Evaluation of SF XXXX – Coverage for Prenatal, Maternity, and Postnatal Care

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

02/12/2024

This report was prepared by the American Institutes for Research (AIR), with actuarial analysis by Actuarial Research Corporation (ARC), at the request of the Minnesota Department of Commerce. AIR and ARC created this document for internal use by the Minnesota Department of Commerce pursuant to Contract No. 216732. The document assumes reader familiarity with the proposed mandated health benefits currently under consideration by the Minnesota State Legislature. The document was prepared solely to assist the Minnesota Department of Commerce. No other use of this document or the information or conclusions contained herein is authorized.

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As requested by Minn. Stat. § 3.197: This report cost approximately $37,239 to prepare, including staff time, printing, and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille, or audio recording. Printed on recycled paper. A 508 compliant version of this report is forthcoming.

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Executive Summary

This proposed mandate would require coverage for services in prenatal, delivery, and postpartum periods for the mother and infant. The bill would extend the duration of postpartum care to a year and would prohibit cost-sharing for all required services associated with prenatal, delivery, and postpartum care. The proposed mandate would also require coverage for the transfer of a mother, a newborn, and/or newborn siblings to a different medical facility when one party requires a medically necessary transfer.

Maternal and infant morbidity is defined as physical or psychological conditions that create adverse health effects for mothers and infants during pregnancy and after delivery. Included are a variety of health conditions and clinical outcomes. Applicable maternal and infant care services that must be covered by insurance include relevant procedures, examinations, screenings, counseling, education, office visits, and inpatient care recommended by a health care provider within the prenatal and delivery periods and for 1 year postpartum.

The Patient Protection and Affordable Care Act includes maternity and infant care as an essential health benefit (EHB) requirement, with the details of covered services largely left to the states. Currently, maternal and infant care is required under Minnesota's EHB benchmark plan, with postpartum care covered for up to 12 weeks. Minnesota public health coverage programs cover continuous postpartum care for up to 12 months. Forty states have implemented similar legislation in public plans. There are no federal or Minnesota state laws specific to requirements for simultaneous or concurrent maternal, newborn, and/or newborn sibling transfer if medically necessary for any one party.

Maternal and infant morbidity and mortality are a public health priority, as they disproportionately impact underserved populations, and maternal and infant morbidity and mortality rates, as well as corresponding health disparities, are associated with lack of access to high-quality prenatal and postpartum care. Studies suggest that expanding maternity coverage could help reduce the high costs associated with preterm births and low birth weight. Cost may be one of several significant barriers that decrease use of prenatal and postpartum care and contribute to adverse health outcomes for mothers and infants.

Due to the broad scope of the mandate, an actuarial analysis to estimate the potential economic impact of the mandate is not feasible. The potential state fiscal impact of this mandate is as follows:

- Minnesota Management and Budget estimates the cost of this legislation for the state plan to be $448,920 for partial Fiscal Year 2025 (FY 2025) and $942,732 for FY 2026.
- There are no estimated defrayal costs associated with this proposed mandate.
- There is no estimated cost to public programs.

Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Bill Requirements

This Senate bill is sponsored by Sen. Mann and has not yet been introduced.

If enacted, this bill would codify the services that must be covered in the prenatal, delivery, and postpartum periods for the mother and infant. This proposed mandate also extends the duration of postpartum care requirements for the mother and infant to a period of 1 year. For each of these required services, the proposed mandate prohibits any cost-sharing during the defined periods. In addition, it would require coverage of the transfer of the mother, the newborn, and/or a newborn sibling when the transfer is medically necessary.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, and the State Employee Group Insurance Program (SEGIP). It would not apply to self-insured employer plans, grandfathered plans, Medicare and Medicare supplemental policies, and Minnesota public health coverage programs.

This bill would amend Minnesota Statutes § 62A.041, subdivision 1; 62A.0411; 62A.047; and 62Q.521.

