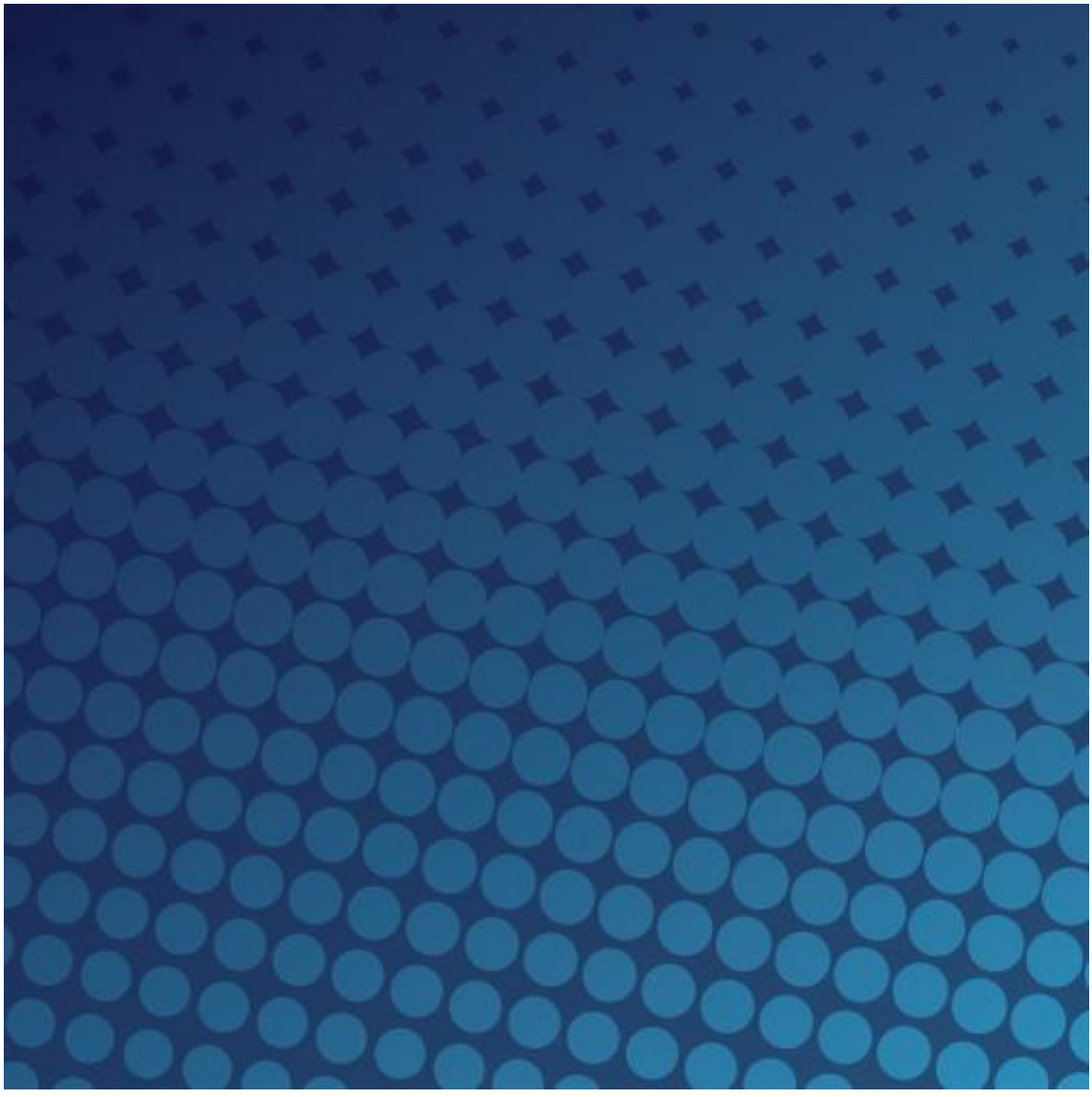
Report on Health Insurance Coverage for Childbirth

PURSUANT TO CHAPTER 787 OF THE LAWS OF 2021

December 16, 2022



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I. Executive Summary

On December 22, 2021, Governor Hochul signed Chapter 787 of the Laws of 2021 ("Chapter 787"), directing the New York State Department of Financial Services ("DFS"), in consultation with the New York State Department of Health ("DOH"), to review covered benefits related to childbirth offered by all health insurance policies and medical assistance in New York State, to review the extent to which such policies meet or exceed the federal Affordable Care Act[1] ("ACA") requirements, and to make recommendations regarding the adoption of statewide standards. This report summarizes DFS's review and survey results of DFS-regulated health insurance companies writing fully insured comprehensive health insurance ("Health Insurance") in New York State.

To gather data for the report, DFS required that insurers authorized to write accident and health insurance in New York State, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, and prepaid health services plans ("Issuers") offering Health Insurance submit information and documentation related to claims incurred for specific covered benefits related to childbirth during the 2019 and 2020 calendar years. DFS reviewed the claims data provided by Issuers and the coverage requirements for childbirth and related services pursuant to the ACA and New York Insurance Law. In addition, DFS reviewed complaints received by the DFS Consumer Assistance Unit related to childbirth. In the regular course of business, DFS also reviews and approves all Health Insurance policy forms prior to them being sold by New York Issuers to ensure compliance with New York law, including benefits related to maternity care coverage.

