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Newborn Coverage

(Supersedes Bulletin 294)

This Bulletin replaces previous guidance issued under Bulletin 294 and clarifies the current requirements regarding coverage of newborn children under medical expense insurance. The Insurance Code contains two types of provisions requiring coverage for newborn care. One requires each parent's policy to provide dependent coverage from the moment of birth and will be referred to below as the "newborn provision." The other requires coverage of certain services as part of maternity coverage and will be referred to below as the "maternity provision." These provisions appear in different chapters depending on the type of health coverage affected but are identical in substance:

Type of Coverage	Newborn Provision	Maternity Provision
Nonprofit hospital and medical service plans	24 M.R.S. § 2319	24 M.R.S. § 2318-A
Individual health insurance	24-A M.R.S. § 2743	24-A M.R.S. § 2743-A
Group health insurance	24-A M.R.S. § 2834	24-A M.R.S. § 2834-A
Health maintenance organizations (HMOs)	24-A M.R.S. § 4234-C	24-A M.R.S. § 4234-B

Maternity Provisions

The maternity provisions require "routine newborn care" to be included as part of any maternity benefit.[1] This means that when a woman gives birth, any health plan in which she is enrolled must treat costs such as hospital nursery charges as part of the expenses of childbirth. This is true even if the child is also covered as a dependent under one or both parents' plan. Normal coordination of benefits (COB) provisions do not apply in this scenario. A plan providing maternity coverage for the mother always pays ahead of the child's own coverage with respect to routine newborn care

[1] Similarly, subparagraph 1302(b)(1)(D) of the Affordable Care Act treats "maternity and newborn care" as a single category within the essential health benefit package.

services provided to the newborn before the mother's hospital discharge date. The mother and newborn must be treated as one person in calculating the deductible, coinsurance, and copayments for this coverage.

The maternity provisions and this priority rule only apply if the mother's plan provides maternity benefits.[2] A carrier covering the newborn may not assert that the mother's plan is primary for routine newborn care under the maternity provision if the mother's plan has no maternity benefit.

Newborn Provisions

Any plan covering either parent must cover a newborn child for 31 days starting from the moment of birth. The carrier may only charge a premium for this 31-day coverage in two scenarios. First, a carrier may charge premium retroactive to the moment of birth if a parent chooses to continue dependent coverage for the newborn after the 31-day period. Second, a carrier may charge a premium for the 31-day coverage if it pays a claim for services within that time period, other than claims that are paid by the mother's plan under the maternity provision. An example of a newborn service within the 31 days that would fall outside the maternity provision is an office visit with the newborn's pediatrician.

A parent may decline the 31-day coverage under the newborn provision. For example, if the parents have separate plans, they may decide that only one of those plans will cover the child. In that case, there is no obligation for the declined plan to cover services provided within the first 31 days, unless that plan covers the mother and the services at issue are routine newborn care services that fall under the maternity provision. If the parents do not affirmatively elect or affirmatively decline coverage under either plan, the default is that the child is automatically covered by both plans but that coverage terminates after 31 days. An affirmative election of one plan and the payment of premium for dependent coverage under that plan, when no premium is paid for dependent coverage under the other plan, has the same effect as declining coverage under the other plan. The parents do not have to both make an affirmative election of one plan and decline coverage under the other plan to avoid coverage under both plans.

When there is 31-day coverage under both parents' plans, normal COB rules apply between those plans when there are claims for services that fall outside the maternity provisions, *e.g.*, an office visit with the newborn's pediatrician.

Carriers must make reasonable efforts to classify these claims appropriately. If a provider submits a claim under the newborn's own plan for services that should be covered under the mother's plan pursuant to the maternity provisions, the carriers have a duty to request additional information about the claim to ensure that they will process it correctly. Again, a carrier is not permitted to charge a premium for the automatic 31-day coverage unless the carrier ultimately pays a claim for newborn services within that time period that are not payable under the maternity provision. Receiving a claim should not trigger a premium charge unless the child's plan is responsible for paying that claim.

[2] Maternity coverage is required for all plans required to provide essential health benefits under the Affordable Care Act and 24-A M.R.S. § 4320-D(2), and is also commonly provided in large group plans.

When A Parent's Plan Does Not Include Dependent Coverage

Coverage must be provided for 31 days under the newborn provisions even if the terms of a parent's coverage do not include dependent coverage. For example, if a parent is covered as a dependent child when the newborn is born, the grandparent's policy that covers the newborn's parent would be responsible for the 31-day coverage even if a grandchild would not otherwise be an eligible dependent under the plan. This provides the parent with time to shop for permanent coverage for the child. The insured should be notified that coverage will end after 31 days, and the notice should advise the insured to seek other coverage within that time to ensure continuous coverage of the newborn.

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NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.