Related Health Conditions and Associated Services

Maternal and infant morbidity is defined as physical or psychological conditions that create adverse health effects for mothers and infants during pregnancy and after delivery. These include a variety of health conditions leading to a variety of clinical outcomes. Maternal and infant mortality is the most severe outcome of maternal and infant morbidity.[1]

Applicable maternal and infant care services that must be covered by insurance include relevant procedures, examinations, screenings, counseling, education, office visits, and inpatient care recommended by a health care provider within the prenatal and delivery periods and for 1 year postpartum.

Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic.

Relevant Federal Laws

The Patient Protection and Affordable Care Act (ACA) includes maternity and newborn care as an essential health benefit (EHB) requirement under section 1302(b)(1)(D).[2,3] The ACA does not list specific benefits for maternity and newborn care, and therefore the details of covered maternity and newborn care services are largely left to the states. Benefits that are described in the ACA focus primarily on preventive care, such as prenatal care and screenings.

The Newborns' and Mothers' Health Protection Act of 1996 requires a minimum inpatient stay of 48 hours following a vaginal delivery and 96 hours following a cesarean section.[4] This law applies to group health plans and individual health insurance policies.

Under the American Rescue Plan Act of 2021, state Medicaid agencies were provided an option to extend coverage for postpartum care to 12 months.[5] This new option took effect in April 2022 and was later made permanent by the Consolidated Appropriations Act of 2023. As of November 14, 2023, 40 states and the District of Columbia have implemented the 12-month extension for postpartum coverage.

There are no federal laws pertaining to transferring a mother, a newborn, and/or newborn siblings together to a different medical facility if a health care provider recommends a transfer for either the mother or newborn.

Relevant Minnesota Laws

In alignment with the ACA, Minnesota provides maternity and newborn care through the Minnesota EHB benchmark plan.[6] This plan covers all medically necessary prenatal care without cost-sharing, all medically necessary inpatient and outpatient maternity care, and one postpartum home health visit. Currently, postpartum care is covered up to 12 weeks from the date of delivery for group insurance, health plans, and accident and health protection plans.[7] In 2022, Minnesota Medicaid expanded continuous postpartum coverage to 12 months for individuals enrolled during their pregnancy.[8] The fiscal cost estimate for this expansion is not directly relevant to the proposed health benefit mandate, as the Medicaid expansion extended the length of eligibility for all Medicaid services in addition to eliminating cost-sharing for postpartum coverage.[9]

There are no Minnesota state laws pertaining to transferring a mother, a newborn, and/or newborn siblings together to a different medical facility if a health care provider recommends a transfer for either the mother or newborn.

State Comparison

As of 2019, forty-two states had a neonatal transport policy, and 37 states had a maternal transport policy (see Table 1).[10] States were included if they had a state-level neonatal or maternal transport policy that established transport to the most appropriate facility based on risk assessment and regardless of reimbursement requirements. As of 2019, thirty-one states had a neonatal transport reimbursement policy, 11 states had a maternal transport reimbursement policy, and 30 states had a Medicaid transport reimbursement policy (see Table 1).[10] Reimbursement policies include those with language on the reimbursement of the transport by a state program or by insurance companies. Medicaid transport reimbursement policies are neonatal or maternal transport reimbursement policies specific to Medicaid. No additional transport or reimbursement policies were identified during this policy review.

Table 1. State Transport and Reimbursement Policies

Policy	States
Neonatal transport policy	AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, IL, IN, IA, KY, LA, ME, MD, MA, MI, MS, MO, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OK, PA, RI, SC, TN, TX, UT, VA, WA, WI, WY
Maternal transport policy	AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, IL, IN, IA, KY, LA, MD, MA, MI, MS, NV, NH, NJ, NM, NY, ND, OH, OK, PA, SC, TN, TX, UT, VA, WA, WI, WY
Neonatal transport reimbursement policy	AL, AK, AZ, AR, CA, CO, DE, GA, ID, IL, IN, ME, MD, MI, MN, MT, NV, NM, NY, NC, OK, OR, RI, SC, SD, TN, TX, UT, WV, WI, WY
Maternal transport reimbursement policy	AK, AZ, AR, GA, MD, MN, MT, NM, TX, UT, WY
Medicaid transport reimbursement policy	AL, AK, AZ, AR, CA, CO, DE, GA, ID, IL, IN, ME, MD, MI, MN, MT, NV, NM, NY, NC, OK, OR, RI, SC, SD, TN, TX, UT, WV, WI

While the transport and reimbursement policies in this section are relevant to the proposed health benefit mandate, they are not the same as the proposed language that would provide coverage for a mother, a newborn, and/or newborn siblings transferred together to a different medical facility if a health care provider recommends a transfer for either the mother or newborn. No current policies that cover this specific element of maternal and newborn transfers were identified during this policy review.