[1] 42 U.S.C. § 18022

DFS did not collect data from self-insured plans because self-insured plans are regulated by the United States Department of Labor, and DFS, as a state regulator, is pre-empted by the Employee Retirement Income Security Act of 1974 ("ERISA") from regulating those plans.

Summary of Findings:

Chapter 787 required DFS to review the following areas. DFS's findings are included under each section.

a) The current range in length of stay coverage periods for surgical and vaginal deliveries across Health Insurance plans offered within New York State distinguishing from simple surgical deliveries and complex deliveries.

Findings (in days):

		Percentiles			Range of Stay	
Type	**Mean**	**25th**	**50th**	**75th**	**Min.**	**Max.**
Vaginal	2.53	2	2	3	1	233
Simple Surg.	3.24	2	3	4	1	132
Complex Surg.	4.91	3	4	5	1	111
All Births	2.80	2	2	3	1	233

b) The average and range of reimbursement to maternal fetal medicine physicians, obstetrics/gynecologic physicians, family practice physicians and licensed midwives for labor and a surgical delivery or vaginal delivery.

Findings:

It should be noted that the range of Issuer reimbursement amounts with $0 values may be attributed to an insured having not met their deductible amount. In addition, some insureds may have had additional coverage which paid the maternity claim first. In those cases, the secondary coverage may not have been required to provide reimbursement.

		Percentiles			Range of Issuer Reimbursement	
Vaginal Births	**Mean**	**25%**	**50%**	**75%**	**Min**	**Max**
Fetal Medicine	$25,513	$16,446	$22,259	$27,032	$0	$230,430
OB/GYN	$16,777	$10,592	$14,655	$20,634	$0	$832,190
Family Practice	$10,661	$7,560	$10,016	$12,944	$0	$40,810
Midwives	$12,006	$7,727	$10,587	$14,178	$0	$75,239

		Percentiles			Range of Issuer Reimbursement	
Surgical Births	**Mean**	**25%**	**50%**	**75%**	**Min**	**Max**
Fetal Medicine	$31,577	$20,480	$30,326	$36,627	$0	$195,349
OB/GYN	$21,790	$14,054	$18,806	$27,134	$0	$236,343
Family Practice	$13,732	$11,257	$13,299	$16,241	$177	$29,203
Midwives	$21,519	$11,708	$18,490	$27,525	$0	$75,934

		Percentiles			Range of Issuer Reimbursement	
All Births	**Mean**	**25%**	**50%**	**75%**	**Min**	**Max**
Fetal Medicine	$27,822	$17,776	$23,857	$32,380	$0	$230,430
OB/GYN	$18,479	$11,511	$16,083	$22,457	$0	$832,190
Family Practice	$11,114	$7,698	$10,377	$13,441	$0	$40,810
Midwives	$12,335	$7,814	$10,732	$14,505	$0	$75,934

c) The current range of out-of-pocket expenses, including upfront payments if applicable, incurred by patients for a surgical delivery or for a vaginal delivery within New York State by the type and amount.

Findings:

		Percentiles				
Type	**Mean**	**25th**	**50th**	**75th**	**Min.**	**Max.**
Vaginal	$1,672	$200	$988	$2,633	$0	$15,800
Surgical	$1,585	$150	$750	$2,496	$0	$18,539
All Births	$1,644	$200	$855	$2,591	$0	$18,539

Wide ranges in cost-sharing are due to the fact that cost-sharing is dependent on the type of policy the insured is utilizing. For instance, Health Insurance plans may feature different types of cost-sharing, including copayments, coinsurance and deductibles.

d) The extent to which health insurance plans offered in New York State provide for additional coverage for the insured in the event of childbirth complications occurring during a vaginal or surgical delivery.

Findings:

All Health Insurance sold in New York is required to provide coverage for childbirth complications occurring during a vaginal or surgical delivery, as well as a number of other protections. Specifically, Health Insurance sold in New York must cover maternity care to the same extent as coverage is provided for illness or disease and may not include annual or lifetime limits.[2] Additionally, Health Insurance must provide coverage for maternal depression screening and treatment,[3] midwifery services, postnatal care, delivery, complications of pregnancy[4], and surrogacy.[5] Also, comprehensive lactation support services must be covered at no cost-sharing.[6] New York insurance regulations[7] also provide that no policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, including for complications of pregnancy.

There are no distinctions for childbirth complications occurring during a vaginal or surgical delivery. Childbirth complications are covered just as any other medically necessary illness or disease is covered under the policy.

e) The extent to which insurance providers cover the cost of newborn care in the neo-natal intensive care unit, under what circumstances, and if related to surgical delivery.

