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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

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DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

29 CFR Part 2590

RIN 1210-AA63

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

45 CFR Parts 144, 146, and 148

RIN 0938-AI17

Interim Rules For Group Health Plans and Health Insurance Issuers Under the Newborns' and Mothers' Health Protection Act

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Interim rules with request for comments.

SUMMARY: This document contains interim rules governing the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). The interim rules provide guidance to employers,

group health plans, health insurance issuers, and participants and beneficiaries relating to new requirements for hospital lengths of stay in connection with childbirth. The rules contained in this document implement changes to the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) made by NMHPA, and changes to the Internal Revenue Code of 1986 (Code) enacted as part of the Taxpayer Relief Act of 1997 (TRA '97). Interested persons are invited to submit comments on the interim rules for consideration by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (Departments) in developing final rules.

DATES: Effective Date: The interim rules are effective January 1, 1999.

Applicability Dates: Group market rules. The interim rules for the group market apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 1999.

Individual market rules. The interim rules for the individual market apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1999.

Comment Date. Written comments on these interim rules are invited and must be received by the Departments on or before January 25, 1999.

ADDRESSES: Written comments should be submitted with a signed original and three copies (except for electronic submissions to the Internal Revenue Service (IRS)) to any of the addresses specified below. For convenience, comments may be addressed to any of the Departments, except that comments relating primarily to the individual market regulations should be addressed to the Department of Health and Human Services (HHS). Any comment that is submitted to any

Department will be shared with the other Departments.

Comments to the IRS can be addressed to:

CC:DOM:CORP:R (REG-109708-97)
Room 5228
Internal Revenue Service
POB 7604, Ben Franklin Station
Washington, DC 20044

In the alternative, comments may be hand-delivered between the hours of 8 a.m. and 5 p.m. to:

CC:DOM:CORP:R (REG-109708-97)
Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, NW.
Washington DC 20224

Alternatively, comments may be transmitted electronically via the IRS Internet site at:

http://www.irs.ustreas.gov/prod/tax_regs/comments.html

Comments to the Department of Labor can be addressed to:

U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Avenue NW., Room N-5669
Washington, DC 20210
Attention: NMHPA Comments

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address.

Comments to HHS can be addressed to:

Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-2892-IFC
P.O. Box 26688
Baltimore, MD 21207

In the alternative, comments may be hand-delivered between the hours of 8:30 a.m. and 5 p.m. to

either:

Room 309-G
Hubert Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

or

Room C5-09-26
7500 Security Boulevard
Baltimore, MD 21244-1850

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC from 9 a.m. to 4 p.m. All submissions to the Department of Labor will be open to public inspection and copying in the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5638, 200 Constitution Avenue, NW., Washington, DC from 8:30 a.m. to 5:30 p.m. All submissions to HHS will be open to public inspection and copying in room 309-G of the Department of Health and Human Services, 200 Independence Avenue, SW., Washington, DC from 8:30 a.m. to 5 p.m.

FOR FURTHER INFORMATION CONTACT: Amy Scheingold Turner, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-4377; Suzanne Long, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-1565; or Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-4695.

SUPPLEMENTARY INFORMATION:

Customer Service Information: Individuals interested in obtaining a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law," which includes information on NMHPA, may call the following toll-free number: 1-800-998-7542.

Information on NMHPA and other recent health care laws is also available on the Department of Labor's website (www.dol.gov/dol/pwba) and the Department of Health and Human Services's website (www.hcfa.gov).

A. Background

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) (Pub. L. 104-204) was enacted on September 26, 1996 to provide protections for mothers and their newborn children with regard to hospital lengths of stay following childbirth.[1] In section 602 of NMHPA, Congress declared its findings that:

> (1) the length of post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the ability and confidence of the mother and the father to care for their newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up health care; and (2) the timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother.

Provisions substantially similar to those in NMHPA were later added to the Internal Revenue Code of 1986 (Code) by the Taxpayer Relief Act of 1997 (TRA '97) (Pub. L. 105-34), which was enacted on August 5, 1997. All references hereafter to "NMHPA" include the relevant provisions of TRA '97.

NMHPA was incorporated into the administrative framework established by Titles I and IV of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104-

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[1] NMHPA adds to protections already established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104-191). Among other things, HIPAA provides that a group health plan and a group health insurance issuer may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

191).[2] These titles of HIPAA include substantially similar changes to the Internal Revenue Code, the Employee Retirement Income Security Act (ERISA), and the Public Health Service Act (PHS Act) relating to group health plans and issuers of group health insurance coverage.[3] Certain other provisions in Titles I and IV of HIPAA amended only ERISA or only the PHS Act. In particular, the PHS Act, as amended by HIPAA, contains provisions governing health insurance issued to small groups and health insurance sold in the individual market. The regulations implementing these provisions added by HIPAA were made available to the public on April 1, 1997 and published in the **Federal Register** on April 8, 1997. The group market regulations were issued jointly by the Secretaries of the Treasury, Labor, and Health and Human Services (HHS) (62 FR 16894). The individual market regulations were issued only by HHS (62 FR 16985). See also 62 FR 31669 - 31670 and 31690 - 31696 (June 10, 1997) (containing technical corrections to both the group market and individual market regulations).

NMHPA applies to health coverage in the large and small group markets, and in the individual market. The Secretaries of the Treasury, Labor, and HHS share jurisdiction over the NMHPA provisions. These provisions are substantially similar, except as follows:

- The NMHPA provisions in the Code generally apply to all group health plans (including

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[2] NMHPA amended Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act (ERISA), and Title XXVII of the Public Health Service Act (PHS Act).

[3] The terms group health plan and health insurance issuer are defined in Code section 9832(a) and (b)(2), ERISA section 733(a) and (b)(2), and PHS Act section 2791(a) and (b)(2). The term group health insurance coverage is defined in ERISA section 733(b)(4) and PHS Act section 2791(b)(4). Generally, any health insurance coverage that does not meet the definition of group health insurance coverage is individual coverage even if State law treats the coverage as group coverage for other purposes. The terms individual health insurance coverage and individual market are defined in PHS Act section 2791(b)(5) and (e)(1).

church plans) other than governmental plans, but they do not apply to health insurance issuers. The NMHPA provisions in the Code do not contain the requirement that a plan provide the special notice that is required under the NMHPA provisions in ERISA and the PHS Act. An employer or plan that fails to comply with the NMHPA provisions in the Code may be subject to an excise tax under section 4980D of the Code.

- The NMHPA provisions in ERISA generally apply to all group health plans other than governmental plans and church plans. These provisions also apply to health insurance issuers that offer health insurance in connection with such group health plans. Generally, the Secretary of Labor enforces the provisions of NMHPA in ERISA, except that no enforcement action may be taken by the Secretary against issuers. However, individuals may generally pursue actions against issuers under ERISA and, in some circumstances, under State law.
- The NMHPA provisions in the PHS Act generally apply to health insurance issuers and to certain State and local governmental plans. States, in the first instance, enforce the PHS Act with respect to issuers. Only if a State does not substantially enforce any provisions under its insurance laws will HHS enforce the provisions, through the imposition of civil money penalties. HHS has primary enforcement authority with respect to State and local governmental plans.

The interim rules being issued today by the Secretaries of the Treasury, Labor, and HHS have been developed on a coordinated basis by the Departments. In addition, these interim rules take into account comments received by the Departments in response to the request for public comments on NMHPA published in the **Federal Register** on June 26, 1997 (62 FR 34604).

Except to the extent needed to reflect the statutory differences described above, the interim rules of each Department are substantively identical. However, there are certain nonsubstantive differences, including certain stylistic differences in language and structure to conform to conventions used by a particular Department. These differences have been minimized and any differences in wording (other than those reflecting differences in the NMHPA statutory provisions described above) are not intended to create any substantive difference. Finally, the individual market regulations are issued solely by HHS.

B. Overview of NMHPA and the Interim Rules

The general rule for hospital lengths of stay

NMHPA and the interim rules provide a general rule under which a group health plan and a health insurance issuer may not restrict mothers' and newborns' benefits for a hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.[4] The general rule requires plans and issuers providing benefits for hospital lengths of stay in connection with childbirth to cover the minimum length of stay for all deliveries. The interim rules provide that the determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider. An example clarifies that delivery does not have to occur inside a hospital in order for an admission to be "in connection with childbirth." NMHPA and the interim rules permit an exception to the 48-hour (or 96-hour) general rule if the attending provider decides, in consultation with the mother, to discharge the mother or her newborn earlier.

[4] The interim rules use the term "vaginal delivery" to clarify that all vaginal deliveries, whether with complications or without complications, are subject to the 48-hour length-of-stay requirement.

