Newborns and Mothers Health Protection Act Rights

Under federal law, group health plans offering group health 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 you, your physician, or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceeded 48 hours (or 96 hours).

For information on pre-certification, please refer to your Summary Plan Description.

Mental Health and Substance Abuse Parity

The Mental Health Parity Act of 1996 prohibits group health plans from having lower annual or aggregate lifetime dollar limits for mental health benefits than for medical/surgical benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 broadened the “parity” requirements by making them applicable to substance use disorder benefits and by mandating parity for financial requirements and treatment limitations. In general, a plan may not impose a financial requirement (deductible, copay, etc.) or quantitative treatment limitation to a mental health/substance abuse classification that is more restrictive than the predominant requirement or limitation applied to substantially all medical/surgical benefits in the same classification. Plans must be tested for compliance with the parity law. While not required to be done annually, it should be done when there is a change to plan design, cost sharing or utilization management provision that affects a financial treatment limitation within a defined classification or subclassification. Plans also may not impose nonquantitative treatment limits for mental health/substance abuse benefits unless certain conditions are met. In November 2013, final mental health parity regulations were issued that generally clarified prior provisions of the law. For example, the final regulations include the requirement that parity be extended to intermediate levels of care, eliminate the “clinically recognized standard of care” exception, and clarify nonquantitative treatment limits. Compliance with the final regulations were required as of the first plan year beginning on or after July 1, 2014.