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations who responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received comments from five organizations, including one health care association that expressed strong support for the mandate and four commercial health carriers that provided information related to insurance coverage.

One organization stated that this mandate codifies existing Minnesota law for required covered services for prenatal, delivery, and postpartum care. Others reported that the mandate's language was inadequate to assess required coverage, although they interpreted it as expanding the definitions of services required during prenatal and postpartum periods beyond the existing statutes. One organization noted that further clarification is needed on the bill's requirements for "Child Supervision Services," including what specific billing codes would apply.

Some respondents noted that the proposed mandate's restriction on cost-sharing for delivery and postpartum represents a substantial change from current policy and could result in significant changes in premiums. While utilization of necessary postpartum services could reduce the number of costly adverse events and result in some downstream savings, it would cause a significant short-term increase in premiums. This requirement may also negatively impact high-deductible health plan qualifications and have tax implications for those with Health Savings Accounts. One respondent noted that the elimination of cost-sharing for all prenatal, delivery, and postpartum services would be critical for improving current morbidity statistics for mothers and infants. Another respondent noted that more research is needed to understand the impact of cost-sharing on clinical outcomes.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed benefit mandate:

- MMB estimates an average $0.58 per member per month (PMPM) increase for PY 2025 and PY 2026, based on changes in coverage for specific services recommended by physicians in prenatal and postpartum periods and on restrictions in cost-sharing for delivery.
- Two respondents noted that most commercial health insurance plans provide full coverage of prenatal care without cost-sharing. If enacted, respondents stated that this proposed mandate may result in an estimated cost increase of up to $3.50 PMPM due to eliminating cost-sharing for delivery and postpartum care.

Stakeholders' results may or may not reflect generalizable estimates for the mandate, depending on the methodology, data sources, and assumptions used for analysis.

Evaluation of Proposed Health Benefit Mandate

Methodology

The following section includes an overview of the literature review performed to examine the potential public health and economic impact of the mandate. The literature review includes moderate- to high-quality relevant peer-reviewed literature and/or independently conducted domestic research that was published within the last 10 years and is related to the public health, economic, or legal impact of the proposed health benefit mandate. For further information on the literature review methodology, please reference https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Public Health Impact

Literature Review

Prevalence of Maternal and Infant Morbidity and Mortality

Maternal and Infant Morbidity. Approximately 1.4% of birthing people experience severe maternal morbidity in the United States.[1] Indicators of maternal morbidity include blood transfusions, eclampsia, hysterectomy, and adult respiratory distress syndrome, each of which may not result in mortality but can negatively impact the health of the birthing person.[1,11] Specific data related to maternal morbidity in Minnesota was not identified. Infant morbidity can be measured through rates of preterm births and infants born with a low birth weight. In 2021, preterm birth and low birth weight accounted for 14.8% of infant deaths.[12] In Minnesota, 9.6% of live births were born preterm, and 7.2% of live births had a low birth weight in 2021, which is slightly below national averages.[12,13]

Maternal and Infant Mortality. The maternal mortality rate in the United States in 2021 was 20 deaths per 100,000 pregnancies.[1] The 2022 maternal mortality rate has not been finalized by the CDC, but early reports indicate a decrease, attributed to a decrease in pregnant individuals affected by COVID-19.[14] Minnesota's pregnancy-related mortality ratio (PRMR) was found to be lower than the national average.[15] In 2017–2018, the PRMR in Minnesota was 8.8 deaths per 100,000 births, a little less than half the national PRMR. Black and Native American individuals are disproportionately represented in the Minnesota maternal mortality rate and account for 23% and 9% of pregnancy-related deaths, respectively. All pregnancy-related deaths in 2017–2018 were determined to be preventable. The infant mortality rate in the United States was 5.4 infant deaths per 1,000 live births in 2021 and increased 3% in 2022.[16] In Minnesota, the infant mortality rate was 4.83 infant deaths per 1,000 live births in 2021.[17]

