Maternity and Newborn Care

Policy Number: BIP091.O
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Newborns' and Mothers' Health Protection Act (NMHPA) of 1996, Title VI

Minimum Hospital Stay - UnitedHealthcare and its contracted providers may not restrict the benefits for any hospital length of stay for a mother and her newborn to less than 48 hours following a vaginal delivery and 96 hours following a Cesarean Section (C-Section). Protections for health plans include allowance of discharge before 48–96 hours if the attending physician, in consultation with the mother, makes the decision.
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

Title VII of the Civil Rights Act, as amended by the Pregnancy Discrimination Act: 42 U.S. Code Section 2000e

https://www.eeoc.gov/statutes/pregnancy-discrimination-act-1978

"(k) The terms 'because of sex' or 'on the basis of sex' include but are not limited to because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 703(h) of this title shall be interpreted to permit otherwise. This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: Provided, That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion."

https://www.eeoc.gov/eeoc/publications/fs-preg.cfm

Note: The Pregnancy Discrimination Act (PDA) amended the Title VII of the Civil Rights Act of 1964 to prohibit employment discrimination based on pregnancy, childbirth, or related medical conditions. In summary, the PDA generally applies to all private and governmental (state and local) employers with 15 or more employees for each working day in at least 20 calendar weeks in the current or preceding calendar year. Any health insurance provided by such employers must cover expenses for pregnancy-related conditions on the same basis as costs for other medical conditions. Health insurance for expenses arising from abortion is not required, except where the life of the mother is endangered. Pregnancy-related expenses should be reimbursed exactly as those incurred for other medical conditions, whether payment is on a fixed basis or a percentage of reasonable-and-customary-charge basis. The amounts payable by the insurance provider can be limited only to the same extent as amounts payable for other conditions (i.e., no additional, increased, or larger deductible can be imposed).

California Health and Safety Code (HSC) Section 1367.695, Direct Access to OB-GYN

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.695&lawCode=HSC

(a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Each health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c.) In implementing this section, a health care service plan may establish reasonable requirements, governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association if those requirements are consistent with the intent of this section, are customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and are no more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in the subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment and any need for follow-up care.

(d) This section does not diminish the requirements of Section 1367.69.

HSC Section 1367.54

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.54&lawCode=HSC

(a) Every group health care service plan contract that provides maternity benefits, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 1999, and every individual health care service plan contract of a type and form first offered for sale on or after January 1, 1999, that provides maternity benefits, except a specialized health care service plan contract, shall provide coverage for participation in the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health pursuant to Section 124977. Notwithstanding any other provision of law, a health care service plan that provides maternity benefits shall not require participation in the statewide prenatal testing program administered by the State Department of Public Health as a prerequisite to eligibility for, or receipt of, any other service.

(b) Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(c) Reimbursement for services covered pursuant to this section shall be paid at the amount set pursuant to Section 124977 and regulations adopted thereunder.

California Expanded AFP Screening Program Update Prenatal Screening Program Expansion: Inclusion of First Trimester Specimens for Sequential Screening

https://www.cdph.ca.gov/Programs/CFH/DGDS/CDPH%20Document%20Library/PNS%20Documents/Patient%20Booklet%20Consent_ENG-ADA.pdf

The California Prenatal Screening Program (currently the Expanded AFP Screening Program) is pleased to announce a program expansion to include first trimester specimens and Nuchal Translucency (NT) results beginning in **late March 2009**. This will allow the California Program to provide Integrated Screening for Down syndrome and Trisomy 18.

A patient's screening options for the chromosomal abnormalities will be:

- **Quad Marker Screening**
  - One blood specimen drawn at 15 weeks-20 weeks of pregnancy (current second trimester program).
- **Serum Integrated Screening**
  - Combines first trimester blood test results (10 weeks-13 weeks 6 days) with second trimester blood test results.
- **Sequential Screening**
  - Combines first and second trimester blood test results with Nuchal Translucency (NT) results. This type of ultrasound is done by clinicians with special training. It measures the back of the fetus' neck to screen for Down syndrome (trisomy 21) and trisomy 18 (Note: the Screening Program does not pay for NT ultrasounds).
  - Patients with first trimester blood specimens and NT will get a preliminary risk assessment for chromosomal abnormalities in the first trimester. This preliminary risk will be revised when the second trimester blood specimen is received. The Prenatal Screening Program will offer follow-up services at State-approved Prenatal Diagnostic Centers for women with screen positive results in the first or second trimesters.

