for enrollee coverage for 7 health care services or an amendment to a schedule of charges before it files a copy of the schedule of 8 charges or the amendment to it with the commissioner. A health maintenance organization may evidence 9 a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The 10 charges in the schedule must be established in accordance with actuarial principles for various categories 11 of enrollees, except that charges applicable to an enrollee may not be individually determined based on the 12 status of the enrollee's health.

13 (7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) 14 through (5) are met. A health maintenance organization may not issue a form before the commissioner 15 approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the 16 notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a 17 hearing within 30 days after receipt of a written request by the filer.

(8) The commissioner may require a health maintenance organization to submit any relevant
 information considered necessary in determining whether to approve or disapprove a filing made pursuant
 to this section."

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22 <u>NEW-SECTION.</u> Section 3. Coverage for minimum hospital stay following shildbirth. (1) For the 23 purposes of this section, "attending health care provider" means a person licensed under Title 37 who is 24 responsible for providing obstetrical and pediatric care to a methor and newborn infant.

25 (2) Each disability insurance plan or group disability insurance plan that is delivered, issued for
 26 delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage
 27 for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of
 28 inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by
 29 cesarean section for a mother and newborn infant in a health care facility as defined in 50 5-101.

30 (3) A decision to shorton the length of inpatient stay to loss than that provided under subsection



(2) must be made by the attending health care provider and the mother. A health services corporation may 1 not terminate the service of an attending health care provider or penalize or otherwise provide financial 2 3 disincentives to an attending health care provider in response to orders by the attending health care 4 provider for eare consistent with the provisions of this section. 5 (4) A membership contract that provides coverage for postdelivery care that is provided to a 6 mother and newborn infant in the home may not be required to provide coverage of inpatient hospital care 7 under-subsection (2) unless the inpatient hospital care is determined to be medically necessary by the 8 attending health care provider. 9 (5) A health service corporation must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subscribers regarding the 10 11 ooverage required by this section. 12 13 NEW SECTION. Section 3. Codification instruction. (1) [Section 1] is intended to be codified as 14 an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to 15 [section 1]. 16 (2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and 17 the provisions of Title 33, chapter 30, part 10, apply to [section 3]. 18 19 NEW SECTION. Section 4. Effective date. [This act] is effective January 1, 1998. -END-

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