ENGROSSED SUBSTITUTE SENATE BILL 6120

State of Washington 54th Legislature 1996 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Quigley, Fairley, Kohl, McAuliffe, Loveland, Drew, Smith, Thibaudeau, Sheldon, Spanel, Rinehart, Bauer, Franklin, Wojahn, Goings, Winsley, Pelz and Rasmussen)

Read first time 01/22/96.

AN ACT Relating to health insurance benefits following the birth of a child; amending RCW 43.73.030; adding a new section to chapter 41.05 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; and creating new sections.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** It is the intent of the legislature that the patient's preference and the judgment of the patient's health care provider about appropriate medical care determine the duration and type of care provided to mothers and their newly born children. It is not the intent of the legislature to establish a maximum time period for such care, but to ensure adequate insurance coverage and choices of postpartum care sites for patients.

NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW to read as follows:

(1)(a) If a state purchased health care plan offered under a contract entered into between the state and the carrier after the effective date of this section includes coverage for maternity

services, decisions on the length of inpatient stay must be made by the attending provider in consultation with the mother, rather than through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice. However, coverage may not be denied for inpatient, postdelivery care to a mother and her newly born child for a period of forty-eight hours after 11:59 p.m. on the day of delivery for a vaginal delivery and ninety-six hours after 11:59 p.m. on the day of delivery for a cesarean section if such care is advised by the attending provider in consultation with the mother.

(b) Any decision to shorten the length of inpatient stay to less than that provided under (a) of this subsection must be made by the attending provider after conferring with the mother.

(c) At the time of discharge, determination of the type and location of continued care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Nothing in this section shall be construed to require attending providers to authorize care they believe to be medically unnecessary.

(2) For the purposes of this section, "attending provider" includes any of the following with hospital privileges: Physicians licensed under chapter 18.57 or 18.71 RCW, certified nurse midwives licensed under chapter 18.79 RCW, midwives licensed under chapter 18.50 RCW, physician’s assistants licensed under chapter 18.57A or 18.71A RCW, and advanced registered nurse practitioners licensed under chapter 18.79 RCW.

(3) If a mother and newborn are discharged pursuant to subsection (1)(b) of this section prior to the inpatient length of stay provided under subsection (1)(a) of this section, coverage may not be denied for three follow-up in-home, clinic, provider office, or hospital outpatient visits within fourteen days of delivery, if recommended by the attending provider. Covered services must include a first visit conducted by the attending provider, as defined in this section, or a registered nurse. Any subsequent visit determined to be medically necessary must be provided by a licensed health care provider if such care is advised by the attending provider. Covered services provided must include, but are not limited to, physical assessment of the mother and newborn, parent education, assistance and training in breast or

bottle feeding, assessment of the home support system, and the performance of any medically necessary and appropriate clinical tests. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(4) No state purchased health care plan that includes coverage for maternity services may deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with the provisions of this section. Nothing in this section shall be construed to prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every state purchased health care plan that includes coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following the effective date of this section.

(6) This section is intended only to establish a standard of coverage, not a standard of medical care.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.20 RCW to read as follows:

(1)(a) If an insurer offers to any individual a health benefit plan that is issued or renewed after the effective date of this section, and that provides coverage for maternity services, decisions on the length of inpatient stay must be made by the attending provider in consultation with the mother, rather than through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice. However, coverage may not be denied for inpatient, postdelivery care to a mother and her newly born child for a period of forty-eight hours after 11:59 p.m. on the day of delivery for a vaginal delivery and ninety-six hours after 11:59

p.m. on the day of delivery for a cesarean section if such care is advised by the attending provider in consultation with the mother.

(b) Any decision to shorten the length of inpatient stay to less than that provided under (a) of this subsection must be made by the attending provider after conferring with the mother.

(c) At the time of discharge, determination of the type and location of continued care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Nothing in this section shall be construed to require attending providers to authorize care they believe to be medically unnecessary.

(2) For the purposes of this section, "attending provider" includes any of the following with hospital privileges: Physicians licensed under chapter 18.57 or 18.71 RCW, certified nurse midwives licensed under chapter 18.79 RCW, midwives licensed under chapter 18.50 RCW, physician's assistants licensed under chapter 18.57A or 18.71A RCW, and advanced registered nurse practitioners licensed under chapter 18.79 RCW.

(3) If a mother and newborn are discharged pursuant to subsection (1)(b) of this section prior to the inpatient length of stay provided under subsection (1)(a) of this section, coverage may not be denied for three follow-up in-home, clinic, provider office, or hospital outpatient visits within fourteen days of delivery, if recommended by the attending provider. Covered services must include a first visit conducted by the attending provider, as defined in this section, or a registered nurse. Any subsequent visit determined to be medically necessary must be provided by a licensed health care provider if such care is advised by the attending provider. Covered services provided must include, but are not limited to, physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and the performance of any medically necessary and appropriate clinical tests. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(4) No insurer that offers to any individual a health benefit plan that provides coverage for maternity services may deselect, terminate

the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with the provisions of this section. Nothing in this section shall be construed to prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every insurer that offers to any individual a health benefit plan that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following the effective date of this section.