[2] Insurance Law §§ 3217-f, 4306-e, 4328; 42 U.S.C. § 300gg-11 and 45 C.F.R. § 147.126
[3] 42 U.S.C. § 247b-13a, Insurance Law §§ 3217-g and 4306-f and Public Health Law § 4406-f
[4] Complications of pregnancy means conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. See 11 NYCRR § 52.2(e)
[5] See DFS Insurance Circular Letter No.1 (2021)
[6] See DFS Insurance Circular Letter No. 5 (2018)
[7] 11 NYCRR § 52.16(c)(3)

Findings:

New York law[8] prohibits prior authorization for services provided in a neonatal intensive care unit ("NICU"). As with any services provided in a medical setting, Issuers are permitted to conduct utilization review to review the services for medical necessity[9] and may deny claims for services that are not medically necessary.

New York Insurance Law[10] requires Issuers to provide coverage for a newborn infant (including an adopted infant) from the moment of birth where family coverage is applicable. This includes coverage for injury or sickness, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care.

f) The extent to which health insurance plans offered in New York State offer maternity coverage for dependents under the age of 26 and the range of services covered.

Findings:

New York law requires Issuers to offer available dependent coverage for married or unmarried children until they attain the age of 26 years, regardless of financial dependence, residency with the policyholder, student status or employment. In addition, every Issuer issuing Health Insurance that provides coverage for dependent children must make available and, if requested by the policyholder, extend coverage under the policy to any unmarried child through age 29, without regard to financial dependence, where the dependent is not insured by or eligible for

[8] Insurance Law §§3217-b(k), 4325(l) and Public Health Law § 4406-c(9)
[9] Utilization Review means the review to determine whether health care services that have been provided are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with, or subsequent to the delivery of such services, are medically necessary. See Insurance Law § 4900(h) and Public Health Law § 4900(8)
[10] Insurance Law §§ 3216(c)(4)(C), 4235(f)(2), 4304(d)(1)(C), and 4305(c)(1)(C)

coverage under an employer health benefit plan as an employee or member, whether insured or self-insured and who lives, works or resides in New York State or the service area of the insurer. Coverage is not required however for a child of the dependent child.[11]

g) The extent to which health insurance plans offered in New York consider pregnancy a life event that makes a woman eligible for special enrollment periods.

Findings:

All individual Health Insurance policies sold in New York must allow for a special enrollment period for pregnant women.[12] A pregnant woman may enroll in a new individual policy at any time after a health care professional certifies that she is pregnant. Upon enrollment, coverage shall be effective as of the first day of the month in which a health care professional certifies the pregnancy.

In summary, DFS review of New York Insurance Law has found that New York laws related to Health Insurance coverage for maternity and newborn care exceeds the requirements set in place by the ACA. Every Health Insurance policy in New York must provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical coverage is provided in the policy. This concept extends to additional coverage for the mother in the event of childbirth complications, coverage for newborns in a NICU and maternity coverage for dependents. DFS reviews and approves all Health Insurance policy forms prior to them being sold by Issuers to ensure compliance with New York law, including benefits related to maternity care coverage.

DFS also reviewed complaints received by the DFS Consumer Assistant Unit and found that there are no major trends in Issuers not providing coverage as required by applicable New York laws

[11] Insurance Law §§ 3216(a)(4)(C), 4235(f)(1)(B), 4304(d)(1)(B), 4305(c)(1)(B)
[12] Insurance Law §§ 3216(l), 4304(l) and 4328(b)(4)(B)

related to childbirth. There may be isolated instances of coverage not being provided in compliance with New York laws, and the DFS Consumer Assistance Unit addresses those on a case by case basis.

II. Introduction

Adrienne A. Harris, the Superintendent of Financial Services, respectfully submits this report, pursuant to Chapter 787, which directs the review of covered benefits related to childbirth offered by all health insurance policies and medical assistance in New York State. Chapter 787 directs DFS to review covered benefits related to childbirth offered by all Health Insurance policies and medical assistance in New York State, to review the extent to which such policies meet or exceed the federal ACA requirements, and to make recommendations regarding the adoption of statewide standards.

The Memorandum in Support of Chapter 787 provides that its purpose is "to uncover hidden costs related to childbirth, shine a light on disparities in rates negotiated by insurers covering the birth, and determine if statewide standards should be adopted".

Chapter 787 directs the review of the following:

a) the current range in length of stay coverage periods for surgical and vaginal deliveries across health insurance plans offered within New York State distinguishing from simple surgical deliveries and complex deliveries;
b) the average and range of reimbursement to maternal fetal medicine physicians, obstetrics/gynecologic physicians, family practice physicians and licensed midwives for labor and a surgical delivery or vaginal delivery;
c) the current range of out-of-pocket expenses, including upfront payments if applicable, incurred by patients for a surgical delivery or for a vaginal delivery within New York State by the type and amount;
d) the extent to which health insurance plans offered in New York State provide for additional coverage for the insured in the event of childbirth complications occurring during a vaginal or surgical delivery;
e) the extent to which insurance providers cover the cost of newborn care in the neo-natal intensive care unit, under what circumstances, and if related to surgical delivery.
f) the extent to which health insurance plans offered in New York State offer maternity coverage for dependents under the age of 26 and the range of services covered, and;

g) the extent to which health insurance plans offered in New York consider pregnancy a life event that makes a woman eligible for special enrollment periods.