Many commenters asked whether the length of stay should be calculated from the time of delivery. Under the interim rules, when delivery occurs in the hospital, the stay begins at the time of delivery (or in the case of multiple births, at the time of the last delivery). When delivery occurs outside the hospital, the stay begins at the time the mother or newborn is admitted.

An attending provider is an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing such care to a mother or newborn child. Therefore, a plan, hospital, managed care organization, or other issuer is not an attending provider. However, a nurse midwife or a physician assistant may be an attending provider if licensed in the State to provide maternity or pediatric care in connection with childbirth.

Prohibitions

As noted above, an exception to the 48-hour (or 96-hour) general rule applies if the attending provider decides, in consultation with the mother, to discharge the mother or newborn earlier. NMHPA and the interim rules prohibit certain practices to ensure that this exception will not result in early discharges that could adversely affect the health or well-being of the mother or newborn.

Specifically, with respect to mothers, NMHPA provides that a group health plan or health insurance issuer may not deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan or policy solely to avoid the NMHPA requirements, or provide monetary payments or rebates to a mother to encourage her to accept less than the minimum protections available under NMHPA. The interim rules clarify that such prohibited payments include payments-in-kind. However, an example in the interim rules clarifies

that a plan or issuer does not violate this prohibition by providing after-discharge, follow-up services to a mother and newborn discharged early if those services are not more than what the mother and newborn would have received if they had stayed in the hospital the full 48 hours (or 96 hours).

In addition, with respect to benefit restrictions, NMHPA and the interim rules provide that a plan or issuer may not restrict the benefits for any portion of a 48-hour (or 96-hour) hospital length of stay in a manner that is less favorable than the benefits provided for any preceding portion of the stay. This prohibition includes certain types of precertification requirements, discussed below in the Authorization and precertification section.

Finally, with respect to attending providers, NMHPA provides that a plan or issuer may not penalize, or otherwise reduce or limit the reimbursement of, an attending provider because the provider furnished care to a mother or newborn in accordance with NMHPA, or provide monetary or other incentives to an attending provider to induce the provider to furnish care to a mother or newborn in a manner inconsistent with NMHPA. The interim rules clarify this prohibition in four ways. First, the prohibition applies to both direct and indirect incentives to attending providers. Second, penalties against an attending provider include taking disciplinary action against or retaliating against the attending provider. Third, the term "compensation" is used in the interim rules rather than the term "reimbursement" to clarify that all forms of remuneration to attending providers are included in the prohibition, and to avoid any confusion that otherwise could result from the fact that the term "reimbursement" has a narrower meaning in some insurance contexts. Fourth, the statutory phrase "to induce" is interpreted to include providing any incentive that could induce an attending provider to furnish care inconsistent with

NMHPA and the interim rules (whether or not a specific attending provider is actually induced to furnish care inconsistent with NMHPA and the interim rules).

Construction

NMHPA and the interim rules apply only to group health plans and health insurance issuers that provide benefits for a hospital stay in connection with childbirth. NMHPA and the interim rules do not require plans and issuers to provide these benefits.[5] In addition, NMHPA and the interim rules do not prevent plans or issuers from imposing deductibles, coinsurance, or other cost-sharing measures for health benefits relating to hospital stays in connection with childbirth as long as the cost-sharing for any portion of a hospital stay subject to the general rule is not less favorable to mothers and newborns than that imposed on any preceding portion of the stay. Thus, for example, with respect to a 48-hour hospital stay, the coinsurance for the second 24 hours cannot be greater than that for the first 24 hours.

With respect to health insurance coverage offered in the individual market, NMHPA and the interim rules apply to all health insurance coverage, and are not limited in their application to

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[5] While NMHPA and the interim rules do not require plans and issuers to provide coverage for hospital stays in connection with childbirth, other legal requirements may apply, including Title VII of the Civil Rights Act of 1964 (Title VII). Title VII prohibits discrimination on the basis of sex, including because of pregnancy, childbirth, or related medical conditions. 42 U.S.C. 2000e-(k). The Equal Employment Opportunity Commission (EEOC) has commented, by letter dated July 28, 1997, that, "[u]nder Title VII, women affected by pregnancy, childbirth, or related medical conditions must be treated the same as individuals affected by other medical conditions. This applies to all aspects of employment, including employer-provided health insurance benefits. . . . Thus, Title VII prohibits a plan from excluding hospital stay benefits in connection with childbirth if the plan provides hospital stay benefits in connection with other medical conditions." EEOC is the federal agency responsible for enforcing Title VII and other federal equal employment opportunity laws. Questions regarding Title VII should be directed to the EEOC.

coverage that is provided to eligible individuals, as defined in section 2741(b) of the PHS Act.

Authorization and precertification

NMHPA and the interim rules contain three provisions that affect authorization and precertification for hospital lengths of stay in connection with childbirth.

- Under paragraph (a) of the interim rules (relating to hospital length of stay), a group health plan or a health insurance issuer may not require a physician or other health care provider to obtain authorization from the plan or issuer to prescribe a hospital length of stay that is subject to the general rule.
- Under paragraph (b) of the interim rules (relating to prohibitions), a plan or issuer may not restrict benefits for part of a stay subject to the general rule in a way that is less favorable than a prior portion of the stay. Under an example in the interim rules, a plan or issuer is precluded from requiring a covered individual to obtain precertification for any portion of a hospital stay that is subject to the general rule if precertification is not required for any preceding portion of the stay. However, the interim rules do not prevent a plan or issuer from requiring precertification for any portion of a stay after 48 hours (or 96 hours), or from requiring precertification for an entire stay.
- In addition, under paragraph (c) of the interim rules (containing rules of construction), a plan or issuer may not increase an individual's coinsurance for any later portion of a 48-hour (or 96-hour) hospital stay. An example illustrates that plans and issuers may vary cost-sharing in certain circumstances, provided the cost-sharing rate is consistent throughout the 48-hour (or 96-hour) hospital length of stay.

Compensation of attending provider

NMHPA and the interim rules do not prevent a group health plan or a health insurance issuer from negotiating with an attending provider the level and type of compensation for care furnished in accordance with the interim rules (including the prohibitions section).

Applicability in certain States

There is an exception to the NMHPA requirements for health insurance coverage in certain States.[6] Specifically, NMHPA and the interim rules do not apply with respect to health insurance coverage if there is a State law [7] that meets any of the following criteria:

- the State law requires health insurance coverage to provide at least a 48-hour (or 96-hour) hospital length of stay in connection with childbirth,
- the State law requires health insurance coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association, or
- the State law requires that decisions regarding the appropriate hospital length of stay in connection with childbirth be left entirely to the attending provider in consultation with the

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[6] The term State includes the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the Canal Zone (i.e., the areas and installations in the Republic of Panama made available to the United States pursuant to the Panama Canal Treaty of 1977 and related agreements, until December 31, 1999.)

[7] Generally, under Part 7 of ERISA and Title XXVII of the PHS Act, a State law that "prevents the application of " those provisions is preempted by section 731(a)(1) of ERISA and sections 2723(a)(1) and 2762(a)(1) of the PHS Act. However, NMHPA specifies that State laws that meet the statutory criteria will apply even though they might otherwise "prevent the application of" the NMHPA requirements. See section 711(f) of ERISA and sections 2704(f) and 2751(c) of the PHS Act.

mother. The interim rules clarify that State laws that require the mother to consent to the decision made by the attending provider satisfy this criterion.

Although this NMHPA exception applies with respect to insured group health plans, it does not apply with respect to a group health plan to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.[8]

Notice requirements under ERISA and the PHS Act

ERISA background. ERISA generally requires that participants in, and beneficiaries receiving benefits under, a group health plan be furnished a summary plan description (SPD) to apprise them of their rights and obligations under the plan. ERISA and its implementing regulations prescribe what is to be included in the SPD, and the manner in which participants and beneficiaries are to be notified of any "material modification" to the terms of the plan or any change in the information required to be included in the SPD. A summary description of a material modification is generally required to be furnished not later than 210 days after the end of the plan year in which the change is adopted. A summary of any material reduction in covered services or benefits is generally required to be furnished not later than 60 days after adoption of the change.

NMHPA changes to ERISA and the PHS Act. The NMHPA amendments to ERISA added section 711(d), which requires that the imposition of the NMHPA requirements is to be

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[8] In conducting an economic analysis of the interim rules, the Departments of Labor and HHS conducted a preliminary review of State laws to determine the applicability of NMHPA's requirements in each State. This discussion, in section D of this preamble, includes a list of the States in which the Departments of Labor and HHS assumed, solely for the purpose of the economic analysis, that NMHPA's requirements apply.

treated as a material modification to the plan, except that the summary description of the modification must be provided by not later than 60 days after the first day of the first plan year in which the requirements apply. NMHPA also amended both the group and individual market provisions of title XXVII of the PHS Act to apply the ERISA notice requirement to certain entities not otherwise subject to ERISA.