Prenatal and Postpartum Care Utilization

Prenatal Care. Utilization of prenatal services, including maternal education, health monitoring, and medically necessary early interventions, is associated with improved maternal and infant health outcomes.[18] As indicated previously, coverage of prenatal services with no cost-sharing is included in the Minnesota benchmark plan (see the Relevant State Policy section).[19] Prenatal care may include prenatal office visits, iron and folic acid supplementation, tetanus immunization (if needed), calcium supplementation for hypertension, utilization of anti-platelet medication for prevention of pre-eclampsia, and hypertension treatment (if needed). A literature scan found that prenatal care leads to better clinical health outcomes.[20] Examples of specific prenatal services and associated maternal and infant health outcomes are listed in Table 2.

Table 2. Prenatal Services and Associated Maternal and Infant Health Outcomes

Treatment type	Clinical outcomes
Iron supplements	Reduced risk of low birth weight for newborn births compared with the risk minus iron supplementation
Calcium supplements	Reduced risk of pre-eclampsia, by 64%, in women with low dietary intake of calcium
Anti-platelet agents	Reduced risk of preterm birth
Prenatal care visits	Reduced morbidity and mortality among women who had more prenatal care visits

Postpartum Care. Postpartum care includes services and supports provided immediately after delivery and continuing on average for 3 to 12 months after delivery.[21] Postpartum care ensures that mothers and infants continue to receive comprehensive care that mitigates morbidity and prevents mortality. Comprehensive care may include visits with a health care provider to maintain the mother's and infant's psychological and physical well-being.

A study conducted to assess health insurance coverage and postpartum outcomes found that more comprehensive insurance coverage or extended health coverage up to 12 months postpartum may be associated with greater utilization of postpartum services and reduced emergency department readmissions for maternal morbidity, such as hemorrhage, acute myocardial infarction, and sepsis.[22]

Maternal and Neonatal Transfers

Prevalence and Coverage for Transfers. In 2020, there were just over 3.6 million live births in the United States.[23] It was estimated that 9%–13% of those births required neonatal intensive care for complex medical needs. Maternal and/or infant transfers to a facility with higher level care may be beneficial for infants who require neonatal intensive care.[24] A systematic review of neonatal and maternal transport and reimbursement policies from the period 2014–2019 found that 31 states have reimbursement policies for neonatal transport, and 11 of these states also have reimbursement policies for maternal transport. Additionally, 30 states have a Medicaid transport reimbursement policy. This review noted that continued development and refining of neonatal and maternal transport policies, including transport reimbursement policies, may lead to better perinatal outcomes, especially among high-risk maternity and neonatal patients.[10] However, there is no literature to address the prevalence of mother, newborn, and/or newborn sibling transfers to the same facility or the associated clinical outcomes. The current research does not explore barriers to simultaneous transfer, such as coverage determinations or clinical decision-making.

Facility Type Considerations. The level of care at the initial facility of birth may affect the likelihood of transfer for mother and newborn. A cross-sectional study to assess neonatal mortality after interhospital transfer of pregnant women for imminent very preterm birth in Illinois found that there is an increased risk of neonatal mortality when mothers deliver at non-level III hospitals or hospitals without a neonatal intensive care unit.[25] Reductions in obstetric resources among rural hospitals have increased the likelihood that mothers may deliver at a non-level III hospital.

Maternal and Infant Health Disparities

Systemic Racism and Maternal and Infant Health Outcomes. Social, political, economic, and environmental conditions, often referred to as social determinants of health, affect maternal and infant health outcomes.

Differences in health insurance coverage and access to care contribute to health disparities. Compared with White women, Black, Native American, and Alaska Native women have higher rates of maternal and infant morbidity and mortality.[26] In Minnesota from 2017 to 2018, Black and Native American women were disproportionately represented among pregnancy-related fatalities, with Black women accounting for 23% of pregnancy-related deaths and Native American women accounting for 8% of pregnancy-related deaths.[27] Structural barriers, such as low income, limited educational opportunities, lack of work flexibility, and transportation difficulties, may disproportionately impact Black, Indigenous, and people of color (BIPOC) and decrease their access to high-quality health care, including prenatal and delivery health services.[26] In Minnesota, 44% of pregnant people experienced at least one barrier to prenatal care, including transportation difficulties, lack of health insurance, and inability to take necessary time away from work.[28]

Economic Impact

Literature Review

Maternal and Infant Morbidity Cost Data and Coverage Implications

Preterm Birth Costs. Preterm birth is the leading cause of infant morbidity and mortality and is associated with high costs for patients and health plans.[29] A large retrospective cohort study of commercially insured individuals found that preterm infants (<37 weeks) incurred average medical expenditures of $76,153. Average expenditures for infants born at 24 weeks gestation (*n* = 418) equaled $603,778, and average spending for infants with low birth weight was $114,437.[30] There are no studies addressing cost-sharing in coverage or the degree to which eliminating cost-sharing in coverage for prenatal or delivery alters clinical outcomes associated with higher cost deliveries and postpartum care.

Postpartum Costs. One cross-sectional study evaluating Medicaid postpartum expansion found that for individuals in the study population who were continuously enrolled in Medicaid 3–12 months postpartum, primary care use increased and emergency department rates decreased compared to commercial populations without equivalent postpartum coverage and cost-sharing.[31] Individuals with low income also reported fewer out-of-pocket costs 3–12 months postpartum compared with those without postpartum care past 3 months, although Medicaid per capita spending on postpartum care increased because of the postpartum expansion.

Maternal Morbidity Costs. A review of literature into nine selected maternal morbidity conditions found that the aggregated cost for all pregnancies or live births in 2019 was $32.3 billion (the cost per pregnancy was treated as the total cost due to these conditions from conception to 5 years postpartum).[1] This estimate includes $18.7 billion in medical costs and $13.6 billion in nonmedical costs, with two thirds of the costs occurring in the first year postpartum. The largest drivers of cost include hypertensive disorders, gestational diabetes mellitus, and hemorrhage. Other noted costs specific to maternal outcomes include productivity loss and cesarean section delivery. This study highlighted the significant economic and societal costs caused by maternal morbidity.

Limitations

While the available literature addresses some clinical outcomes and costs associated with coverage for prenatal, delivery, and postpartum periods, there are no studies that address the effects of eliminating cost-sharing for such coverage. Given the broad range of postpartum services, there are no data to address the potential costs to health plans associated with an expanded non-cost-sharing period of 12 months. Furthermore, there is no research on the following: costs for mother and infant concurrent transfers, the percentage of mothers or

newborn siblings who require continued hospitalization and who would require transfer, and neonate and associated clinical outcomes.

There are no studies addressing whether attending provider referral patterns, facility constraints, or coverage result in infants, mothers, and newborn siblings not receiving concurrent transfer or affect the frequency at which this occurs. Further, the literature is insufficient to specifically address the proposed mandate's potential impact on access to and cost of neonatal transfers or maternal and infant mortality and morbidity rates. It is also insufficient to determine the prevalence of mothers continuing to require hospitalization at the point of infant transfer, the public health implications of mothers and infants being transferred simultaneously, and the clinical appropriateness of transfers based on facility type.

Data Limitations

Due to the broad scope of the mandate, an actuarial analysis to estimate the potential economic impact of the mandate is not feasible. The mandate coverage requirements could potentially apply to all care required during prenatal and postpartum periods, and thus there is no clearly defined set of services to analyze claims from the Minnesota All Payer Claims Database (MN APCD). Furthermore, infant and maternal health care claims cannot be linked in the MN APCD to assess the costs or cost savings associated with the infant and maternal transfer requirements of the mandate. Due to the limited number of newborn and maternal transfers, the inability to link maternal and newborn claims, and the inability to assess uncovered transfers or the prevalence of mothers and infants being transferred simultaneously, we are unable to assess the potential economic impact of this coverage requirement.

