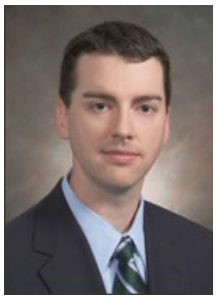
Final Rules for Mothers' and Newborns' Health Protection Act of 1996 Implemented.

By: Robert J. Baker, Esquire



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On December 19, 2008, the final rules for compliance with the Newborns' and Mothers' Health Protection Act of 1996 ("the Newborns' Act"), with respect to group health plans and insurers took effect and apply to plan years beginning on or after January 1, 2009. These final rules were previously issued by the Department of Health and Human Services, The Department of Labor and the Treasury Department on October 20, 2008.

By way of background, the Newborns' Act was originally enacted on September 26, 1996 to provide protections for mothers and their newborns with respect to hospitalization and the length of stays after childbirth. Interim final rules were issued on October 27, 1998, which have been recently finalized.

The interim final rules provided the following guidance:

- The attending provider makes the determination that an admission is in connection with childbirth;
- Determined when the hospital stay begins for purposes of application of the general rule;
- An exception to the 48-hour (or 96-hour if childbirth was by cesarean section) general rule if the attending provider decides, in consultation with the mother, to discharge the mother or her newborn earlier;
- Clarified the application of authorization and precertification requirements with respect to the 48-hour (or 96-hour if childbirth was by cesarean section) stay;
- Explained the application of benefit restrictions and cost-sharing rules with respect to the 48-hour (or 96-hour if childbirth was by cesarean section) stay;
- Clarified the prohibitions with respect to a plan or issuer offering mothers incentives or disincentives to encourage less than the 48-hour (or 96-hour if childbirth was by cesarean section) stay;
- Clarified the prohibitions against incentives and penalties with respect to attending providers; and
- Included the statutory notice provisions under ERISA and the Public Health Services Act.[1]

In general, the final rules do not change the interim final rules. However, the final rules provide certain clarifications of the interim rules issued in 1998.

The final rules provide that the length of hospital stay is determined by the time of delivery as opposed to the time of admission or onset of labor. Additionally, if delivery occurs outside the hospital, the length of stay begins at the time the mother or newborn is admitted to the hospital.[2]

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[1] Federal Register, Vol. 73, No. 203, October 20, 2008, 62410
[2] Id. at 62411.

Continuing, the mandatory coverage period provisions are not violated if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier.[3] The final rules explain that the attending provider is defined by an analysis of the individual state licensure rules and the actual performance of care. As such, the attending provider is restricted to an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child.[4]

The final rules do not provide a specific list of titles or positions, and as a result, it is unknown whether or not the definition specifically includes a nurse midwife or physician assistant. Rather, the final rules refer to state licensure rules and the actual performance of care. Additionally, the final rules prohibit the designation of a plan, hospital, managed care organization or other issuer as an attending provider.

The final rules also prohibit plans and issuers from penalizing attending providers who provide care in accordance with the final rules. Additionally, plans and issuers are prohibited from inducing attending providers to provide care in a manner that is inconsistent with the final rules. However, the final rules specifically outline that plans and issuers are able to negotiate with attending providers the level and type of compensation for care furnished in accordance with the regulations.[5] Likewise, the final rules prohibit plans and insurers to require an attending provider to obtain authorization from the plan or issuer to prescribe a hospital length of stay that is subject to the general rule.[6]

Additionally, the final rules also provide certain notice requirements. Specifically, plans that are subject to ERISA must provide participants and beneficiaries a summary plan description apprising them of their rights and obligations. Likewise, although they are not subject to the provisions of ERISA, nonfederal governmental plans also have certain notice requirements under the Newborns' Act. These plans must provide notice to each participant and beneficiary who is covered with explanation of the application of federal and state law.[7]

Further, the final rules include an exception for health insurance coverage if there is a state law that meets any of the following criteria:

- The state law requires health insurance coverage to provide at least a 48-hour (or 96-hour if childbirth was by cesarean section) 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 to the attending provider in consultation with the mother. The interim final rules and these final regulations clarify that state laws that require the decision to be made by the attending provider with the consent of the mother satisfy this criterion.[8]

Lastly, although this 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. Accordingly, self-insured plans in all states generally are required to comply with the federal requirements, unless the plan has opted out of the Public Health Services Act notice requirements.[9]

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[3] Id.
[4] Id.
[5] Id.
[6] Id. at 62412
[7] Id.
[8] Id. at 62413
[9] Id.

In summary, while the final rules provide only minor changes from the interim final rules, certain clarification were provided. As such, it is recommended that employers review their plan documents to ensure compliance with the final rules. Mr. Baker may be contacted with questions or concerns regarding compliance with this issue.