**6120-S AMS QUIG S5269.2**

**SSB 6120** - S AMD - 121
By Senators Quigley and Moyer

ADOPTED 2/12/96

Beginning on page 1, after line 13, strike all material through "section." on page 9, line 23, and insert the following:

"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."

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