In accordance with Chapter 787, DFS collected data regarding all benefits related to childbirth offered by Issuers providing Health Insurance within New York State, during the 2019 and 2020 calendar years, in order to review the extent to which policies meet or exceed the federal ACA requirements. DFS also reviewed complaints received by the DFS Consumer Assistance Unit related to childbirth. DFS also reviews and approves all Health Insurance policy forms prior to them being sold by New York Issuers to ensure compliance with New York law, including benefits related to maternity care coverage.

DFS did not collect data from self-insured plans because self-insured plans are regulated by the United States Department of Labor, and DFS, as a state regulator, is pre-empted by ERISA from regulating those plans.

A. The Department of Financial Services

DFS is New York's banking, insurance, and financial services regulator, established in 2011 by the Legislature which consolidated the New York Banking Department and Insurance Department and authorized the resulting agency to oversee a broader array of financial products and services, with the goal of modernizing regulation. DFS now supervises and regulates the activities of nearly 3,000 financial institutions with total assets of more than $8.4 trillion, including more than 1,700 insurance companies and 1,200 banking and other financial institutions. DFS seeks to build an equitable, transparent, and resilient financial system that benefits individuals and supports business. DFS and its employees are responsible for empowering consumers and protecting them from financial harm; ensuring the health of

regulated entities; driving economic growth in New York through responsible innovation; and preserving the stability of the global financial system.

DFS's Health Bureau currently oversees health Issuers including those writing accident and Health Insurance, health maintenance organizations, not-for-profit health plans, continuing care retirement communities, municipal cooperative health benefit plans, student health plans and prepaid health service plans.

The Health Bureau performs the following functions:

- reviewing rate and form filings submitted by Issuers for approval to ensure compliance with consumer protections in state and federal laws and regulations;
- protecting consumer benefits by ensuring the financial solvency of Issuers, including through financial exams;
- enforcing consumer protections and other legal requirements of Issuers, primarily through market conduct exams;
- reviewing transactions involving regulated entities, including mergers, acquisitions, reinsurance, payment of dividends and investments in affiliated companies; and
- proposing new rules to protect consumers and promote insurance, including statutes, regulations and guidance.

Additionally, the DFS Consumer Assistance Unit receives complaints from consumers and health care providers about Issuers. Complaints typically involve issues related to prompt payment, reimbursement, coverage, network adequacy, benefits, rates and premiums. After reviewing each complaint, the Consumer Assistance Unit determines whether the Issuer acted appropriately. If the Consumer Assistance Unit determines that the Issuer did not act in

accordance with its statutory and contractual obligations, the Issuer must resolve the problem to come into compliance.

III. Background

A. Maternity Care Requirements for Health Insurance

The ACA requires individual and small group health insurance policies and contracts ("policies") to provide essential health benefits ("EHB"). The ACA lists maternity and newborn care as an EHB. [13] Federal law[14] dictates that state law governs maternity and newborn care where state law provides: (1) at least a 48-hour hospital length of stay following a normal vaginal delivery and at least 96-hour hospital length of stay following a cesarean section; (2) maternity and pediatric care in accordance with guidelines established by the American College of Obstetrician and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations; or (3) the hospital length of stay for maternity care is left to the decision of the attending provider in consultation with the mother.

New York Insurance Law provides broader benefits for maternity and newborn care than the federal requirements. Pursuant to New York law[15], every policy[16] shall provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical coverage is provided for illness or disease under the policy. Such coverage includes:

- inpatient hospital coverage for a mother and newborn, other than for perinatal complications, for at least 48-hours after childbirth for any delivery other than a

[13] 42 U.S.C. § 18022(b)(1)(D)
[14] 42 U.S.C. § 300gg-51 and 29 U.S.C. § 1185
[15] Insurance Law §§ 3216(i)(10), 3221(k)(5), and 4303(c)
[16] Except for a grandfathered health plan. A "grandfathered health plan" means coverage provided by an issuer in which an individual was enrolled on March 23, 2010, for as long as the coverage maintains grandfathered status in accordance with 42 U.S.C § 18011(e). Ins. Law §§ 3216(i)(17)(F), 3221(l)(8)(G), 4303(j)(4).

cesarean-section birth and at least 96-hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance;

- midwife services by a licensed midwife pursuant to Article 140 of the education law;
- parent education, assistance and training in breast and bottle feeding, and the performance of any necessary maternal and newborn clinical assessment;
- the cost of renting or purchasing one (1) breast pump per pregnancy in conjunction with childbirth;
- one home care visit (not subject to deductibles, copayments and/or coinsurance), which is in addition to rather than in lieu of any home health care coverage available under the policy if the insured chooses to discharge from the hospital early;
- not less than two payments, at reasonable intervals, and for services rendered, for prenatal care and a separate payment for the delivery and postnatal care; and
- The inpatient use of pasteurized donor human milk, (including fortifiers as medically necessary) for which a health care professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than 1,500 grams or a congenital or acquired condition that places the infant at a high risk of development of necrotizing enterocolitis[17].