(6) This section is intended only to establish a standard of coverage, not a standard of medical care.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.21 RCW to read as follows:

(1)(a) If a group disability insurance contract or blanket disability insurance contract that is issued or renewed after the effective date of this section, providing health care services, provides coverage for maternity services, decisions on the length of inpatient stay must be made by the attending provider in consultation with the mother, rather than through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice. However, coverage may not be denied for inpatient, postdelivery care to a mother and her newly born child for a period of forty-eight hours after 11:59 p.m. on the day of delivery for a vaginal delivery and ninety-six hours after 11:59 p.m. on the day of delivery for a cesarean section if such care is advised by the attending provider in consultation with the mother.

(b) Any decision to shorten the length of inpatient stay to less than that provided under (a) of this subsection must be made by the attending provider after conferring with the mother.

(c) At the time of discharge, determination of the type and location of continued care must be made by the attending provider in consultation with the mother rather than by contract or agreement

between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Nothing in this section shall be construed to require attending providers to authorize care they believe to be medically unnecessary.

(2) For the purposes of this section, "attending provider" includes any of the following with hospital privileges: Physicians licensed under chapter 18.57 or 18.71 RCW, certified nurse midwives licensed under chapter 18.79 RCW, midwives licensed under chapter 18.50 RCW, physician's assistants licensed under chapter 18.57A or 18.71A RCW, and advanced registered nurse practitioners licensed under chapter 18.79 RCW.

(3) If a mother and newborn are discharged pursuant to subsection (1)(b) of this section prior to the inpatient length of stay provided under subsection (1)(a) of this section, coverage may not be denied for three follow-up in-home, clinic, provider office, or hospital outpatient visits within fourteen days of delivery, if recommended by the attending provider. Covered services must include a first visit conducted by the attending provider, as defined in this section, or a registered nurse. Any subsequent visit determined to be medically necessary must be provided by a licensed health care provider if such care is advised by the attending provider. Covered services provided must include, but are not limited to, physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and the performance of any medically necessary and appropriate clinical tests. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(4) No group disability insurance contract or blanket disability insurance contract, providing health care services, that provides coverage for maternity services, may deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with the provisions of this section. Nothing in this section shall be construed to prevent any insurer from

reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every group disability insurance contract or blanket disability insurance contract, providing health care services, that provides coverage for maternity services, must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following the effective date of this section.

(6) This section is intended only to establish a standard of coverage, not a standard of medical care.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.44 RCW to read as follows:

(1)(a) If a health service contractor offers a health benefit plan that is issued or renewed after the effective date of this section, and that provides coverage for maternity services, decisions on the length of inpatient stay must be made by the attending provider in consultation with the mother, rather than through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice. However, coverage may not be denied for inpatient, postdelivery care to a mother and her newly born child for a period of forty-eight hours after 11:59 p.m. on the day of delivery for a vaginal delivery and ninety-six hours after 11:59 p.m. on the day of delivery for a cesarean section if such care is advised by the attending provider in consultation with the mother.

(b) Any decision to shorten the length of inpatient stay to less than that provided under (a) of this subsection must be made by the attending provider after conferring with the mother.

(c) At the time of discharge, determination of the type and location of continued care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Nothing in this section shall be construed to require attending providers to authorize care they believe to be medically unnecessary.

(2) For the purposes of this section, "attending provider" includes any of the following with hospital privileges: Physicians licensed

under chapter 18.57 or 18.71 RCW, certified nurse midwives licensed under chapter 18.79 RCW, midwives licensed under chapter 18.50 RCW, physician's assistants licensed under chapter 18.57A or 18.71A RCW, and advanced registered nurse practitioners licensed under chapter 18.79 RCW.

(3) If a mother and newborn are discharged pursuant to subsection (1)(b) of this section prior to the inpatient length of stay provided under subsection (1)(a) of this section, coverage may not be denied for three follow-up in-home, clinic, provider office, or hospital outpatient visits within fourteen days of delivery, if recommended by the attending provider. Covered services must include a first visit conducted by the attending provider, as defined in this section, or a registered nurse. Any subsequent visit determined to be medically necessary must be provided by a licensed health care provider if such care is advised by the attending provider. Covered services provided must include, but are not limited to, physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and the performance of any medically necessary and appropriate clinical tests. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(4) No health service contractor that offers a health benefit plan that provides coverage for maternity services may deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with the provisions of this section. Nothing in this section shall be construed to prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every health service contractor that offers a health benefit plan that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits

sent to the policyholder, or January 1 of the year following the effective date of this section.

(6) This section is intended only to establish a standard of coverage, not a standard of medical care.

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.46 RCW to read as follows:

(1)(a) If a health maintenance organization offers a health benefit plan that is issued or renewed after the effective date of this section, and that provides coverage for maternity services, decisions on the length of inpatient stay must be made by the attending provider in consultation with the mother, rather than through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice. However, coverage may not be denied for inpatient, postdelivery care to a mother and her newly born child for a period of forty-eight hours after 11:59 p.m. on the day of delivery for a vaginal delivery and ninety-six hours after 11:59 p.m. on the day of delivery for a cesarean section if such care is advised by the attending provider in consultation with the mother.