State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the estimated cost to public programs.

- MMB estimates the cost of this legislation for the state plan to be $448,920 for partial Fiscal Year 2025 (FY 2025) and $942,732 for FY 2026.
- There are no estimated defrayal costs associated with this proposed mandate.
- There is no estimated cost to state public programs.

Fiscal Impact Estimate for SEGIP

MMB provided SEGIP's fiscal impact analysis, which is based on the prevalence of applicable conditions in the membership of SEGIP health plans, potential changes in utilization, and the potential for future high-cost cases. The partial fiscal year impact of the proposed legislation on SEGIP is estimated to be $448,920 for FY 2025 ($0.58 PMPM medical cost × 129,000 members × 6 months). By FY 2026, the estimated impact will equal $942,732, and it will increase by 5% for all following years to account for medical price inflation. The analysis noted that the language of the bill poses a conflict for SEGIP's high-deductible health plan (HDHP), which is required under state statute. Since the bill's language does not make a specific exemption for HDHPs, the federal requirements for HDHPs would preempt application of the state benefit mandate. Additionally, in the analysis, MMB assumes there would need to be a mechanism in place for the health plan administrators to identify provider-recommended care.

Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 essential health benefits (EHBs) defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA.[2,32] For further defrayal requirements and methodology, please visit https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

If enacted, this bill would not constitute an additional benefit mandate requiring defrayal, as it does not relate to any new requirements for specific care, treatment, or services that are not already covered by Minnesota's benchmark plan. Minnesota's benchmark plan includes coverage for prenatal care, maternity and newborn care, and postpartum services.[19] Additionally, federally mandated EHBs related to this mandate include ambulatory patient services, emergency services, hospitalization, and maternity and newborn care.[33]

Fiscal Impact for State Public Programs

There is no estimated cost to Minnesota public health coverage programs, as the proposed health benefit mandate does not apply to these programs.

Appendix A. Bill Text

A bill for an act relating to insurance; requiring health plans to cover prenatal, maternity, and postnatal care; amending Minnesota Statutes 2022, sections 62A.041, subdivision 1; 62A.0411; 62A.047; 62Q.521; repealing Minnesota Statutes 2022, section 62A.041, subdivision 2.

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

Section 1. Minnesota Statutes 2022, section 62A.041, subdivision 1, is amended to read:

Subdivision 1. **Discrimination prohibited against unmarried women.** Each ~~group policy of accident and health insurance and each group health maintenance contract~~ health plan as defined in section 62Q.01, subdivision 3, shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each ~~group policy and each group contract~~ health plan shall provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

~~Each individual policy of accident and health insurance and each individual health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each individual policy and each individual contract shall also provide the same coverage for that child as that provided for the child of a married insured or a married enrollee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage~~.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2022, section 62A.0411, is amended to read:

62A.0411 MATERNITY CARE.

Subdivision 1. **Minimum inpatient care.** (a) Every health plan ~~as defined in section 62Q.01, subdivision 3, that provides maternity benefits~~ must~~, consistent with other coinsurance, co-payment, deductible, and related contract terms,~~ provide coverage of a minimum of 48 hours of

inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn. The health plan shall not provide any compensation or other nonmedical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified in this section.

(b) In addition to the coverage required under paragraph (a), every health plan must provide coverage for all inpatient care of a mother and her newborn recommended by a health care provider acting within the provider's scope of practice, related to the delivery and associated well-being of the mother and newborn, including but not limited to all procedures, examinations, screenings, counseling, education, and inpatient care extending beyond the minimum durations provided in paragraph (a).

(c) In the event a health care provider, acting within the provider's scope of practice, recommends that either the mother or newborn be transferred to a different medical facility, every health plan must provide the coverage required under this section for all of the mother, newborn, and newborn siblings, at both medical facilities. The coverage required under this paragraph includes, but is not limited to, expenses related to the transfer of all individuals transferred.

