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104TH CONGRESS
2D SESSION

H. R. 3226

To require that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 29, 1996

Mr. SOLOMON (for himself and Mr. MILLER of California) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Economic and Educational Opportunities, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To require that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Newborns' and Mothers' Health Protection Act of 1996''.

SEC. 2. FINDING.

Congress finds that—

(1) the length of post-delivery inpatient care 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 infant, the ability and confidence of the mother to care for her infant, the adequacy of support systems at home, and the access of the mother and infant to appropriate follow-up health care; and

(2) the timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother.

SEC. 3. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOLLOWING BIRTH.

(a) IN GENERAL.—Except as provided in subsection (b), a health plan or an employee health benefit plan that provides maternity benefits, including benefits for childbirth, shall ensure that coverage is provided with respect to a mother who is a participant, beneficiary, or policyholder under such plan and her newborn child for a minimum of 48 hours of in-patient care following a normal vaginal delivery, and a minimum of 96 hours of in-patient care following a caesarean section, without requiring the attending provider to obtain authorization from the health

plan or employee health benefit plan in order to keep a mother and her newborn child in the inpatient setting for such period of time.

(b) EXCEPTION.—Notwithstanding subsection (a), a health plan or an employee health benefit plan shall not be required to provide coverage for post-delivery in-patient care for a mother who is a participant, beneficiary, or policyholder under such plan and her newborn child during the period referred to in subsection (a) if—

(1) a decision to discharge the mother and her newborn child prior to the expiration of such period is made by the attending provider in consultation with the mother; and

(2) the health plan or employee health benefit plan provides coverage for post-delivery follow-up care as described in section 4.

SEC. 4. POST-DELIVERY FOLLOW-UP CARE.

(a) IN GENERAL.—In the case of a decision to discharge a mother and her newborn child from the inpatient setting prior to the expiration of 48 hours in the case of a normal vaginal delivery or 96 hours in the case of a caesarean section, the health plan or employee health benefit plan shall provide coverage for timely post-delivery care. Such health care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse

practitioner, nurse midwife or physician assistant experienced in maternal and child health in—

(1) the home, a provider's office, a hospital, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or

(2) another setting determined appropriate under regulations promulgated by the Secretary, in consultation with the Secretary of Health and Human Services, (including a birthing center or an intermediate care facility);

except that such coverage shall ensure that the mother has the option to be provided with such care in the home.

(b) TIMELY CARE.—As used in subsection (a), the term ''timely post-delivery care'' means health care that is provided—

(1) following the discharge of a mother and her newborn child from the inpatient setting; and

(2) in a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs within the 24- to 72-hour period immediately following discharge.

(c) CONSISTENCY WITH STATE LAW.—The Secretary shall, with respect to regulations promulgated under subsection (a) concerning appropriate post-delivery care settings, ensure that, to the extent practicable, such regulations are consistent with State licensing and practice laws.

SEC. 5. PROHIBITIONS.

(a) TERMS AND CONDITIONS.—In implementing the requirements of this Act, a health plan or an employee health benefit plan may not—

(1) deny enrollment, renewal, or continued coverage to a mother and her newborn child who are participants, beneficiaries or policyholders based on compliance with this Act;

(2) provide monetary incentives to mothers to encourage such mothers to request less than the minimum coverage required under this Act; or

(3) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide treatment in a manner inconsistent with this Act.

(b) PROVIDERS.—In implementing the requirements of this section, a health plan or an employee health benefit plan may not penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided treatment in accordance with this Act.

(c) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to require that a mother who is a participant, beneficiary, or policyholder covered under this Act—

(1) give birth in a hospital; or

(2) stay in the hospital for a fixed period of time following the birth of her child.

SEC. 6. NOTICE.

(a) EMPLOYEE HEALTH BENEFIT PLAN.—An employee health benefit plan shall provide notice to each participant regarding coverage required under this Act in accordance with regulations promulgated by the Secretary.

(b) HEALTH PLAN.—A health plan shall provide notice to each policyholder regarding coverage required under this Act.

(c) REQUIREMENTS.—Notice required under this section shall be in writing, prominently positioned in, and be transmitted—

(1) in a mailing made within 120 days of the date of enactment of this Act by such plan to the participant or policyholder; and

(2) as part of the annual informational packet sent to the participant or policyholder.