California Code of Regulations Title 28, Section 1300.67, Scope of Basic Health Care Services

Cal. Code Regs. Tit. 28, § 1300.67 - Scope of Basic Health Care Services | State Regulations | US Law | LII / Legal Information Institute (cornell.edu)

(g) (2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. "Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

HSC Section 1357.500

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1357.500&lawCode=HSC

As used in this article, the following definitions shall apply:

(a) "Child" means a child described in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations.

(b) "Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (m).

(v) "Family" means the subscriber and his or her dependent or dependents.

HSC Section 1373(c), (Specific to the Coverage of Grandchildren)

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1373.&lawCode=HSC

Which in part states:

(c) Every plan contract that provides coverage to the spouse or dependents of the subscriber or spouse shall grant immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any subscriber or spouse covered and to each minor child placed for adoption from and after the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including but not limited to a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the subscriber's or spouse's right to control the health care of the child placed for adoption. No plan may be entered into or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn infants of, or children placed for adoption with, a subscriber or spouse covered as required by this subdivision.

2024 HSC Division 2 - Licensing Provisions Chapter 2.2 - Health Care Service Plans, Article 5 – Standards, Section 1367.624

https://law.justia.com/codes/california/code-hsc/division-2/chapter-2-2/article-5/section-1367-624/

The provision of medically necessary pasteurized donor human milk obtained from a tissue bank licensed pursuant to Chapter 4.1 (commencing with Section 1635) is a basic health care service, as defined in subdivision (b) of Section 1345 and any regulations adopted thereunder

HSC Section 1367.625, Maternal Mental Health Program

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.625&lawCode=HSC

(a) A health care service plan shall develop a maternal mental health program designed to promote quality and cost-effective outcomes. The program shall consist of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider. The program shall be developed consistent with sound clinical principles and program guidelines and criteria shall be provided to relevant medical providers, including all contracting obstetric providers. As part of a maternal mental health program the health care service plan is encouraged to improve screening, treatment, and referral to maternal mental health services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees about the program.

(b) For the purposes of this section:
  (1) "Contracting obstetric provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, and who is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.
  (2) "Maternal mental health" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.
(c) This section does not apply to specialized health care service plans, except specialized behavioral health-only plans offering professional mental health services.
(d) For purposes of this section, "health care service plan" includes Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section applies to Medi-Cal managed care plan contracts only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.
(e) Notwithstanding subdivision (a), a Medi-Cal managed care plan shall continue to comply with any quality measures required or adopted by the State Department of Health Care Services. Quality measures included in a Medi-Cal managed care plan's maternal mental health program shall not be inconsistent with quality measures required or adopted by the State Department of Health Care Services.

HSC Section 1374.56

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.56.&lawCode=HSC
Testing and Treatment of phenylketonuria (PKU)
(a) On or after July 1, 2000, every health care service plan contract, except a specialized health care service plan contract, issued, amended, delivered, or renewed in this state that provides coverage for hospital, medical, or surgical expenses shall provide coverage for the testing and treatment of phenylketonuria (PKU) under the terms and conditions of the plan contract.
(b) Coverage for treatment of phenylketonuria (PKU) shall include those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
(c) Coverage pursuant to this section is not required except to the extent that the cost of the necessary formulas and special food products exceeds the cost of a normal diet.
(d) For purposes of this section, the following definitions shall apply:
  (1) "Formula" means an enteral product or enteral products for use at home that are prescribed by a physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as medically necessary for the treatment of phenylketonuria (PKU).
  (2) "Special food product" means a food product that is both of the following:
    (A) Prescribed by a physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.
    (B) Used in place of normal food products, such as grocery store foods, used by the general population.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Notes:

- The term “child”:
  - **Includes** other dependents, including grandchildren for whom the subscriber has assumed a parent-child relationship and assumption of parental duties by the subscriber, as certified by the subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 as determined eligible by the employer group. The child may continue coverage beyond age 26 if determined to be permanently disabled by UnitedHealthcare.
  - **Does not include** foster children which is an optional benefit that may be purchased by the employer.
- UnitedHealthcare may seek recovery of actual costs incurred by UnitedHealthcare from a member who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate.
- Certain Prenatal services are covered as preventive care. Refer to the Medical Policy titled Preventive Care Services.