(b) Any decision to shorten the length of inpatient stay to less than that provided under (a) of this subsection must be made by the attending provider after conferring with the mother.

(c) At the time of discharge, determination of the type and location of continued care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Nothing in this section shall be construed to require attending providers to authorize care they believe to be medically unnecessary.

(2) For the purposes of this section, "attending provider" includes any of the following with hospital privileges: Physicians licensed under chapter 18.57 or 18.71 RCW, certified nurse midwives licensed under chapter 18.79 RCW, midwives licensed under chapter 18.50 RCW, physician’s assistants licensed under chapter 18.57A or 18.71A RCW, and advanced registered nurse practitioners licensed under chapter 18.79 RCW.

(3) If a mother and newborn are discharged pursuant to subsection (1)(b) of this section prior to the inpatient length of stay provided under subsection (1)(a) of this section, coverage may not be denied for

three follow-up in-home, clinic, provider office, or hospital outpatient visits within fourteen days of delivery, if recommended by the attending provider. Covered services must include a first visit conducted by the attending provider, as defined in this section, or a registered nurse. Any subsequent visit determined to be medically necessary must be provided by a licensed health care provider if such care is advised by the attending provider. Covered services provided must include, but are not limited to, physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and the performance of any medically necessary and appropriate clinical tests. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(4) No health maintenance organization that offers a health benefit plan that provides coverage for maternity services may deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with the provisions of this section. Nothing in this section shall be construed to prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every health maintenance organization that offers a health benefit plan that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following the effective date of this section.

(6) This section is intended only to establish a standard of coverage, not a standard of medical care.

NEW SECTION. **Sec. 7.** The insurance commissioner shall adopt rules to implement sections 1 through 6 of this act, which shall be consistent, when appropriate, with the guidelines for postpartum care adopted by the department of health under this act.

NEW SECTION. **Sec. 8.** The legislature finds that residents of Washington require a system of maternity care that provides adequate prenatal and postnatal services to maintain and improve the health of women and their newborns. The changing health care market challenges the ability of providers to ensure a system of such care. The health care policy board has the authority to research, investigate, and develop options on issues on the scope, financing, and delivery of health care and has agreed to take on this task if requested by the legislature.

Sec. 9. RCW 43.73.030 and 1995 c 265 s 11 are each amended to read as follows:

The board shall have the following powers and duties:

(1) Periodically make recommendations to the appropriate committees of the legislature and the governor on issues including, but not limited to the following:

(a) The scope, financing, and delivery of health care benefit plans including access for both the insured and uninsured population;

(b) Long-term care services including the finance and delivery of such services in conjunction with the basic health plan by 1999;

(c) The use of health care savings accounts including their impact on the health of participants and the cost of health insurance;

(d) Rural health care needs;

(e) Whether Washington is experiencing an increase in immigration as a result of health insurance reforms and the availability of subsidized and unsubsidized health care benefits;

(f) The status of medical education and make recommendations regarding steps possible to encourage adequate availability of health care professionals to meet the needs of the state's populations with particular attention to rural areas;

(g) The implementation of community rating and its impacts on the marketplace including costs and access;

(h) The status of quality improvement programs in both the public and private sectors;

(i) Models for billing and claims processing forms, ensuring that these procedures minimize administrative burdens on health care providers, facilities, carriers, and consumers. These standards shall also apply to state-purchased health services where appropriate;

(j) Guidelines to health carriers for utilization management and review, provider selection and termination policies, and coordination of benefits and premiums; and

(k) Study the feasibility of including long-term care services in a medicare supplemental insurance policy offered according to RCW 41.05.197;

(2) Review rules prepared by the insurance commissioner, health care authority, department of social and health services, department of labor and industries, and department of health, and make recommendations where appropriate to facilitate consistency with the goals of health reform;

(3) Make recommendations on a system for managing health care services to children with special needs and report to the governor and the legislature on their findings by January 1, 1997;

(4) Conduct a comparative analysis of individual and group insurance markets addressing: Relative costs; utilization rates; adverse selection; and specific impacts upon small businesses and individuals. The analysis shall address, also, the necessity and feasibility of establishing explicit related policies, to include, but not be limited to, establishing the maximum allowable individual premium rate as a percentage of the small group premium rate. The board shall submit an interim report on its findings to the governor and appropriate committees of the legislature by December 15, 1995, and a final report on December 15, 1996;

(5) Conduct an analysis of the financing and delivery of maternity care included in public and private individual and group insurance markets and address and develop options for a system of maternity care that includes, but is not limited to, appropriate level of prenatal, inpatient, and outpatient care, physical assessment of the newborn, the performance of any medically necessary and appropriate clinical tests, parent education, lactation and bottle feeding education, and assistance and assessment of home support;

(6) Develop sample enrollee satisfaction surveys that may be used by health carriers.

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