

§ 148.170

form that meets one of the following requirements?

(i) Is the policy form comparable to comprehensive health insurance coverage offered in the individual market in the State?

(ii) Is the policy form comparable to a standard option of coverage available under the group or individual health insurance laws of the State?

(3) Does the mechanism prohibit pre-existing condition exclusions for all eligible individuals?

(4) Is the State implementing one of the following:

(i) The NAIC Small Employer and Individual Health Insurance Availability Model Act (Availability Model), adopted on June 3, 1996, revised to reflect HIPAA requirements.

(ii) The Individual Health Insurance Portability Model Act (Portability Model), adopted on June 3, 1996, revised to reflect HIPAA requirements.

(iii) A qualified high-risk pool that provides eligible individuals health insurance or comparable coverage without a preexisting condition exclusion, and with premiums and benefits consistent with the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect August 21, 1996), revised to reflect HIPAA requirements.

(iv) A mechanism that provides for risk spreading or provides eligible individuals with a choice of all available individual health insurance coverage.

(5) Has the State enacted all legislation necessary for implementing the alternative mechanism?

(6) If the State has not enacted all legislation necessary for implementing the alternative mechanism, will the necessary legislation be enacted by January 1, 1998?

(h) *Limitation of HCFA's authority.* HCFA does not make a preliminary or final determination on any basis other than that a mechanism is not considered an acceptable alternative mechanism or is not being implemented.

(Approved by the Office of Management and Budget under control number 0938-0703.)

[62 FR 16995, Apr. 8, 1997; 62 FR 17005, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

45 CFR Subtitle A (10-1-00 Edition)

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

§ 148.170

45 CFR Subtitle A (10-1-00 Edition)

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 new-

born 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

§ 148.210

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.

[63 FR 57562, Oct. 27, 1998]

Subpart D—Enforcement; Penalties; Preemption

§ 148.210 Preemption.

(a) *Scope.* (1) This section describes the effect of sections 2741 through 2763 and 2791 of the PHS Act on a State's authority to regulate health insurance issuers in the individual market. This section makes clear that States remain subject to section 514 of ERISA, which generally preempts State law that relates to ERISA-covered plans.

(2) Sections 2741 through 2763 and 2791 of the PHS Act cannot be construed to affect or modify the provisions of section 514 of ERISA.

(b) *Regulation of insurance issuers.* The individual market rules of this part do not prevent a State law from establishing, implementing, or continuing in effect standards or requirements unless the standards or requirements prevent the application of a requirement of this part.

45 CFR Subtitle A (10–1–00 Edition)

§ 148.220 Excepted benefits.

The requirements of this part do not apply to individual health insurance coverage in relation to its provision of the benefits described in paragraphs (a) and (b) of this section (or any combination of the benefits).

(a) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances:

(1) Coverage only for accident (including accidental death and dismemberment).

(2) Disability income insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Coverage issued as a supplement to liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Credit-only insurance (for example, mortgage insurance).

(8) Coverage for on-site medical clinics.

(b) *Other excepted benefits.* The requirements of this part do not apply to individual health insurance coverage described in paragraphs (b)(1) through (b)(6) of this section if the benefits are provided under a separate policy, certificate, or contract of insurance. These benefits include the following:

(1) Limited scope dental or vision benefits. These benefits are dental or vision benefits that are limited in scope to a narrow range or type of benefits that are generally excluded from benefit packages that combine hospital, medical, and surgical benefits.

(2) Long-term care benefits. These benefits are benefits that are either—

(i) Subject to State long-term care insurance laws;

(ii) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Code; or

(iii) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(3) Coverage only for a specified disease or illness (for example, cancer policies), or hospital indemnity or other fixed indemnity insurance (for