[17] Insurance Law §§ 3216(i)(34), 3221(l)(20) and 4303(oo)

IV. DFS Review of 2019-2020 Maternity Care Coverage in New York for Health Insurance

In response to Chapter 787, DFS surveyed all Issuers authorized to write Health Insurance in New York State. Each Issuer was required to submit a detailed response including documentation and data regarding claims for covered benefits related to childbirth. DFS reviewed data for claims incurred during the 2019 and 2020 calendar years (this applies to admission dates and/or service dates in 2019 and 2020). DFS also reviewed complaints received by the DFS Consumer Assistance Unit related to childbirth.

Below are summaries of the information collected by DFS for each specific area specified in Chapter 787.

A. The current range in length of stay coverage periods for surgical and vaginal deliveries across health insurance plans offered within New York State distinguishing from simple surgical deliveries and complex deliveries.

Issuer claims data included service dates and procedure codes for each birth. The procedure codes allowed for identification of vaginal, simple surgical, and complex surgical births. The data had the following distribution of these three types of birth:

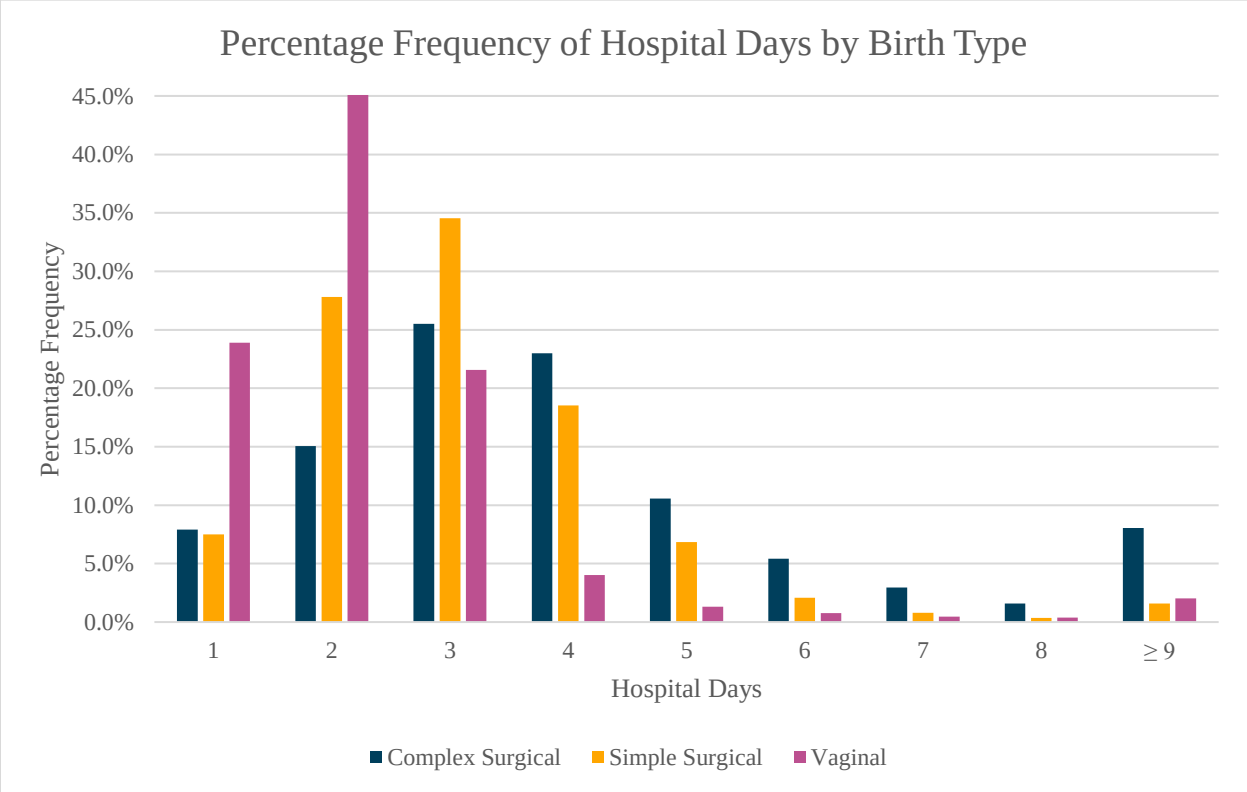
Type	Percentage of Births
Vaginal	68.3%
Simple Surgical	28.9%
Complex Surgical	2.8%

Service dates provided in the data were used to calculate an insured's length of stay for a given birth. The length of stay was calculated as the number of days between the beginning and ending service dates, or one if the dates were equal. This calculation does not account for what hours patients were discharged. For example, a patient may be in hospital from 9:00 AM to 9:00 PM the next day (i.e. 36 hours), and would only be counted as one day.

After the length of stay was calculated, each unique observation was labeled by type of birth to obtain the length of stay statistics below:

		Percentiles			Range of Stay	
Type	**Mean**	**25th**	**50th**	**75th**	**Min.**	**Max.**
Vaginal	2.53	2	2	3	1	233
Simple Surg.	3.24	2	3	4	1	132
Complex Surg.	4.91	3	4	5	1	111
All Births	2.80	2	2	3	1	233

The following graph presents a detailed visualization of the data received from Issuers:



Each bar of the graph above represents the percentage frequency of the number of hospital days for a given birth type in the experience period. For example, 45.6% of the insureds with a vaginal birth had a hospital stay of 2 days.

B. The average and range of reimbursement to maternal fetal medicine physicians, obstetrics/gynecologic physicians, family practice physicians and licensed midwives for labor and a surgical delivery or vaginal delivery.

Issuers provided detail-level data that included rendering provider identifiers for each birth in the experience period. These identifiers were used to identify births that were performed by maternal fetal medicine physicians, obstetrics/gynecologic physicians, family practice physicians and licensed midwives. The total Issuer reimbursement amount for each birth was calculated and used to obtain the reimbursement statistics below. It should be noted that the range of Issuer reimbursement amounts with $0 values may be attributed to an insured having not met their deductible amount. In addition, some insureds may have had additional coverage which paid the maternity claim first. In those cases, the secondary coverage may not have been required to provide reimbursement.

		Percentiles			Range of Issuer Reimbursement	
Vaginal Births	**Mean**	**25%**	**50%**	**75%**	**Min**	**Max**
Fetal Medicine	$25,513	$16,446	$22,259	$27,032	$0	$230,430
OB/GYN	$16,777	$10,592	$14,655	$20,634	$0	$832,190
Family Practice	$10,661	$7,560	$10,016	$12,944	$0	$40,810
Midwives	$12,006	$7,727	$10,587	$14,178	$0	$75,239

		Percentiles			Range of Issuer Reimbursement	
Surgical Births	**Mean**	**25%**	**50%**	**75%**	**Min**	**Max**
Fetal Medicine	$31,577	$20,480	$30,326	$36,627	$0	$195,349
OB/GYN	$21,790	$14,054	$18,806	$27,134	$0	$236,343
Family Practice	$13,732	$11,257	$13,299	$16,241	$177	$29,203
Midwives	$21,519	$11,708	$18,490	$27,525	$0	$75,934

		Percentiles			Range of Issuer Reimbursement	
All Births	**Mean**	**25%**	**50%**	**75%**	**Min**	**Max**
Fetal Medicine	$27,822	$17,776	$23,857	$32,380	$0	$230,430
OB/GYN	$18,479	$11,511	$16,083	$22,457	$0	$832,190
Family Practice	$11,114	$7,698	$10,377	$13,441	$0	$40,810
Midwives	$12,335	$7,814	$10,732	$14,505	$0	$75,934

C. The current range of out-of-pocket expenses, including upfront payments if applicable, incurred by patients for a surgical delivery or for a vaginal delivery within New York State by the type and amount.

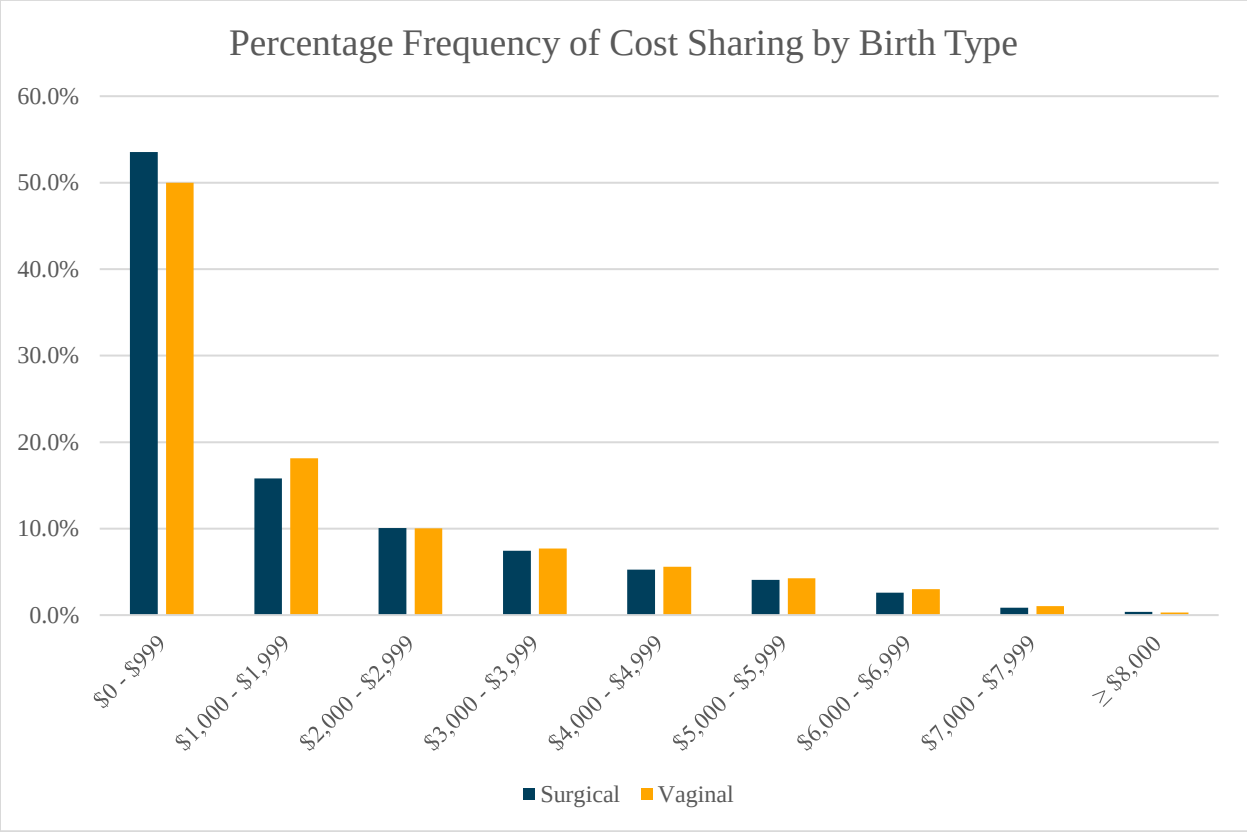
Issuer claims data included cost sharing amounts paid by the insured and procedure codes for each birth. The procedure codes allowed for identification of vaginal and surgical births. The data indicates the following distribution of the two types of birth:

Type	Percentage of Births
Vaginal	68.3%
Surgical	31.7%

Cost sharing amounts provided in the data were used to calculate an insured's payment for a given birth. Wide ranges in cost-sharing are due to the fact that cost-sharing is dependent on the type of policy the insured is utilizing. For instance, Health Insurance plans may feature different types of cost-sharing, including copayments, coinsurance and deductibles. Each observation was grouped by type of birth to obtain the cost sharing payment statistics below:

		Percentiles				
Type	**Mean**	**25th**	**50th**	**75th**	**Min.**	**Max.**
Vaginal	$1,672	$200	$988	$2,633	$0	$15,800
Surgical	$1,585	$150	$750	$2,496	$0	$18,539
All Births	$1,644	$200	$855	$2,591	$0	$18,539

The following graph presents a detailed visualization of the data received from issuers:



Each bar of the graph represents the percentage frequency of the insured's cost sharing for a given birth type in the experience period. For example, 53.5% of the insureds with a surgical birth paid $0 to $999 dollars in cost sharing for their birthing-related maternity care.

D. The extent to which health insurance plans offered in New York State provide for additional coverage for the mother in the event of childbirth complications occurring during a vaginal or surgical delivery.

While most births in New York are routine, complications may occur during delivery, whether or not the birth was initially considered high-risk. Every mother's health, age, background and experience with childbirth is different, unique and distinct. Similarly, there can be a wide range of health complications that arise during childbirth. Many complications may necessitate immediate medical attention that also may entail medical expenses. In New York, there are consumer

protections in place that shield insureds from surprise billing[18], unknown medical billing[19], and unwarranted denial of medical bills.[20]

Health Insurance sold in New York is required to cover maternity care to the same extent as coverage is provided for illness or disease and may not include annual or lifetime limits.[21] Additionally, Health Insurance must provide coverage for maternal depression screening and treatment, midwifery services, postnatal care, delivery, complications of pregnancy, and surrogacy. Also, comprehensive lactation support services must be covered at no cost-sharing. New York insurance regulations also provide that no policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, including for complications of pregnancy.

There are no distinctions for childbirth complications occurring during a vaginal or surgical delivery. Childbirth complications are covered just as any other medically necessary illness or disease is covered under the policy.

DFS reviews and approves all Health Insurance policy forms prior to them being sold by Issuers to ensure compliance with New York law, including benefits related to maternity care coverage.

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[18] 23 NYCRR § 400, 42 U.S.C. §§ 300gg-111, 300gg-131 and 300gg-132

[19] Minimum standards for policy forms include a requirement that there be an explanation of an insured's financial responsibility for premiums, coinsurance, copayments, deductibles and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatments or services. See Insurance law §§ 3217-a(a)(5), 4324(a)(5)

[20] See DFS Insurance Circular Letter No. 4 (2021)

[21] Insurance Law §§ 3217-f and 4306-e; 42 U.S.C. § 300gg-11 and 45 CFR § 147.126

E. The extent to which insurance providers cover the cost of newborn care in the neonatal intensive care unit, under what circumstances, and if related to surgical delivery.

New York law prohibits prior authorization for services provided in a NICU. As with any services provided in a medical setting, Issuers are permitted to review the services for medical necessity and may deny claims for services that are not medically necessary.

New York Insurance Law requires Issuers to provide coverage for a newborn infant (including an adopted infant) from the moment of birth where family coverage is applicable. This includes coverage for injury or sickness, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care.