Prenatal and Postnatal Care

Prenatal and Postnatal care must be provided by a plan provider, including a network/participating licensed/Certified Nurse-Midwife only when available within and authorized by the member’s network/participating medical group. Examples include but are not limited to:

- Prenatal office visits.
- Postnatal (after delivery) office visits up to 6 weeks post-delivery.
- Outpatient (office visit) physician services.
- Screening and diagnostic laboratory (including the California Prenatal Screening Program) and radiological procedures: Refer to the *Federal/State Mandated Regulations* section.
- Prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available.
- Educational materials for individual needs provided in physician's office.
- Maternal mental health condition, including but not limited to Prenatal or Postnatal screening for maternal mental health conditions by a licensed healthcare practitioner who provides Prenatal or Postnatal care for a member.

Inpatient Maternity Care

Inpatient maternity care, including but not limited to:

- Inpatient hospital care. A minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section are covered. Coverage for inpatient hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48- or 96-hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating physician.
- Labor, delivery and recovery room care, treatment, and services.
- Alternative birthing center services when provided or arranged by a network hospital affiliated with the member’s network medical group.
- Delivery by either normal/vaginal or cesarean-section (C-Section).
- Treatment of a miscarriage and complications of pregnancy or childbirth.
- Physician services (visits) related to all medically necessary inpatient maternity care, treatment, and services.
- All medically necessary ancillary services related to inpatient maternity care, treatment, and services, including but not limited to diagnostic laboratory and/or radiologic procedures.
- Services of a licensed/Certified Nurse-Midwife only when available within the member’s network/participating medical group.
- Circumcision.
  - For male newborns performed at the hospital prior to hospital discharge.
  - For male newborns performed after hospital discharge when:
    - Circumcision was delayed by the network provider during first hospitalization. Unless the delay was for medical reasons, the circumcision is covered after discharge only through the twenty-eight (28) day neonatal period, or
    - Circumcision was determined to be medically inappropriate during first hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.) The circumcision is covered when the network provider determines it is medically safe and the circumcision is performed within 90 days from that determination.

  All other requests for circumcision must be reviewed for medical necessity by the network medical group or UnitedHealthcare medical director or designee.

Newborn Care

Postnatal hospital services are covered, including special care nursery.

Not Covered

- Non-medically indicated diagnostic testing such as:
  - Any procedure intended solely for sex determination (e.g., ultrasound)
  - Blood testing to determine paternity
- Non-medically necessary screening of newborns to determine carrier status for inheritance disorders when there would not be an immediate medical benefit or when results would not be used to begin medical interventions/treatment while a newborn.
- Take home medications and/or supplies, unless member has a supplemental pharmacy benefit.
- Childbirth classes (e.g., Lamaze).
- Elective home delivery unless covered under the *Federal/State Mandated Regulations* section.
- Maternity services for non-UnitedHealthcare member acting as surrogate to UnitedHealthcare member.
- Educational courses on childcare.
- Newborn coverage of a grandchild unless the employer provides the coverage or the subscriber, subscriber's spouse or domestic partner has guardianship as filed in a court or provides proof of placement for adoption.

Definitions

Certified Nurse-Midwife (CNM) or Certified Midwife (CM): CNMs and CMs are educated in graduate-level midwifery programs accredited by the Accreditation Commission for Midwifery Education (ACME). CNMs and CMs pass a national certification exam administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM or CM. CNMs and CMs provide care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996: The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. The NMHPA applies to all group health plans, including self-insured plans, and health insurance coverage, subject to any state specific regulations. Plans and issuers that do not provide maternity benefits are not required to offer them, and thus are not subject to the provisions of the Act. In general, group health plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

Postnatal: Begins immediately after the birth of the baby and extends up to six weeks (42 days) after birth.

Prenatal: The time a female is pregnant, before birth occurs.

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World Health Organization. (2010). WHO technical consultation on postpartum care. WHO Technical Consultation on Postpartum and Postnatal Care - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK310595/. Accessed February 28, 2025.

Policy History/Revision Information

Date	Summary of Changes
05/01/2025	**Federal/State Mandated Regulations** • Revised language pertaining to the: ○ *Title VII of the Civil Rights Act 42 U.S. Code Section 2000e*

Date	Summary of Changes
	○ *California Health and Safety Code Section 1367.625* • Added language pertaining to the *California Health and Safety Code*: ○ *Section 1367.624* ○ *Section 1374.56* **Not Covered** • Revised list of non-covered services; added "non-medically necessary screening of newborns to determine carrier status for inheritance disorders when there would not be an immediate medical benefit or when results would not be used to begin medical interventions/treatment while a newborn" **Supporting Information** • Archived previous policy version BIP091.N

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.