The Department of Labor published interim regulations implementing section 711(d) of ERISA on April 8, 1997 (62 FR 16979), issued separately from the HIPAA regulations published on the same date.

Section 2704(d) of the PHS Act requires nonfederal governmental plans to comply with the notice requirement contained in section 711(d) of ERISA as if that section applied to the plan. Similarly, section 2751(b) of the PHS Act requires a health insurance issuer in the individual market to comply with the notice requirement in section 711(d) of ERISA as if that section applied to the issuer and as if the issuer were a group health plan.

The NMHPA interim rules published today include the notice provisions applicable under the PHS Act. They are based on the requirements contained in the Department of Labor's original notice regulations, but have been adapted for two reasons. First, changes were made to accommodate the Departments' interpretations of NMHPA's substantive requirements as contained in these interim rules. A revision of the notice provisions applicable to plans subject to ERISA recently was published in the **Federal Register** in order to accommodate these interpretations. 63 FR 48372 (September 9, 1998). Second, the statute provides that covered individuals in both the individual and group markets (in group health plans subject to either ERISA or the PHS Act) be notified of their rights under NMHPA. While there are fundamental

differences in the types of entities regulated under ERISA as compared to the PHS Act, and in the structure of the two Acts, the Departments are coordinating their work on these two regulations to ensure that affected individuals will receive the same disclosure of rights, adapted as appropriate to take into account the different contexts.

Substance of the PHS Act notice requirements — *In the group market*. Section 2704 of the PHS Act applies the NMHPA requirements to group health plans that are subject to the group market provisions of Part A of Title XXVII of the PHS Act. The only group health plans that are subject to the PHS Act are nonfederal governmental plans, which are not directly subject to any ERISA requirements. In addition, these plans may elect to be exempt from most of the requirements of Title XXVII, including the NMHPA requirements, with respect to self-insured benefits. Section 2704(d) states that a group health plan subject to the PHS Act "shall comply with the notice requirement under section 711(d) of [ERISA] with respect to the requirements of this section as if such section applied to such plan."

These interim rules interpret section 2704(d) of the PHS Act to require that nonfederal governmental plans that provide benefits for hospital lengths of stay in connection with childbirth, and that are subject to the NMHPA requirements, provide participants and beneficiaries with a statement describing those requirements. The statement must be included in the plan document that provides a description of plan benefits to participants and beneficiaries and must be furnished to participants and beneficiaries not later than 60 days after the first day of the first plan year beginning on or after the effective date of these interim rules.[9] The interim rules set forth the

[9] Although the specific requirements of these interim rules therefore apply for plan years beginning on or after January 1, 1999, the underlying statutory requirement went into effect for plan years beginning on or after January 1, 1998, the effective date of NMHPA.

language that must be used by plan administrators to satisfy the notice requirement for group health plans subject to the PHS Act.

In the individual market. Section 2751(a) of the PHS Act applies the NMHPA requirements to health insurance issuers in the individual market. Section 2751(b) states that a health insurance issuer subject to the individual market provisions of the PHS Act "shall comply with the notice requirement under section 711(d) of [ERISA] with respect to [the NMHPA requirements] as if such section applied to such issuer and such issuer were a group health plan." Issuers in the individual market are not subject to any federal requirements comparable to disclosure of a "summary plan description" under ERISA, although they may be subject to similar State law requirements. In addition, the concept of a "plan year" does not apply in the individual market, and the effective date of the NMHPA requirements is not tied to a plan year. Accordingly, the requirements of these interim rules apply to health insurance coverage "offered, sold, issued, renewed, in effect, or operated" in the individual market on or after the effective date of these interim rules.[10]

These interim rules interpret section 2751(b) of the PHS Act to require that issuers of individual health insurance coverage that includes benefits for hospital lengths of stay in connection with childbirth must include a statement in the insurance contract describing the NMHPA requirements, and, not later than 60 days after the effective date of the interim rules, provide covered individuals with a rider or equivalent document that gives notice of the NMHPA requirements. The interim rules set forth the language that must be used in an insurance contract

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[10] Although the specific requirements of these interim rules therefore apply on or after January 1, 1999, the underlying statutory requirement went into effect January 1, 1998, the effective date of NMHPA.

(or rider) to satisfy the notice requirement added by NMHPA.

Effective dates

Group market. NMHPA applies to group health plans and group health insurance issuers for plan years beginning on or after January 1, 1998. The interim rules for the group market apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 1999.

Individual market. NMHPA applies to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998. The interim rules for the individual market apply to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1999.

C. Interim Rules and Request for Comments

Section 9833 of the Code (formerly section 9806), section 734 of ERISA (formerly section 707), and section 2792 of the PHS Act authorize the Secretaries of the Treasury, Labor, and HHS to promulgate any interim final rules that they determine are appropriate to carry out the provisions of Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act, which include the NMHPA provisions. The Departments have determined that interim final rules are appropriate because there is a need to define the substance of the federal requirements and the scope of their applicability in anticipation of the 1999 plan year.

Many commenters have asked the Departments to clarify certain NMHPA provisions. For example, the Departments have been asked when the 48-hour (or 96-hour) stay begins, and whether the requirements apply only after birth in a hospital. In addition, NMHPA does not apply

to health insurance coverage if there is a State law that meets certain criteria outlined in the NMHPA exception. Currently, there are many States that have such laws meeting the NMHPA exception. Commenters have asked the Departments to clarify the applicability of federal law in these States as well as in other States that do not have a law meeting NMHPA's criteria.

On June 26, 1997 the Departments of Labor and HHS issued a Request for Information (RFI) inviting comments on the NMHPA provisions. After consideration of the many comments received in response to the Departments' RFI and in light of the outstanding questions relating to the substance and applicability of NMHPA, the Departments have determined that it is appropriate to issue interim final rules at this time to ensure that group health plans and health insurance issuers have timely guidance before they prepare their open season materials in anticipation of the 1999 plan year. (More than one half of plans begin their fiscal years on January 1.) Written comments on these interim rules are invited.

D. Executive Order 12866, Effect of the Statute, and Paperwork Reduction Act — The Departments of Labor and HHS

Executive Order 12866

Executive Order 12866 requires agencies to assess all costs and benefits of available regulatory alternatives, and when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Section 3(f) of Executive Order 12866 requires agencies to prepare a regulatory impact analysis for any rule that is deemed a "significant regulatory action" according to specified criteria. This includes whether the rule may have an annual effect on the economy of $100 million or more or certain other specified effects, or

whether the rule raises novel legal or policy issues arising out of the President's priorities.

The Office of Management and Budget (OMB) has determined this to be a major rule, as well as an economically significant regulatory action under Section 3(f) of Executive Order 12866. The estimated impact of NMHPA on insured costs is in the range of $130 million to $200 million. The following analysis was conducted by the Departments of Labor and Health and Human Services.

The interim rules, for the most part, mirror the statutory provisions, which are largely self-executing. While the interim rules make interpretations or clarifications to some of the statutory provisions, none of these has a significant economic impact. The effect of the statute is addressed below.

Effect of the statute

NMHPA was passed in response to a finding by the Congress that group health plans and health insurance issuers tend to limit benefits for hospital lengths of stay in connection with childbirth. The main intent of the law was to ensure that adequate care is provided to mothers and their newborns during the first few critical days following birth. The Congress was concerned that the decision to discharge the mother and newborn was being driven by the financial motivations of plans and issuers, rather than the medical interests of the patient.

NMHPA was modeled after guidelines developed by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). NMHPA allows the attending provider, in consultation with the mother, to make hospital length of stay decisions, rather than the plan or issuer. Although mothers and their newborns are not obligated to stay in the hospital for any period of time following delivery, plans and issuers must

now cover at least 48 hours following a vaginal delivery and at least 96 hours following a delivery by cesarean section unless the attending provider, in consultation with the mother, decides to discharge earlier.

Many believe that the minimum length of stay requirements of 48 hours for a vaginal delivery and 96 hours for a cesarean section will have a positive impact on the overall health and well-being of mothers and newborns. The longer stays will allow health care providers sufficient time to screen for metabolic and genetic disorders in newborns. It will also permit time to provide parental education to mothers and to assess their ability to care for their newborn.

Although some services performed in an inpatient hospital setting may be effectively provided in other settings, such as clinics or physicians' offices, not all women have had access to the full range of appropriate follow-up care. NMHPA ensures that many women and newborns with health coverage will now be provided an acceptable level of postpartum care.

