Newborns' and Mothers'
Health Protection Act of 1996 (NMHPA)
Helpful Tips

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1. NMHPA notification --- Group health plans or health insurance issuers are required to provide you with a notice about your rights under NMHPA. If you are in a group health plan, the notice will usually be included in the plan document (sometimes referred to as the "Summary Plan Description") that provides a description of the benefits covered under your plan. If you have individual health insurance coverage, the notice of your rights under NMHPA, will generally be included in your insurance contract.

Self-funded non Federal governmental plans may opt-out of the NMHPA requirements. For more information on NMHPA opt-outs go to http://www.cms.hhs.gov/SelfFundedNonFedGovPlans/.

Example 1: Jane Smith joined Company ABC on April 27th and enrolled in the group health plan. She did not receive an individual NMHPA notification. Jane had a child on June 2nd and wanted to get more information about her rights under NMHPA. When she called Human Resources on June 20th, they explained that the policy provides NMHPA benefits and the NMHPA notification was in the Employee Orientation materials that Jane received on April 27th. Upon reviewing the materials, specifically the Summary Plan Description, she saw the NMHPA notification. Company ABC did notify Jane; therefore, it has complied with the NMHPA.

Example 2: Jane Smith purchased an individual health insurance policy from Issuer ABC on April 27th and did not receive an individual NMHPA notification. Jane had a child on June 2nd and wanted to get more information about her rights under NMHPA. When Jane contacted her insurance agent she was told that the policy provides NMHPA benefits and the NMHPA notification was in the insurance contract. Upon reviewing the contract, she saw the NMHPA notification. Issuer ABC complied with NMHPA.

Example 3: Jane Smith was hired by a non Federal governmental employer on April 27th and enrolled in the employer's group health plan. She did not receive an individual NMHPA notification. Jane, who is expecting a child in June, wanted to get more information about her rights under NMHPA. When she called Human Resources (HR)

HR explained that the employer elected to exempt its self-funded non Federal governmental plan from NMHPA requirements as permitted by Federal law.

Accordingly, the non Federal governmental employer does not have to provide NMHPA benefits. HR asked Jane to review the Employee Orientation materials that she received on April 27th. Upon reviewing the materials, she saw that the documentation includes a notice to plan enrollees stating that the employer has elected to exempt its self-funded plan from the standards relating to benefits for mothers and newborns. Jane may have other non-HIPAA protections under state law. She should contact the Department of Insurance (DOI) for the state in which she resides and ask DOI if she is entitled to any additional protections.

2. Enrollment --- Eligibility for enrollment into a health plan is determined according to the terms of the health plan and the rules of the issuer. Read your plan documents to determine the timeframe in which you must enroll your newborn in order for the newborn to be added to your policy. To discuss state laws, contact your state Department of Insurance (DOI). Go to CMS Webpage, Health Insurance Reform for Consumers http://www.cms.hhs.gov/HealthInsReformforConsume/, scroll down to the Downloads, select "DOI Contact Information – State Status Chart".

For more information on enrollment, see the HIPAA Helpful Tips, go to http://www.cms.hhs.gov/HealthInsReformforConsume/, scroll down to Downloads, select HIPAA Helpful Tips.

Example 1: Jane Smith joined Company ABC on April 27th and enrolled in the group health plan. Jane gave birth on December 1st to Abigail. Jane read her plan documents regarding enrollment and immediately contacted her employer via return receipt mail. Jane indicated the appropriate information regarding her newborn. The employer contacted the insurance issuer and Abigail was enrolled and covered in accordance with the terms of the plan.

Example 2: Jane Smith joined Company ABC on April 27th and enrolled in the group health plan. Jane gave birth on December 1st to Abigail. Jane had no intention of enrolling Abigail in any health plan. After 30 days the child had no health coverage. Jane wanted to know whether Company ABC had to cover Abigail for the first 30 days of her life or whether they could retroactively cancel Abigail's coverage since the newborn is not participating in the plan.

Jane should read her policy contract and/or summary of benefits to determine whether her child was covered for the first 30 days. She should also contact her state Department of Insurance (DOI) to discuss state law. Go to CMS Webpage, Health Insurance Reform for Consumers http://www.cms.hhs.gov/HealthInsReformforConsume/, scroll down to the Downloads, select "DOI Contact Information – State Status Chart".

3. Timeframes for a 48-hour or 96-hour hospital stay --- In accordance with the Newborns' and Mothers' Health Protection Act, a group health plan or an individual market policy cannot restrict hospital stay benefits to less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section delivery.

Self-funded non Federal governmental plans may opt-out of the NMHPA requirements. For more information on NMHPA opt-outs go to http://www.cms.hhs.gov/SelfFundedNonFedGovPlans/.

Example 1: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted into the hospital on Monday, June 1st at 2:30 pm. Jane gives birth by vaginal delivery on Tuesday, June 2nd at 10:00 am. The 48-hour period, described in the above-mentioned helpful tip, ends on Thursday, June 4th at 10:00 am.

Example 2: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted into the hospital on Monday, June 1st at 2:30 pm. Jane gives birth by Caesarian section on Tuesday, June 2nd at 10:00 am. The 96-hour period, described in the above-mentioned helpful tip, ends on Saturday, June 6th at 10:00 am.

Example 3: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, gives birth at home by vaginal delivery on Tuesday, June 2nd at 10:00 am. After the delivery Jane bleeds excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding on Tuesday, June 2nd at 2:00 pm. The 48-hour period, described in the above-mentioned helpful tip, starts when she is admitted to the hospital and ends on Thursday, June 4th at 2:00 pm.

Example 4: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, gives birth at home by vaginal delivery. The child, Abigail Smith, later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth. The hospital length of stay NMHPA requirements do not apply to Abigail's admission to the hospital because the admission is not in connection with childbirth.

Example 5: Jane Smith gave birth on June 2nd at 10:00 am. Jane works for a non Federal governmental employer that has elected to exempt its self-funded group health plan from NMHPA requirements; therefore, the NMHPA does not apply to her situation. Jane may have other non-HIPAA protections under state law. She should contact the Department of Insurance (DOI) for the state in which she resides and ask DOI if she is entitled to any additional protections.

4. Permission for a 48-hour or 96-hour hospital stay --- In accordance with the Newborns' and Mothers' Health Protection Act, a group health plan or a policy issued in the individual market cannot restrict benefits for the hospital stay to less than 48 hours

following a vaginal delivery or 96 hours following a Cesarean section delivery. The group health plan or individual market policy cannot require you or your attending provider to get permission (sometimes called prior authorization or pre-certification based upon medical necessity) for the 48-hour hospital stay related to a vaginal delivery, or the 96-hour hospital stay related to a Caesarian section delivery. A group health plan or an individual market policy may require you to get permission, sometimes called prior authorization or pre-certification based upon medical necessity, for any portion of a stay after the timeframes mentioned above. A group health plan or individual market policy generally can require you to notify the group health plan or issuer (of the individual market policy) of the pregnancy in advance of an admission if you wish to use certain providers or facilities, or to reduce your out-of-pocket costs. If the attending provider consults with the mother, and both are in agreement, the mother may voluntarily leave the hospital before the 48-hour/96-hour hospital stay.

Self-funded non Federal governmental plans may opt-out of the NMHPA requirements. For more information on NMHPA opt-outs go to http://www.cms.hhs.gov/SelfFundedNonFedGovPlans/.

Example 1: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted into the hospital. Jane gives birth by vaginal delivery on Tuesday, June 2nd at 10:00 am. Jane is entitled to the 48-hour period which begins upon delivery and ends on Thursday, June 4th at 10:00 am. The insurance company provides benefits for any hospital length of stay of up to 24 hours; in this case it would be Wednesday, June 3rd at 10:00 am. For longer stays, the plan requires an attending provider to complete a certificate of medical necessity. The insurance company then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary. The requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 24 hours and 48 hours following a vaginal delivery is prohibited by the NMHPA.

Example 2: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted into the hospital. Jane gives birth by Caesarian section on Tuesday, June 2nd at 10:00 am. The insurance company provides benefits for hospital lengths of stay in connection with childbirth. She is entitled to the 96-hour period which begins upon delivery and ends on Saturday, June 6th at 10:00 am.

This plan automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, Jane must call the plan to obtain pre-certification 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.

The requirement to obtain pre-certification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by the NMHPA 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, the NMHPA does not prohibit a plan from requiring pre-certification for any period after the first 96 hours.) In addition, if the plan's utilization reviewer denied Jane, or her daughter Abigail, benefits within the 96-hour stay, this would also be an NMHPA violation.

Example 3: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted to the hospital on Monday, June 1st at 2:30 pm. Jane gives birth by Caesarian section on Tuesday, June 2nd at 10:00 am. The insurance company provides benefits for hospital lengths of stay in connection with childbirth. She is entitled to the 96-hour period which begins upon delivery and ends on Saturday, June 6th at 10:00 am.

On Friday, June 5th, Jane's attending provider consults with her, and the attending provider for the newborn also consults with Jane. All parties agree that both Jane and her daughter Abigail may go home. The attending providers authorize the early discharge of both the mother and the newborn. They are discharged approximately 72-hours after the delivery. The plan pays for the 72-hour hospital stays. Since all parties agreed to the discharge after 72-hours, this scenario complies with the NMHPA. If either the mother or the newborn is readmitted, the hospital stay for the readmission is not subject to the NMHPA.

Example 4: Jane Smith gave birth on June 2nd at 10:00 am. Jane works for a non Federal governmental employer that has elected to exempt its self-funded group health plan from NMHPA requirements; therefore, the NMHPA does not apply to her situation. Jane may have other non-HIPAA protections under state law. She should contact the Department of Insurance (DOI) for the state in which she resides and ask DOI if she is entitled to any additional protections.

5. Deductibles or other cost-sharing arrangements --- In accordance with NMHPA, plans or health insurance issuers may impose deductibles or other cost-sharing arrangements for hospital stays in connection with childbirth only if the deductible, coinsurance, or other cost-sharing amounts for the later portion of the protected 48-hour (or 96-hour) stay are not greater than those imposed for the earlier portion of the stay. For more information on NMHPA go to http://www.cms.hhs.gov/HealthInsReformforConsume/05_TheNewborns'andMothers'HealthProtectionAct.

Self-funded non Federal governmental plans may opt-out of the NMHPA requirements. For more information on NMHPA opt-outs go to http://www.cms.hhs.gov/SelfFundedNonFedGovPlans/.

Example 1: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted into the hospital on Monday, June 1st at 2:30 pm. Jane gives birth by vaginal delivery on Tuesday, June 2nd at 10:00 am. The 48-hour period begins upon delivery and ends on Thursday, June 4th at 10:00

am. The insurance covered 80 percent of the cost of the hospital stay for the first 24-hour period and 50 percent of the cost for the second 24-hour period. The insurance company is not permitted to cover 80 percent of the cost for the first 24 hours and only 50 percent of the cost for the second 24 hours.

Example 2: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted into the hospital on Monday, June 1st at 2:30 pm. Jane gives birth by Caesarian section on Tuesday, June 2nd at 10:00 am. The 96-hour period begins upon delivery and ends on Saturday, June 6th at 10:00 am. The insurance covered 80 percent of the cost of the hospital stay for the first 48-hour period and 50 percent of the cost for the second 48-hour period. The insurance company is not permitted to cover 80 percent of the cost for the first 48 hours and only 50 percent of the cost for the second48 hours.

Example 3: Jane Smith gave birth on June 2nd at 10:00 am. Jane works for a non Federal governmental employer that has elected to exempt its self-funded group health plan from NMHPA requirements; therefore, the NMHPA does not apply to her situation. Jane may have other non-HIPAA protections under state law. She should contact the Department of Insurance (DOI) for the state in which she resides and ask DOI if she is entitled to any additional protections.

6. Incentives to shorten a hospital stay --- In accordance with NMHPA, plans and health insurance issuers cannot offer incentives to you or your doctor to shorten your hospital stay or your newborn's hospital stay. This includes payments (payments-in-kind such as baby supplies) or rebates in return for agreeing to an early discharge. Plans and health insurance issuers are prohibited from pressuring you to agree to an early discharge.

They may not deny you or your newborn child eligibility or continued eligibility to enroll or renew coverage under your plan or individual policy. Plans and health insurance issuers cannot pressure attending providers to discharge you or your newborn child early by giving them financial or other incentives. Such illegal incentives would include reducing or limiting their compensation or penalizing them by taking disciplinary action against them. For more information on NMHPA go to http://www.cms.hhs.gov/HealthInsReformforConsume/05_TheNewborns'andMothers'HealthProtectionAct.asp#TopOfPage.

Self-funded non Federal governmental plans may opt-out of the NMHPA requirements. For more information on NMHPA opt-outs go to http://www.cms.hhs.gov/SelfFundedNonFedGovPlans/.

Example1: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted into the hospital on Monday, June 1st at 2:30 pm. Jane gives birth by vaginal delivery on Tuesday, June 2nd at 10:00 am. The 48-hour period begins upon delivery and ends on Thursday, June 4th at 10:00 am. If Jane and her daughter Abigail are discharged within 24 hours (by Wednesday,

June 3rd 10:00 am) after the delivery, the plan will waive the copayment and deductible. This practice violates the NMHPA.

Example 2: Jane Smith, a pregnant woman covered under a group health plan or individual market policy, goes into labor and is admitted into the hospital on Monday, June 1st at 2:30 pm. Jane gives birth by vaginal delivery on Tuesday, June 2nd at 10:00 am. The 48-hour period begins upon delivery and ends on Thursday, June 4th at 10:00 am. On Wednesday, June 3rd at 1:00 pm, Jane's attending provider consults with her, and the attending provider for the newborn also consults with Jane. All parties agree that both Jane and her daughter Abigail may go home. The attending providers authorize the early discharge of both the mother and the newborn.

The plan provides 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. Since the follow-up visit does not provide any services beyond what Jane and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by the NMHPA.

Example 3: Jane Smith's 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 Jane's stay if she notifies the plan of the pregnancy in advance of admission and uses whatever hospital the plan may designate. This practice does not violate the NMHPA because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay.

Example 4: Jane Smith gave birth on June 2nd at 10:00 am. Jane works for a non Federal governmental employer that has elected to exempt its self-funded group health plan from NMHPA requirements; therefore, the NMHPA does not apply to her situation. