

as part of the notice describing the disease management program.

(ii) *Conclusion.* In this *Example 5*, the plan violates the requirements of paragraph (d)(1) of this section because the requests for genetic information are not limited to those situations in which it is necessary to make a determination regarding whether the disease management program is medically appropriate for the individuals.

Example 6. (i) *Facts.* Same facts as *Example 4*, except the disease management program provides an enhanced benefit in the form of a lower annual deductible to individuals under the program; the lower deductible applies with respect to all medical expenses incurred by the individual. Thus, whether or not a claim relates to diabetes, the individual is provided with a lower deductible based on the individual providing the plan with genetic information.

(ii) *Conclusion.* In this *Example 6*, because the enhanced benefits include benefits not related to the determination of medical appropriateness, making available the enhanced benefits is within the meaning of underwriting purposes. Accordingly, the plan may not request or require genetic information (including family history information) in determining eligibility for enhanced benefits under the program because such a request would be for underwriting purposes and would violate paragraph (d)(1) of this section.

(f) *Effective/applicability date.* This section applies for plan years beginning on or after December 7, 2009.

(g) *Expiration date.* This section expires on or before October 1, 2012.

[T.D. 9464, 74 FR 51678, Oct. 7, 2009]

§ 54.9811-1 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 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) *Facts.* 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) *Conclusion.* 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) *Facts.* 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) *Conclusion.* 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) *Facts.* 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) *Conclusion.* 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 specified in 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) *Facts.* 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) *Conclusion.* 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. Therefore, a plan, hospital, managed care organization, or other issuer is not an attending provider.

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

Example. (i) *Facts.* 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 at-

tending 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) *Conclusion.* 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) *Facts.* 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) *Conclusion.* 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) *Facts.* 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) *Conclusion.* 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 specified in 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) *Facts.* 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) *Conclusion.* 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, the requirement to obtain precertification from the plan based on medical necessity for a hospital length of stay within the 96-hour period 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 specified in 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) *Facts.* 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) *Conclusion.* 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) *Facts.* 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) *Conclusion.* 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) for rules relating to a disclosure requirement imposed under section 711(d) of ERISA (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 that relate to care following childbirth 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 section 731(a) of ERISA.* See 29 CFR 2590.711(e)(3) for a rule providing that the preemption provisions contained in section 731(a)(1) of ERISA and 29 CFR 2590.731(a) do not supersede a state law if the state law is described in paragraph (e)(1) of 29 CFR 2590.711 (which is substantially similar to paragraph (e)(1) of this section).

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

Example 1. (i) *Facts.* 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) *Conclusion.* 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) *Facts.* 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 and pediatric care in accordance with guidelines that relate to care following childbirth established by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

(ii) *Conclusion.* 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/applicability date.* This section applies to group health plans for plan years beginning on or after January 1, 2009.

[T.D. 9427, 73 FR 62420, Oct. 20, 2008]

§ 54.9812-1T Parity in the application of certain limits to mental health benefits (temporary).

(a) *Definitions.* For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits—(1) In general—(i) General parity requirement.* A group health plan that provides both medical/surgical benefits and mental health benefits

must comply with paragraph (b) (2), (3), or (6) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this