Many States[11] have enacted laws that prescribe benefits for hospital lengths of stay in connection with childbirth. NMHPA provides that the federal NMHPA requirements do not apply with respect to health insurance coverage[12] if there is a State law that satisfies one or more

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[11] For purposes of Part 7 of ERISA and Title XXVII of the PHS Act (including the NMHPA provisions), the term State includes the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the Canal Zone (i.e., the areas and installations in the Republic of Panama made available to the United States pursuant to the Panama Canal Treaty of 1977 and related agreements, until December 31, 1999.)

[12] The term health insurance coverage means "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including any items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." ERISA section 733(b)(1) and PHS Act section 2791(b)(1). The term health insurance issuer means "an insurance company, insurance service, or insurance organization

of the following criteria: (1) requires such coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour length of stay following a delivery by cesarean section, (2) requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations, or (3) requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother.

Accordingly, the federal NMHPA requirements do not apply to insured plans (and partially-insured plans, to the extent benefits for hospital lengths of stay in connection with childbirth are provided through insurance coverage) in States in which a State law meets one or more of the above criteria. Moreover, the federal NMHPA requirements do not apply to issuers (both in the group market and the individual market) in States in which State law meets one or more of the above criteria. However, the federal NMHPA requirements apply to self-insured plans (and partially-insured plans, to the extent benefits for hospital lengths of stay in connection with childbirth are provided other than through insurance coverage), regardless of State law.

According to a chart developed by the National Association of Insurance Commissioners for a hearing in September 1997 before the House Committee on Ways and Means, Subcommittee on Health, many States already had provisions in their laws or regulations prescribing benefits for hospital lengths of stay in connection with childbirth before the enactment of NMHPA.

. . . which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance . . . . Such term does not include a group health plan." ERISA section 733(b)(2) and PHS Act section 2791(b)(2).

Subsequently, for purposes of this discussion of the Effect of the Statute, the Departments performed a preliminary review of State laws as of July 1, 1998.[13] As a result of this review, it is estimated that 40 States have laws that appear to meet the criteria specified in NMHPA. These States are as follows: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, and West Virginia.

Accordingly, in these 40 States, only church plans, self-insured private-sector employer-sponsored group health plans,[14] and self-insured nonfederal governmental plans[15] will be affected by NMHPA. Based on data from the March 1996 Current Population Survey and other sources, Price Waterhouse has estimated that there are approximately 270,000 self-insured ERISA plans

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[13] In conducting the review, the Departments considered State statutes, regulations, rules, bulletins, and case law. However, the review did not take into account other State actions that should be considered when making a legal determination regarding whether a State law meets the criteria specified in NMHPA.

[14] Hereafter, other private-sector employer-sponsored group health plans are referred to as ERISA plans.

[15] The term nonfederal governmental plan means a governmental plan that is not a federal governmental plan. PHS Act section 2791(d)(8)(C). The term governmental plan generally means a plan established or maintained for its employees by the government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. PHS Act section 2791(d)(8)(A). The term federal governmental plan means a governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of such government. PHS Act section 2791(d)(8)(B).

covering 53 million individuals. In addition, based on data from the March 1996 Current Population Survey and other sources, Price Waterhouse estimated that there are approximately 30,000 self-insured nonfederal governmental plans covering 18 million individuals.[16]

NMHPA will also affect insured ERISA plans, insured church plans, insured nonfederal governmental plans, and issuers in the individual market in States that do not have a law meeting one or more of the criteria specified in NMHPA. For purposes of this review of the Effect of the Statute, the Departments performed a preliminary review of State laws as of July 1, 1998. As a result of this review, it is estimated that the federal NMHPA requirements will apply to health insurance coverage in 18 States.[17] These States are as follows: Delaware, Hawaii, Idaho, Michigan, Mississippi, Nebraska, Oregon, Utah, Vermont, Wisconsin, Wyoming, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the Canal Zone (i.e., the areas and installations in the Republic of Panama made available to the United States pursuant to the Panama Canal Treaty of 1977 and related agreements, until December 31, 1999).

Based on data from the March 1996 Current Population Survey and other sources, Price Waterhouse estimated that there are approximately 2.5 million insured ERISA plans, 145,000

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[16] Sponsors of self-insured nonfederal governmental plans can elect to have their plans exempted from most of the requirements of Title XXVII of the PHS Act, including the NMHPA requirements, with respect to self-insured benefits. To date, fewer than 600 sponsors have elected to have their plans exempted in whole or in part, and at least some of these plans have chosen to be exempt from NMHPA. This means the number of self-insured nonfederal governmental plans affected by NMHPA will be less than the 30,000 plans cited above.

[17] The federal NMHPA provisions appear to apply in these 18 States because either the State has not enacted any law that meets the NMHPA criteria or the State has incorporated the federal NMHPA requirements by reference.

insured nonfederal governmental plans, and 1,000 issuers in the individual market. For a variety of reasons, these totals cannot be broken down by State. These reasons include a lack of detailed data at the State level and inconsistencies in how data are reported, both within and across States. In addition, the complexities and volatility of today's health care environment, the segmentation of the health care markets, and the rapid increase in various forms of managed care arrangements make it difficult to define and track such plans.[18]

The Congressional Budget Office (CBO) did not estimate costs for implementing NMHPA, passed by the Congress in September 1996. However, CBO estimated the costs for implementing S.969, the Senate version of NMHPA. While there are several differences between S.969 and the final joint legislation[19], the CBO estimates for implementing S. 969 are the only relevant cost data available, and can be used as a baseline estimate for the cost impact of NMHPA.

After making adjustments to reflect the effects of State laws in effect at the time of their estimates, CBO concluded that about 900,000 insured births a year have shorter hospital lengths of stay than the minimum lengths of stay provided under NMHPA. CBO assumed that some of these births would result in an additional inpatient day, and some would receive a follow-up visit. Some mothers would still choose to go home before the full time allowed by NMHPA, while others are already receiving a timely follow-up visit and therefore would not incur any additional

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[18] See, for example, Chollet, D.J., Kirk, A.M. and Ermann, R.D. (1997). Mapping Insurance Markets: The Group and Individual Insurance Markets in 26 States. Washington: The Alpha Center.

[19] S. 969 contained provisions for post-delivery follow-up care, or home health visits. In addition, the costs provided by CBO assumed an implementation date of January 1, 1997, rather than January 1, 1998.

costs. CBO estimated that inpatient hospital days would increase by approximately 400,000 days and follow-up care would increase by approximately 200,000 visits annually.

CBO estimated that the additional utilization due to the implementation of S. 969 would have resulted in an aggregate increase in insured costs of 0.06 percent for all employment-based and individually purchased health plans. CBO assumed that, in response to the increase in premiums, employers and individuals may choose to reduce coverage or drop benefits. Although some plans may make slight reductions in overall benefits to offset this minimal increase in cost, the Departments believe that virtually no employers will drop health coverage entirely or drop coverage for hospital stays in connection with childbirth. After taking behavioral responses into account, CBO estimated that employer contributions for health insurance would only rise by about 0.02 percent and most of that increase likely would be passed back to employees in the form of reduced wages.

Applying the same 0.06 percent increase to the cost of health insurance for covered employees of nonfederal governmental plans would raise expenditures. However, CBO assumed that most of these costs would be passed back to employees.

Apart from increased benefit costs for their employees, States may face additional costs for enforcing NMHPA's requirements on issuers of health insurance in the group and individual markets. Because States currently regulate the private-sector health insurance market, CBO assumed that the increase in costs would be marginal. However, in cases where States fail to implement NMHPA or their own laws meeting the criteria specified in NMHPA, the federal government assumes enforcement authority. Depending on the need for federal enforcement, some of the aforementioned costs may be shifted to the federal government.

Although the CBO estimates for implementing S. 969 can be used as a baseline for determining the cost impact of NMHPA, they must be updated to reflect the enactment in several additional States of laws or regulations meeting the criteria specified in NMHPA and for the elimination of post-delivery follow up care. Adjusting the CBO estimates for 28 States that had laws that met the criteria specified in NMHPA at the time of NMHPA's enactment, reduces the number of people directly affected by NMHPA. Approximately 60 percent of people covered by insured ERISA plans and therefore subject to State laws, are in the 28 States that had enacted laws prior to NMHPA.

With fewer people affected, the assumed increase in utilization is also lower, which should translate into a smaller increase in aggregate health care costs. However, as discussed previously, S. 969 had a provision for follow-up visits in place of an additional inpatient day. CBO assumed that about one-third of the additional utilization would be follow-up visits, and that the cost of a follow-up visit is only about one-fourth the cost of a post-delivery hospital day.