SEC. 7. APPLICABILITY.

(a) CONSTRUCTION.—

(1) IN GENERAL.—A requirement or standard imposed under this Act on a health plan shall be deemed to be a requirement or standard imposed on the health plan issuer. Such requirements or standards shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act. In the case of a health plan offered by a health plan issuer in connection with an employee health benefit plan, the requirements or standards imposed under this Act shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act.

(2) LIMITATION.—Except as provided in section 8(c), the Secretary shall not enforce the requirements or standards of this Act as they relate to health plan issuers or health plans. In no case shall a State enforce the requirements or standards of this Act as they relate to employee health benefit plans.

(b) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to affect or modify the provisions of

section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 8. ENFORCEMENT.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each health plan issued, sold, renewed, offered for sale or operated in such State by a health plan issuer meet the standards established under this Act. A State shall submit such information as required by the Secretary demonstrating effective implementation of the requirements of this Act.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—With respect to employee health benefit plans, the standards established under this Act shall be enforced in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO ENFORCE.—In the case of the failure of a State to substantially enforce the standards and requirements set forth in this Act with respect to health plans, the Secretary, in consultation with the Secretary of Health and Human Services, shall enforce the stand-

ards of this Act in such State. In the case of a State that fails to substantially enforce the standards set forth in this Act, each health plan issuer operating in such State shall be subject to civil enforcement as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(d) REGULATIONS.—The Secretary, in consultation with the Secretary of Health and Human Services, may promulgate such regulations as may be necessary or appropriate to carry out this Act.

SEC. 9. DEFINITIONS.

As used in this Act:

(1) ATTENDING PROVIDER.—The term ''attending provider'' shall include the obstetrician-gynecologists, pediatrician, family physician, or other physician attending the mother or newly born child. Such term shall also include any other health care provider who, in accordance with applicable State law, may be primarily responsible for the care of a

mother and her newborn child (including nurse midwives and nurse practitioners).

(2) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(8)).

(3) EMPLOYEE HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''employee health benefit plan'' means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))) that provides or pays for health benefits (such as provider and hospital benefits) for participants and beneficiaries whether—

(i) directly;

(ii) through a health plan offered by a health plan issuer as defined in paragraph (4); or

(iii) otherwise.

(B) RULE OF CONSTRUCTION.—An employee health benefit plan shall not be con-

strued to be a health plan or a health plan issuer.

(C) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(4) GROUP PURCHASER.—The term ''group purchaser'' means any person (as defined under paragraph (9) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)) or entity that purchases or pays for health benefits (such as provider or hospital benefits) on behalf of participants or beneficiaries in connection with an employee health benefit plan.

(5) HEALTH PLAN.—

(A) IN GENERAL.—The term ''health plan'' means any group health plan or individual health plan.

(B) GROUP HEALTH PLAN.—The term ''group health plan'' means any contract, policy, certificate or other arrangement offered by a health plan issuer to a group purchaser that

provides or pays for health benefits (such as provider and hospital benefits) in connection with an employee health benefit plan.

(C) INDIVIDUAL HEALTH PLAN.—The term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health plan issuer that provides or pays for health benefits (such as provider and hospital benefits) and that is not a group health plan.

(D) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(E) CERTAIN PLANS INCLUDED.—Such term includes any plan or arrangement not described in any clause of subparagraph (D) which provides for benefit payments, on a periodic basis, for—

(i) a specified disease or illness, or

(ii) a period of hospitalization,

without regard to the costs incurred or services rendered during the period to which the payments relate.

(6) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a health plan.

(7) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(8) SECRETARY.—The term ''Secretary'' unless otherwise specified means the Secretary of Labor.

SEC. 10. PREEMPTION.

The provisions of this Act shall not preempt those provisions of State law that require health plans to provide a minimum of 48 hours of in-patient care in the case of a normal vaginal delivery, and 96 hours of in-patient care in the case of a caesarean section, or that require health plans to provide for maternity and pediatric care that is in accordance with guidelines established by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, and to provide follow-up care consistent with this Act.

SEC. 11. EFFECTIVE DATE.

Except as otherwise provided for in this Act, the provisions of this Act shall apply as follows:

(1) With respect to health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1997.

(2) With respect to employee health benefit plans, such provisions shall apply to such plans on the first day of the first plan year beginning on or after January 1, 1997.

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