In the case of individual or two-person coverage the Issuer also must permit the person to whom the contract is issued to elect such coverage of the newborn infant from the moment of birth. In this circumstance, Issuers may require an insured to notify the Issuer that they want to add the newborn infant as a dependent and may require the payment of an additional premium. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the Issuer may require that the notice and/or payment of additional premium be made within no less than 30 days of the date of birth to make coverage effective from the moment of birth. If an insured fails to timely enroll a newborn pursuant to the terms of the policy, the Issuer may deny enrollment of the newborn only for the period prior to the insured's request for enrollment of the newborn.[22]

[22] Insurance Law §§ 3216(c)(4)(C), 4235(f)(2), 4304(d)(1)(C), and 4305(c)(1)

DFS reviews and approves all Health Insurance policy forms prior to them being sold by Issuers to ensure compliance with New York law, including benefits related to maternity care coverage.

F. The extent to which health insurance plans offered in New York State offer maternity coverage for dependents under the age of 26 and the range of services covered.

New York law[23] requires Issuers to offer available dependent coverage for married or unmarried children until they attain the age of 26 years, regardless of financial dependence, residency with the policyholder, student status or employment. In addition, every Issuer issuing Health Insurance that provides coverage for dependent children must make available and, if requested by the policyholder, extend coverage under the policy to any unmarried child through age 29, without regard to financial dependence, where the dependent is not insured by or eligible for coverage under an employer health benefit plan as an employee or member, whether insured or self-insured and who lives, works or resides in New York State or the service area of the insurer.[24] Coverage is not required however for a child of the dependent child.

It is important to note that the terms of the policy cannot vary based on age (except for children who attained age 26 or older). For example, coverage cannot have an additional surcharge if the child is over 18. Premiums may increase based on how many dependents are added to the plan, but the cost cannot increase due to the age of any child. Also, no Issuer shall refuse to renew any such policy because of the physical or mental condition or the health of any person covered thereunder.[25]

[23] Insurance Law §§ 3216(a)(3) and (4)(iii), 4235(f)(1)(A)(i), 4304(d)(1)(A)(i), 4305(c)(1)(A)(i), 42 U.S.C. § 300gg-14 and 45 CFR § 147.120
[24] Insurance Law §§ 3216(a)(4)(C), 4235(f)(1)(B), 4304(d)(1)(B) and 4305(c)(1)(B)
[25] Insurance Law §§ 3216(l), 3221(q)(1), 4304(b)(3) and 4328(b)(6)

Maternity care coverage is required to be provided to the same extent as coverage is provided for illness or disease under the policy or contract as identified in this report above in section III.A. whether the insured is a primary insured or dependent insured. Inpatient hospital coverage for the mother and newborn, other than for perinatal complications shall be provided for at least 48-hours after childbirth for any delivery other than a cesarean-section birth and at least 96-hours following a caesarean section. However, Issuers are not required to cover the newborn of the dependent beyond the initial 48 or 96-hour hospital delivery stay.

All dependents, regardless of age, are entitled to the same benefits provided under the policy as the primary insured, as described in Section III of this report above.

DFS reviews and approves all Health Insurance policy forms prior to them being sold by Issuers to ensure compliance with New York law, including benefits related to maternity care coverage.

G. The extent to which health insurance plans offered in New York consider pregnancy a life event that makes a woman eligible for special enrollment periods.

All individual Health Insurance policies sold in New York must allow for a special enrollment period for pregnant women. A pregnant woman may enroll in a new individual policy at any time after a health care professional certifies that she is pregnant. Upon enrollment, coverage shall be effective as of the first day of the month in which a health care professional certifies the pregnancy. DFS reviews and approves all Health Insurance policy forms prior to them being sold by New York Issuers to ensure compliance with New York law, including benefits related to maternity care coverage.

V. Conclusions

Chapter 787 required DFS to review and summarize the extent to which maternity and newborn care is covered in New York and whether that coverage meets or exceeds the requirements of the ACA. DFS review has found that New York Insurance Law requires a broad range of coverage requirements for maternity and newborn care, which exceed the requirements of the ACA.

DFS reviews and approves all Health Insurance policy forms prior to them being sold by New York Issuers to ensure compliance with New York law, including benefits related to maternity care coverage. Every Health Insurance policy is required to provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical coverage is provided for any other illness or disease under the policy. This concept extends to additional coverage for the mother in the event of childbirth complications, coverage (without prior authorization requirements) for newborns in a NICU and maternity coverage for dependents.

DFS also reviewed complaints received by the DFS Consumer Assistant Unit and found that there are no major trends in Issuers not providing coverage as required by applicable New York laws related to childbirth. There may be isolated instances of coverage not being provided in compliance with New York laws, and the DFS Consumer Assistance Unit addresses those on a case by case basis.

DFS screened its regulated entities to analyze the actual costs incurred by insureds accessing coverage for maternity and newborn care in New York. As more fully set forth above, DFS required that Issuers submit information and documentation related to claims incurred for childbirth related services during the 2019 and 2020 calendar years. Analysis of the claims data

indicated that the median insured experienced a 2.80-day hospital stay, and paid $1,644 in cost sharing. Additionally, the median reimbursement for a birth performed by specific providers were the following:

- Maternal fetal medicine physicians: $27,822
- Obstetrics/gynecologic physicians: $18,479
- Family practice physicians: $11,114
- Licensed midwives: $12,335