Based on those assumptions, if all of those who would have chosen a follow-up visit under S. 969 elected to remain in the hospital for an additional day, the estimated aggregate increase in insured costs would be 0.07 percent, slightly higher than the CBO estimate. If, however, mothers and physicians determine that some of the follow-up care is unnecessary, and that less than the minimum hospital length of stay is necessary, some of the additional costs will not be incurred. If none of the follow-up visits were converted to additional inpatient days, the estimated aggregate increase in insured costs would be 0.04 percent. Therefore, the impact of NMHPA on insured costs is in the 0.04 to 0.07 percent range, or $130 million to $200 million (1996 dollars).

It should be noted that since the enactment of NMHPA, twelve additional States have

enacted laws or regulations meeting the criteria specified in NMHPA. These laws apply to an additional 25 percent of those in fully insured health insurance plans. While some of these States passed legislation in direct response to the federal law, other States had already considered hospital lengths of stay for childbirth, but without final passage of legislation. Thus, the estimates of the statutory impacts, as of the date of enactment, probably overstate the direct impact of NMHPA.

Paperwork Reduction Act

The interim rules contain no new information collection requirements that are subject to review and approval by OMB under the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35). The agencies reported the information collection burdens associated with NMHPA in the interim rules (*Interim Rules Amending ERISA Disclosure Requirements for Group Health Plans*) implementing section 711(d) of ERISA that were published in the **Federal Register** on April 8, 1997 (62 FR 16979). OMB approved these information collection requirements under OMB control number 1210-0039. Subsequently, the agencies published the OMB control number in the **Federal Register** at 62 FR 36205 (July 7, 1997).

In addition, the group and individual market notification requirements for group health plans under section 2704(d), and issuers under 2751(b) of the PHS Act, are not considered "information" as defined in 5 CFR 1320.3(c)(2) and are therefore not subject to the Paperwork Reduction Act of 1995. In particular, 5 CFR 1320.3(c)(2) states that "the public disclosure of information originally supplied by the federal government to the recipient for the purpose of disclosure to the public is not included within the definition" of a collection of information.

E. Regulatory Flexibility Act, Unfunded Mandates Reform Act of 1995, and Small

Business Regulatory Enforcement Fairness Act of 1995

Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq*) requires that, whenever an agency is required to publish a general notice of proposed rulemaking, the agency shall prepare and make available for public comment an initial regulatory flexibility analysis. The analysis describes the impact of the rule on small entities and identifies any significant alternatives to the rule which accomplish the stated objectives of the applicable law and which would minimize the impact on small entities. For purposes of the RFA, States and individuals are not considered small entities. Small employers and small group health plans are considered small entities.

Since these rules are being issued as interim final rules and not as a Notice of Proposed Rulemaking (NPRM), the RFA does not apply and a regulatory flexibility analysis is not required. Nonetheless, the Departments have considered the likely impact of the rules on small entities and believe that the rules will not have a significant impact on a substantial number of small entities for the following reasons: 1) the major provisions of the rules mirror the statutory provisions, which are largely self-executing and do not afford the Departments substantial discretion to exercise regulatory flexibility; 2) the interpretations or clarifications to the statutory provisions that are made by these rules are minor and will not have a significant impact; and 3) because most States have laws that apply in place of the NMHPA standards, in those States the interim rules will not apply to insurance issuers, which are subject to State law, and will have no impact on group health plans that purchase insurance in those States. Therefore the main impact of these rules will be on group health plans that self-insure. Because small plans are more likely to purchase State-regulated insurance than to self-insure, they will be less likely to be affected by these rules.

Although, for the reasons stated, we believe that these rules will not have a significant impact on small entities, specific data that would permit a complete evaluation of the impact on small entities is not currently available. Therefore, the Departments invite interested persons to submit comments on the impact of these rules on small entities for consideration in the development of the final rules implementing NMHPA. Consistent with the RFA, the Departments also encourage the public to submit comments on alternative rules that will accomplish the stated purpose of NMHPA and minimize the impact on small entities.

Unfunded Mandates Reform Act of 1995

The Unfunded Mandates Reform Act of 1995 (UMRA, Pub. L. 104-4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of $100 million by State, local, and Indian tribal governments or the private sector. These rules are not subject to the UMRA because they are interim rules. However, consistent with the policy embodied in the UMRA, the interim rules have been designed to be the least burdensome alternative for State, local, tribal governments, and the private sector.

Small Business Regulatory Enforcement Fairness Act of 1996

The Administrator of the Office of Information and Regulatory Affairs of OMB has determined that this is a major rule for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) (SBREFA). In general, SBREFA provides, among other things, that a federal agency must submit all rules for full Congressional review. Pursuant to SBREFA, Congress has 60 session days to review and approve or disapprove a major rule. The Secretaries have determined that the effective date of these interim rules is January 1, 1999. Because the effective date of these interim rules is more than 60 days after publication in the

Federal Register and receipt by Congress, the requirements of SBREFA have been satisfied with respect to these rules.

Statutory Authority

The Department of the Treasury temporary rule is adopted pursuant to the authority contained in section 7805 and in section 9833 of the Code (26 U.S.C. 7805, 9833), as added by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and amended by TRA '97 (Pub. L. 105-34, 111 Stat. 788).

The Department of Labor interim final rule is adopted pursuant to the authority contained in sections 505, 711, 734 of ERISA (29 U.S.C. 1135, 1181, and 1194), as added by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and amended by NMHPA (Pub. L. 104-204, 110 Stat. 2935), and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

The HHS interim final rule is adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C.300gg through 300gg-63, 300gg-91, and 300gg-92), as added by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and amended by NMHPA (Pub. L. 104-204, 110 Stat. 2935).

List of Subjects

26 CFR Part 54

Excise taxes, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Employee benefit plans, Employee Retirement Income Security Act, Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Parts 144 and 146

Health care, Health insurance, Reporting and recordkeeping requirements, State regulation of health insurance.

45 CFR Part 148

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Internal Revenue Service

26 CFR Chapter I

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54--PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding an entry for §54.9811-1T in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Section 54.9811-1T also issued under 26 U.S.C. 9833. * * *

Par. 2. Section 54.9801-1T is amended by:

1. Revising paragraph (a).

2. Revising the first sentence of paragraph (c).

The revisions read as follows:

§54.9801-1T Basis and scope (temporary).

(a) Statutory basis. Sections 54.9801-1T through 54.9801-6T, 54.9802-1T, 54.9811-1T, 54.9812-1T, 54.9831-1T, and 54.9833-1T (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

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(c) Similar Requirements under the Public Health Service Act and Employee Retirement Income Security Act. Sections 2701, 2702, 2704, 2705, 2721, and 2791 of the Public Health Service Act and sections 701, 702, 703, 711, 712, 732, and 733 of the Employee Retirement Income Security Act of 1974 impose requirements similar to those imposed under Chapter 100 of

Subtitle K with respect to health insurance issuers offering group health insurance coverage. * * *

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Par. 3. In §54.9801-2T, the introductory text is revised to read as follows:

§54.9801-2T Definitions (temporary).

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§54.9801-1T through 54.9801-6T, 54.9802-1T, 54.9811-1T, 54.9812-1T, 54.9831-1T, and 54.9833-1T.

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Par. 4. Section 54.9811-1T is added to read as follows:

§54.9811-1 Standards relating to benefits for mothers and newborns (temporary).

(a) Hospital length of stay — (1) General rule. Except as provided in paragraph (a)(5) of this section, a group health plan that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than —

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) When stay begins — (i) Delivery in a hospital. If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) Delivery outside a hospital. If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a

medical decision to be made by the attending provider.

(3) Examples. The rules of paragraphs (a)(1) and (2) of this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this Example 1, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this Example 2, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) A woman covered under a group health plan gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this Example 3, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) Authorization not required — (i) In general. A plan may not require that a physician or other health care provider obtain authorization from the plan, or from a health insurance issuer offering health insurance coverage under the plan, for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (See also paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) Example. The rule of this paragraph (a)(4) is illustrated by the following example:

Example. (i) In the case of a delivery by cesarean section, a group health plan subject to

the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the plan requires an attending provider to complete a certificate of medical necessity. The plan then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) In this Example, the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by cesarean section is prohibited by this paragraph (a)(4).

(5) Exceptions — (i) Discharge of mother. If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) Discharge of newborn. If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) Attending provider defined. For purposes of this section, attending provider means an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child.

(iv) Example. The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A pregnant woman covered under a group health plan subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by cesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother and the newborn. Both are discharged approximately 72 hours after the delivery. The plan pays for the 72-hour hospital stays.

(ii) In this Example, the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the

readmission is not subject to this section.

(b) Prohibitions — (1) With respect to mothers — (i) In general. A group health plan may not —

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) Examples. The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under the plan are discharged within 24 hours after the delivery, the plan will waive the copayment and deductible.

