

§ 58-3-169. Required coverage for minimum hospital stay following birth.

(a) Definitions. – As used in this section:

(1) "Attending providers" includes:

- a. The obstetrician-gynecologists, pediatricians, family physicians, and other physicians primarily responsible for the care of a mother and newborn; and
- b. **(Effective until contingency met – see note)** The nurse midwives and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.
- b. **(Effective once contingency met – see note)** The nurse midwives, physician assistants, and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.

(2) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any of the following kinds of insurance:

- a. Accident,
- b. Credit,
- c. Disability income,
- d. Long-term or nursing home care,
- e. Medicare supplement,
- f. Specified disease,
- g. Dental or vision,
- h. Coverage issued as a supplement to liability insurance,
- i. Workers' compensation,
- j. Medical payments under automobile or homeowners, and
- k. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
- l. Hospital income or indemnity.

(3) "Insurer" means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 50A of this Chapter.

(b) In General. – Except as provided in subsection (c) of this section, an insurer that provides a health benefit plan that contains 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 the plan and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.

(c) Exception. – Notwithstanding subsection (b) of this section, an insurer is not required to provide coverage for postdelivery inpatient length of stay for a mother who is a participant,

beneficiary, or policyholder under the insurer's health benefit plan and her newborn child for the period referred to in subsection (b) of this section if:

- (1) A decision to discharge the mother and her newborn child before the expiration of the period is made by the attending provider in consultation with the mother; and
- (2) The health benefit plan provides coverage for postdelivery follow-up care as described in subsections (d) and (e) of this section.

(d) **Postdelivery Follow-Up Care.** – In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the health benefit plan shall provide coverage for timely postdelivery care. This 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 birthing center, an intermediate care facility, 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 federal regulations promulgated under Title VI of Public Law 104-204.

The attending provider in consultation with the mother shall decide the most appropriate location for follow-up care.

(e) **Timely Care.** – As used in subsection (d) of this section, "timely postdelivery 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 not later than the 72-hour period immediately following discharge.

(f) **Prohibitions.** – An insurer shall not:

- (1) Deny enrollment, renewal, or continued coverage with respect to its health benefit plan to a mother and her newborn child who are participants, beneficiaries, or policyholders, based on compliance with this section;
- (2) Provide monetary payments or rebates to mothers to encourage the mothers to request less than the minimum coverage required under this section;
- (3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided treatment to an individual policyholder, participant, or beneficiary in accordance with this section; or
- (4) Provide monetary or other incentives to an attending provider to induce the provider to provide treatment to an individual policyholder, participant, or beneficiary in a manner inconsistent with this section.

(g) **Effect on Mother.** – Nothing in this section requires that a mother who is a participant, beneficiary, or policyholder covered under this section:

- (1) Give birth in a hospital; or
- (2) Stay in the hospital for a fixed period of time following the birth of her child.

(h) **Level and Type of Reimbursements.** – Nothing in this section prevents an insurer from negotiating the level and type of reimbursement with an attending provider for care provided in accordance with this section. (1997-259, s. 19; 2019-202, s. 8; 2025-37, s. 6.1(h).)