Subd. 2.**Minimum postdelivery outpatient care.**(a) The health plan must also provide coverage for postdelivery outpatient care to a mother and her newborn if the duration of inpatient care is less than the minimums provided in this section.

(b) Postdelivery outpatient care consists of a minimum of one home visit by a registered nurse and all postdelivery outpatient care of a mother and her newborn recommended by a health care provider acting within the provider's scope of practice, related to the delivery and associated well-being of the mother and newborn, including but not limited to all procedures, examinations, screenings, counseling, education, and office visits. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four days following the discharge of the mother and her child.

Subd. 3.**Prohibition on cost-sharing; limitations.** Except for the coverage required by subdivision 1,

paragraph (c), which is not recommended by a health care provider, the coverage required under this section must be provided without cost-sharing, including but not limited to deductible, co-pay, or coinsurance. The coverage required under this section must be provided without any limitation that is not generally applicable to other coverages under the plan.

Subd. 4.**Health plan defined.** For purposes of this section, the term "health plan" means a health plan as defined in section 62Q.01, subdivision 3.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2022, section 62A.047, is amended to read:

62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES.

Subdivision 1. **Coverage required.** ~~A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident,~~ Each health plan as defined in section 62Q.01, subdivision 3, must provide coverage for child health supervision services and prenatal care services. ~~The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. This section does not prohibit the use of policy waiting periods for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. Nothing in this section applies to a commercial health insurance policy issued as a companion to a health maintenance organization contract, a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only accident coverage. A policy, contract, or certificate described under this section may not apply to preexisting condition limitations to individuals under 19 years of age. This section does not apply to individual coverage under a grandfathered plan.~~ A health plan may not limit coverage under this section based

on an individual's preexisting condition.

Subd. 2.**Prohibition on cost-sharing; limitations.** The coverage required under this section must be provided without cost-sharing, including but not limited to deductible, co-pay, or coinsurance. The coverage required under this section must be provided without any limitation that is not generally applicable to other coverages under the plan.

Subd. 3.**Child health supervision services defined.** For purposes of this section, "child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

Subd. 4.**Prenatal care services defined.** For purposes of this section, the term "prenatal care services" means:

(1) the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists; and

(2) all prenatal care of a mother and her child recommended by a health care provider acting within the provider's scope of practice, related to the pregnancy, delivery, and associated well-being of the mother and child, including but not limited to all procedures, examinations, screenings, counseling, education, and office visits.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2022, section 62Q.521, is amended to read:

62Q.521 POSTNATAL CARE.

(a) For purposes of this section, "comprehensive postnatal visit" means a visit with a health care

provider that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

(b) A health plan must provide coverage for the following:

(1) a comprehensive postnatal visit with a health care provider not more than three weeks from the date of delivery;

(2) any postnatal visits recommended by a health care provider between three and 11 weeks from the date of delivery; and

(3) a comprehensive postnatal visit with a health care provider 12 weeks from the date of delivery; and

(4) all postnatal care of a mother and infant, prior to the infant reaching age one, recommended by a health care provider acting within the provider's scope of practice, including but not limited to all procedures, examinations, screenings, counseling, education, and office visits.

(c) The requirements of this section are separate from and cannot be met by a visit made pursuant to section 62A.0411.

(d) The coverage required under this section must be provided without cost-sharing, including but not limited to deductible, co-pay, or coinsurance. The coverage required under this section must be provided without any limitation that is not generally applicable to other coverages under the plan.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

Sec. 5. **REPEALER.**

Minnesota Statutes 2022, section 62A.041, subdivision 2, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2025.

Appendix B. Key Search Terms for Literature Scan

Comprehensive or extended health insurance

Continuity prenatal care

Health expenditures

Health insurance coverage

Healthcare utilization

Maternal care

Mother baby separation

Mother newborn separation

Postpartum complications

Postpartum maternal care

Postpartum period

Pregnancy

Pregnancy-related conditions

Prenatal care

Quality of maternal care

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