(ii) In this Example 1, because waiver of the copayment and deductible is in the nature of a rebate that the mother would not receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the plan violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

Example 2. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the plan provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) In this Example 2, because the follow-up visit does not provide any services beyond what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) With respect to benefit restrictions — (i) In general. Subject to paragraph (c)(3) of

this section, a group health plan may not restrict the benefits for any portion of a hospital length of stay required under paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) Example. The rules of this paragraph (b)(2) are illustrated by the following example:

Example. (i) A group health plan subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by cesarean section, the plan automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the participant or beneficiary must call the plan to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the plan will not provide benefits for any succeeding 24-hour period.

(ii) In this Example, the requirement to obtain precertification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit a plan from requiring precertification for any period after the first 96 hours.) In addition, if the plan's utilization reviewer denied any mother or her newborn benefits within the 96-hour stay, the plan would also violate paragraph (a) of this section.

(3) With respect to attending providers. A group health plan may not directly or indirectly —

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) Construction. With respect to this section, the following rules of construction apply:

(1) Hospital stays not mandatory. This section does not require a mother to —

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) Hospital stay benefits not mandated. This section does not apply to any group health plan that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Cost-sharing rules — (i) In general. This section does not prevent a group health plan from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay required under paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) Examples. The rules of this paragraph (c)(3) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The plan covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) In this Example 1, the plan violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the plan also violates the similar rule in paragraph (b)(2) of this section.)

Example 2. (i) A group health plan generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the plan will cover 80 percent of the cost of the stay if the participant or beneficiary notifies the plan of the pregnancy in advance of

admission and uses whatever hospital the plan may designate.

(ii) In this Example 2, the plan does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay required under paragraph (a) of this section. (In addition, the plan does not violate the rules in paragraph (a)(4) or (b)(2) of this section.)

(4) Compensation of attending provider. This section does not prevent a group health plan from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(d) Notice requirement. See 29 CFR 2520.102-3(u) and (v)(2) for rules relating to a notice requirement imposed under section 711 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181) on certain group health plans that provide benefits for hospital lengths of stay in connection with childbirth.

(e) Applicability in certain States — (1) Health insurance coverage. The requirements of section 9811 and this section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) The State law requires the coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) Group health plans — (i) Fully-insured plans. For a group health plan that provides benefits solely through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 9811 and this section do not apply.

(ii) Self-insured plans. For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 9811 and this section apply.

(iii) Partially-insured plans. For a group health plan that provides some benefits through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 9811 and this section apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.

(3) Preemption provisions under ERISA. See 29 CFR 2590.711(e)(3) regarding how rules parallel to those under paragraph (e)(1) of this section relate to other preemption provisions under the Employee Retirement Income Security Act of 1974.

(4) Examples. The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) A group health plan buys group health insurance coverage in a State that

requires that the coverage provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) In this Example 1, the coverage is subject to State law, and the requirements of section 9811 and this section do not apply.

Example 2. (i) A self-insured group health plan covers hospital lengths of stay in connection with childbirth in a State that requires health insurance coverage to provide for maternity care in accordance with guidelines established by the American College of Obstetricians and Gynecologists and to provide for pediatric care in accordance with guidelines established by the American Academy of Pediatrics.

(ii) In this Example 2, even though the State law satisfies the criterion of paragraph (e)(1)(ii) of this section, because the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the plan is subject to the requirements of section 9811 and this section.

(f) Effective date. Section 9811 applies to group health plans for plan years beginning on or after January 1, 1998. This section applies to group health plans for plan years beginning on or after January 1, 1999.

Par. 5. In §54.9831-1T, paragraph (b)(1) is revised to read as follows:

§54.9831-1T Special rules relating to group health plans (temporary).

* * * * *

(b) Excepted benefits--(1) In general. The requirements of §§54.9801-1T through 54.9801-6T, 54.9802-1T, 54.9811-1T, and 54.9812-1T do not apply to any group health plan in relation to its provision of the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

* * * * *

Deputy Commissioner of Internal Revenue

Michael P. Dolan

Approved: 8/14/98

Assistant Secretary of the Treasury

Donald C. Lubick

Pension and Welfare Benefits Administration

29 CFR Chapter XXV

29 CFR Part 2590 is amended as follows:

PART 2590 —RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

1. The authority citation for Part 2590 is revised to read as follows:

Authority: Secs. 107, 209, 505, 701-703, 711, 712, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173, 1181, 1182, and 1191-1194), as amended by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and NMHPA (Pub. L. 104-204, 110 Stat. 2935), and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

Subpart B — Other Requirements

2. § 2590.711 is revised to read as follows:

§ 2590.711 Standards relating to benefits for mothers and newborns.

(a) Hospital length of stay — (1) General rule. Except as provided in paragraph (a)(5) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than —

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) When stay begins — (i) Delivery in a hospital. If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) Delivery outside a hospital. If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) Examples. The rules of paragraphs (a)(1) and (2) of this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this Example 1, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this Example 2, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) A woman covered under a group health plan gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this Example 3, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) Authorization not required — (i) In general. A plan or issuer may not require that a physician or other health care provider obtain authorization from the plan or issuer for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (See also paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain

notice requirements.)

(ii) Example. The rule of this paragraph (a)(4) is illustrated by the following example:

Example. (i) In the case of a delivery by cesarean section, a group health plan subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the plan requires an attending provider to complete a certificate of medical necessity. The plan then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) In this Example, the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by cesarean section is prohibited by this paragraph (a)(4).

(5) Exceptions — (i) Discharge of mother. If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) Discharge of newborn. If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) Attending provider defined. For purposes of this section, attending provider means an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child.

(iv) Example. The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A pregnant woman covered under a group health plan subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by cesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother

and the newborn. Both are discharged approximately 72 hours after the delivery. The plan pays for the 72-hour hospital stays.

(ii) In this Example, the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the readmission is not subject to this section.

(b) Prohibitions — (1) With respect to mothers — (i) In general. A group health plan, and a health insurance issuer offering group health insurance coverage, may not —

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) Examples. The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under the plan are discharged within 24 hours after the delivery, the plan will waive the copayment and deductible.

(ii) In this Example 1, because waiver of the copayment and deductible is in the nature of a rebate that the mother would not receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the plan violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

Example 2. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the plan provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) In this Example 2, because the follow-up visit does not provide any services beyond

what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) With respect to benefit restrictions — (i) In general. Subject to paragraph (c)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not restrict the benefits for any portion of a hospital length of stay required under paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) Example. The rules of this paragraph (b)(2) are illustrated by the following example:

Example. (i) A group health plan subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by cesarean section, the plan automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the participant or beneficiary must call the plan to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the plan will not provide benefits for any succeeding 24-hour period.

(ii) In this Example, the requirement to obtain precertification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit a plan from requiring precertification for any period after the first 96 hours.) In addition, if the plan's utilization reviewer denied any mother or her newborn benefits within the 96-hour stay, the plan would also violate paragraph (a) of this section.

(3) With respect to attending providers. A group health plan, and a health insurance issuer offering group health insurance coverage, may not directly or indirectly —

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider

to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) Construction. With respect to this section, the following rules of construction apply:

(1) Hospital stays not mandatory. This section does not require a mother to —

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) Hospital stay benefits not mandated. This section does not apply to any group health plan, or any group health insurance coverage, that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Cost-sharing rules — (i) In general. This section does not prevent a group health plan or a health insurance issuer offering group health insurance coverage from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay required under paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) Examples. The rules of this paragraph (c)(3) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The plan covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) In this Example 1, the plan violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the plan also violates the similar rule in paragraph (b)(2) of this section.)

Example 2. (i) A group health plan generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the plan will cover 80 percent of the cost of the stay if the participant or beneficiary notifies the plan of the pregnancy in advance of admission and uses whatever hospital the plan may designate.

(ii) In this Example 2, the plan does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay required under paragraph (a) of this section. (In addition, the plan does not violate the rules in paragraph (a)(4) or (b)(2) of this section.)

(4) Compensation of attending provider. This section does not prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(d) Notice requirement. See 29 CFR 2520.102-3 (u) and (v)(2) (relating to the disclosure requirement under section 711(d) of the Act).

(e) Applicability in certain States — (1) Health insurance coverage. The requirements of section 711 of the Act and this section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) The State law requires the coverage to provide for maternity and pediatric care in

accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) Group health plans — (i) Fully-insured plans. For a group health plan that provides benefits solely through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 711 of the Act and this section do not apply.

(ii) Self-insured plans. For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 711 of the Act and this section apply.

(iii) Partially-insured plans. For a group health plan that provides some benefits through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 711 of the Act and this section apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.

