

Bulletin 294

NEWBORN COVERAGE

This is intended to clarify the 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. In each case, the newborn provision is listed first, followed by the maternity provision:

- Nonprofit hospital and medical service plans - Title 24 M.R.S.A. §§ 2319 and 2318-A;
- Individual health insurance - Title 24-A M.R.S.A. §§ 2743 and 2743-A;
- Group health insurance - Title 24-A M.R.S.A. §§ 2834 and 2834-A; and
- Health maintenance organizations (HMOs) - Title 24-A M.R.S.A. §§ 4234-C and 4234-B

There is an overlap between these two provisions. In cases where the mother and father are covered by separate plans and the father elects to add the newborn under his plan, questions arise as to which carrier should pay for services such as hospital nursery charges associated with the birth. Our interpretation is that coverage is provided by both plans and normal coordination of benefits (COB) provisions apply. In the future, the Bureau intends to propose a COB rule that would specify that the mother's plan is primary in these situations. However, at present the COB provisions in the contracts control. Normally, this means the plan covering the parent with the earlier birthday will be primary.

In order to continue coverage under the newborn provision beyond the first 31 days, the parent must make an affirmative election of coverage and pay any applicable premium. However, for services within the first 31 days, coverage is automatically available. A premium may be charged for this coverage only if the parent either requests continued coverage beyond the 31 days, or files a benefit claim for services rendered within the 31 days. If coverage under the newborn provision is available from two plans, the parents may choose to cover the child under one of the plans while declining coverage under the other plan. In that case, the plan covering the child may not coordinate benefits unless the other plan is covering the same services on the mother's behalf under the maternity provision.

For services that are within the scope of the maternity provision, coverage must be provided without imposing any separate deductible or copayment for the child. A claim under the maternity provision does not constitute an election to cover the child under the newborn provision, and does not trigger any obligation to pay premium on behalf of the child.

Another issue that arises concerns the applicability of the newborn provision in situations where the newborn does not meet the definition of an "eligible dependent" under the plan. An example would be if the new mother is covered as a dependent under her parent's plan, and the definition of "eligible dependent" excludes grandchildren. It is the Bureau's interpretation that the plan must cover the newborn child for the initial 31 days as required by the statute. 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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information is needed.