(3) Relation to section 731(a) of the Act. The preemption provisions contained in section 731(a)(1) of the Act and § 2590.731(a) do not supersede a State law described in paragraph

(e)(1) of this section.

(4) Examples. The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) A group health plan buys group health insurance coverage in a State that requires that the coverage provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) In this Example 1, the coverage is subject to State law, and the requirements of section 711 of the Act and this section do not apply.

Example 2. (i) A self-insured group health plan covers hospital lengths of stay in connection with childbirth in a State that requires health insurance coverage to provide for maternity care in accordance with guidelines established by the American College of Obstetricians and Gynecologists and to provide for pediatric care in accordance with guidelines established by the American Academy of Pediatrics.

(ii) In this Example 2, even though the State law satisfies the criterion of paragraph (e)(1)(ii) of this section, because the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the plan is subject to the requirements of section 711 of the Act and this section.

(f) Effective date. Section 711 of the Act applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1998. This section applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1999.

Signed at Washington, DC this 19 day of October, 1998.

Meredith Miller
Deputy Assistant Secretary for Policy, Pension and Welfare Benefits Administration, U.S. Department of Labor.

Health Care Financing Administration

45 CFR Subtitle A, Subchapter B

45 CFR Subtitle A, Subchapter B, is amended as set forth below:

A. Part 144 is amended as follows:

PART 144--REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

1. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92.

2. Section 144.101 is revised to read as follows:

§ 144.101 Basis and purpose.

Part 146 of this subchapter implements sections 2701 through 2723 of the Public Health Service Act (PHS Act, 42 U.S.C. 300gg, et seq.). Its purpose is to improve access to group health insurance coverage, to guarantee the renewability of all coverage in the group market, and to provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth. Part 148 of this subchapter implements sections 2741 through 2763 of the PHS Act. Its purpose is to improve access to individual health insurance coverage for certain eligible individuals who previously had group coverage, to guarantee the renewability of all coverage in the individual market, and to provide protections for mothers and newborns with respect to coverage for hospital stays in

connection with childbirth. Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this subchapter and provide the basis for issuing these regulations, respectively.

3. In **§** 144.102, paragraph (b) is revised to read as follows:

§ 144.102 Scope and applicability.

* * * * *

(b) The protections afforded under 45 CFR parts 144 through 148 to individuals and employers (and other sponsors of health insurance offered in connection with a group health plan) are determined by whether the coverage involved is obtained in the small group market, the large group market, or the individual market. Small employers, and individuals who are eligible to enroll under the employer's plan, are guaranteed availability of insurance coverage sold in the small group market. Small and large employers are guaranteed the right to renew their group coverage, subject to certain exceptions. Eligible individuals are guaranteed availability of coverage sold in the individual market, and all coverage in the individual market must be guaranteed renewable. All coverage issued in the small or large group market, and in the individual market, must provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth.

* * * * *

B. Part 146 is amended as follows:

PART 146--REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

1. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92).

2. In **§** 146.101, paragraph (a) is revised, paragraphs (b)(2) through (b)(4) are redesignated as paragraphs (b)(3) through (b)(5), respectively, and a new paragraph (b)(2) is added to read as follows:

§ 146.101 Basis and scope.

(a) Statutory basis. This part implements sections 2701 through 2723 of the PHS Act. Its purpose is to improve access to group health insurance coverage, to guarantee the renewability of all coverage in the group market, and to provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth. Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this subchapter and provide the basis for issuing these regulations, respectively.

(b) * * *

(2) Subpart C. Subpart C of this part sets forth the requirements that apply to plans and issuers with respect to coverage for hospital stays in connection with childbirth. It also sets forth the regulations governing parity between medical/surgical benefits and mental health benefits in group health plans and health insurance coverage offered by issuers in

connection with a group health plan.

* * * * *

Subpart C--Requirements Relating to Benefits

3. Section 146.130 is added to Subpart C to read as follows:

§ 146.130 Standards relating to benefits for mothers and newborns.

(a) Hospital length of stay — (1) General rule. Except as provided in paragraph (a)(5) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than —

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) When stay begins — (i) Delivery in a hospital. If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) Delivery outside a hospital. If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) Examples. The rules of paragraphs (a)(1) and (a)(2) of

this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this Example 1, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this Example 2, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) A woman covered under a group health plan gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this Example 3, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) Authorization not required — (i) In general. A plan or issuer may not require that a physician or other health care provider obtain authorization from the plan or issuer for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (See also paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) Example. The rule of this paragraph (a)(4) is

illustrated by the following example:

Example. (i) In the case of a delivery by cesarean section, a group health plan subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the plan requires an attending provider to complete a certificate of medical necessity. The plan then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) In this Example, the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by cesarean section is prohibited by this paragraph (a)(4).

(5) Exceptions — (i) Discharge of mother. If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) Discharge of newborn. If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) Attending provider defined. For purposes of this section, attending provider means an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child.

(iv) Example. The rules of this paragraph (a)(5) are

illustrated by the following example:

Example. (i) A pregnant woman covered under a group health plan subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by cesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother and the newborn. Both are discharged approximately 72 hours after the delivery. The plan pays for the 72-hour hospital stays.

(ii) In this Example, the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the readmission is not subject to this section.

(b) Prohibitions — (1) With respect to mothers — (i) In general. A group health plan, and a health insurance issuer offering group health insurance coverage, may not —

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) Examples. The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under the plan are discharged within 24 hours after the delivery, the plan will waive the copayment and deductible.

(ii) In this Example 1, because waiver of the copayment and deductible is in the nature of a rebate that the mother would not

receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the plan violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

Example 2. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the plan provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) In this Example 2, because the follow-up visit does not provide any services beyond what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) With respect to benefit restrictions — (i) In general. Subject to paragraph (c)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not restrict the benefits for any portion of a hospital length of stay required under paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) Example. The rules of this paragraph (b)(2) are illustrated by the following example:

Example. (i) A group health plan subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by cesarean section, the plan automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the participant or beneficiary must call the plan to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the plan will not provide benefits for any succeeding 24-hour period.

(ii) In this Example, the requirement to obtain precertification for the two 24-hour periods immediately

following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit a plan from requiring precertification for any period after the first 96 hours.) In addition, if the plan's utilization reviewer denied any mother or her newborn benefits within the 96-hour stay, the plan would also violate paragraph (a) of this section.

(3) With respect to attending providers. A group health plan, and a health insurance issuer offering group health insurance coverage, may not directly or indirectly —

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) Construction. With respect to this section, the following rules of construction apply:

(1) Hospital stays not mandatory. This section does not require a mother to —

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) Hospital stay benefits not mandated. This section does not apply to any group health plan, or any group health insurance coverage, that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Cost-sharing rules — (i) In general. This section does not prevent a group health plan or a health insurance issuer offering group health insurance coverage from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay required under paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) Examples. The rules of this paragraph (c)(3) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The plan covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) In this Example 1, the plan violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the plan also violates the similar rule in paragraph (b)(2) of this section.)

Example 2. (i) A group health plan generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the plan will cover 80 percent of the cost of the stay if the participant or beneficiary notifies the plan of the pregnancy in advance of admission and uses whatever hospital the plan may designate.

(ii) In this Example 2, the plan does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay required under paragraph (a) of this section. (In addition, the plan does not violate the rules in paragraph (a)(4) or paragraph (b)(2) of this section.)

(4) Compensation of attending provider. This section does not prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(d) Notice requirement. Except as provided in paragraph (d)(4)of this section, a group health plan that provides benefits for hospital lengths of stay in connection with childbirth must meet the following requirements:

(1) Required statement. The plan document that provides a description of plan benefits to participants and beneficiaries must disclose information that notifies participants and beneficiaries of their rights under this section.

(2) Disclosure notice. To meet the disclosure requirement set forth in paragraph (d)(1) of this section, the following disclosure notice must be used:

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g.,your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

(3) Timing of disclosure. The disclosure notice in paragraph (d)(2) of this section shall be furnished to each participant covered under a group health plan, and each

beneficiary receiving benefits under a group health plan, not later than 60 days after the first day of the first plan year beginning on or after January 1, 1999.

(4) Exceptions. The requirements of this paragraph (d) do not apply in the following situations:

(i) Self-insured plans. The benefits for hospital lengths of stay in connection with childbirth are not provided through health insurance coverage, and the group health plan has made the election described in §146.180 to be exempted from the requirements of this section.

(ii) Insured plans. The benefits for hospital lengths of stay in connection with childbirth are provided through health insurance coverage, and the coverage is regulated under a State law described in paragraph (e) of this section.

(e) Applicability in certain States — (1) Health insurance coverage. The requirements of section 2704 of the PHS Act and this section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) The State law requires the coverage to provide for maternity and pediatric care in accordance with guidelines

established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) Group health plans — (i) Fully-insured plans. For a group health plan that provides benefits solely through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 2704 of the PHS Act and this section do not apply.

(ii) Self-insured plans. For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 2704 of the PHS Act and this section apply.

(iii) Partially-insured plans. For a group health plan that provides some benefits through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 2704 of the PHS Act and this section

apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.

(3) Relation to section 2723(a) of the PHS Act. The preemption provisions contained in section 2723(a)(1) of the PHS Act and § 146.143(a) do not supersede a State law described in paragraph (e)(1) of this section.

(4) Examples. The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) A group health plan buys group health insurance coverage in a State that requires that the coverage provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) In this Example 1, the coverage is subject to State law, and the requirements of section 2704 of the PHS Act and this section do not apply.

Example 2. (i) A self-insured group health plan covers hospital lengths of stay in connection with childbirth in a State that requires health insurance coverage to provide for maternity care in accordance with guidelines established by the American College of Obstetricians and Gynecologists and to provide for pediatric care in accordance with guidelines established by the American Academy of Pediatrics.

(ii) In this Example 2, even though the State law satisfies the criterion of paragraph (e)(1)(ii) of this section, because the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the plan is subject to the requirements of section 2704 of the PHS Act and this section.

(f) Effective date. Section 2704 of the PHS Act applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1998. This section applies to group health plans, and

health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1999.

C. Part 148 is amended as follows:

PART 148--REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

1. The authority citation for part 148 continues to read as follows:

Authority: Secs. 2741 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg-41 through 300gg-63, 300gg-91, and 300gg-92).

2. Section 148.101 is revised to read as follows:

§ 148.101 Basis and purpose.

This part implements sections 2741 through 2763 and 2791 and 2792 of the PHS Act. Its purpose is to improve access to individual health insurance coverage for certain eligible individuals who previously had group coverage, and to guarantee the renewability of all coverage in the individual market. It also provides certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth.

3. In **§** 148.102, paragraphs (a) heading,(a)(2), and (b) are revised to read as follows:

§ 148.102 Scope, applicability, and effective dates.

(a) Scope and applicability. * * *

(2) The requirements of this part that pertain to guaranteed availability of individual health insurance coverage for certain eligible individuals apply to all issuers of individual health insurance coverage in a State, unless the State implements an acceptable alternative mechanism as described in §148.128. The requirements that pertain to guaranteed renewability for all individuals, and to protections for mothers and newborns with respect to hospital stays in connection with childbirth, apply to all issuers of individual health insurance coverage in the State, regardless of whether a State implements an alternative mechanism.

(b) Effective date. Except as provided in §§148.124 (certificate of coverage), 148.128 (alternative State mechanisms), and 148.170 (standards relating to benefits for mothers and newborns), the requirements of this part apply to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

4. A new subpart C is added to read as follows:

Subpart C--Requirements Related to Benefits

§ 148.170 Standards relating to benefits for mothers and newborns.

(a) Hospital length of stay — (1) General rule. Except as provided in paragraph (a)(5) of this section, an issuer offering health insurance coverage in the individual market that provides benefits for a hospital length of stay in connection with

childbirth for a mother or her newborn may not restrict benefits for the stay to less than —

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) When stay begins — (i) Delivery in a hospital. If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) Delivery outside a hospital. If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) Examples. The rules of paragraphs (a)(1) and (a)(2) of this section are illustrated by the following examples. In each example, the issuer provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a policy issued in the individual market goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this Example 1, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a policy issued in the individual market gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this Example 2, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) A woman covered under a policy issued in the individual market gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this Example 3, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) Authorization not required — (i) In general. An issuer may not require that a physician or other health care provider obtain authorization from the issuer for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (See also paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) Example. The rule of this paragraph (a)(4) is illustrated by the following example:

Example. (i) In the case of a delivery by cesarean section, an issuer subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the issuer requires an attending provider to complete a certificate of medical necessity. The issuer then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) In this Example, the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by cesarean section is prohibited by this paragraph (a)(4).

(5) Exceptions — (i) Discharge of mother. If a decision to discharge a mother earlier than the period specified in paragraph

(a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) Discharge of newborn. If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) Attending provider defined. For purposes of this section, attending provider means an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child.

(iv) Example. The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A pregnant woman covered under a policy offered by an issuer subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by cesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother and the newborn. Both are discharged approximately 72 hours after the delivery. The issuer pays for the 72-hour hospital stays.

(ii) In this Example, the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the readmission is not subject to this section.

(b) Prohibitions — (1) With respect to mothers — (i) In

general. An issuer may not —

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll in or renew coverage solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) Examples. The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the issuer is subject to the requirements of this section, as follows:

Example 1. (i) An issuer provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under a policy issued in the individual market are discharged within 24 hours after the delivery, the issuer will waive the copayment and deductible.

(ii) In this Example 1, because waiver of the copayment and deductible is in the nature of a rebate that the mother would not receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the issuer violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

Example 2. (i) An issuer provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the issuer provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) In this Example 2, because the follow-up visit does not provide any services beyond what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) With respect to benefit restrictions — (i) In general. Subject to paragraph (c)(3) of this section, an issuer may not restrict the benefits for any portion of a hospital length of stay required under paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) Example. The rules of this paragraph (b)(2) are illustrated by the following example:

Example. (i) An issuer subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by cesarean section, the issuer automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the covered individual must call the issuer to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the issuer will not provide benefits for any succeeding 24-hour period.

(ii) In this Example, the requirement to obtain precertification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit an issuer from requiring precertification for any period after the first 96 hours.) In addition, if the issuer's utilization reviewer denied any mother or her newborn benefits within the 96-hour stay, the issuer would also violate paragraph (a) of this section.

(3) With respect to attending providers. An issuer may not directly or indirectly —

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a covered individual in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a covered individual in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) Construction. With respect to this section, the following rules of construction apply:

(1) Hospital stays not mandatory. This section does not require a mother to —

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) Hospital stay benefits not mandated. This section does not apply to any issuer that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Cost-sharing rules — (i) In general. This section does not prevent an issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay required under paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) Examples. The rules of this paragraph (c)(3) are

illustrated by the following examples. In each example, the issuer is subject to the requirements of this section, as follows:

Example 1. (i) An issuer provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The issuer covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) In this Example 1, the issuer violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the issuer also violates the similar rule in paragraph (b)(2) of this section.)

Example 2. (i) An issuer generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the issuer will cover 80 percent of the cost of the stay if the covered individual notifies the issuer of the pregnancy in advance of admission and uses whatever hospital the issuer may designate.

(ii) In this Example 2, the issuer does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay required under paragraph (a) of this section. (In addition, the issuer does not violate the rules in paragraph (a)(4) or paragraph (b)(2) of this section.)

(4) Compensation of attending provider. This section does not prevent an issuer from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(5) Applicability. This section applies to all health insurance coverage issued in the individual market, and is not limited in its application to coverage that is provided to eligible individuals as defined in section 2741(b) of the PHS

Act.

(d) Notice requirement. Except as provided in paragraph (d)(4) of this section, an issuer offering health insurance in the individual market must meet the following requirements with respect to benefits for hospital lengths of stay in connection with childbirth:

(1) Required statement. The insurance contract must disclose information that notifies covered individuals of their rights under this section.

(2) Disclosure notice. To meet the disclosure requirement set forth in paragraph (d)(1) of this section, the following disclosure notice must be used:

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the

48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

(3) Timing of disclosure. The disclosure notice in paragraph (d)(2) of this section shall be furnished to the covered individuals in the form of a copy of the contract, or a rider (or equivalent amendment to the contract), not later than March 1, 1999.

(4) Exception. The requirements of this paragraph (d) do not apply with respect to coverage regulated under a State law described in paragraph (e) of this section.

(e) Applicability in certain States — (1) Health insurance coverage. The requirements of section 2751 of the PHS Act and this section do not apply with respect to health insurance coverage in the individual market if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following

a delivery by cesarean section.

(ii) The State law requires the coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) Relation to section 2762(a) of the PHS Act. The preemption provisions contained in section 2762(a) of the PHS Act and § 148.210(b) do not supersede a State law described in paragraph (e)(1) of this section.

(f) Effective date. Section 2751 of the PHS Act applies to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998. This section applies to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1999.

Dated: Aug. 27, 1998

Nancy-Ann Min DeParle

Administrator, Health Care Financing Administration.

Dated: Sept. 21, 1998

Donna E. Shalala

Secretary, Department of Health and Human Services.

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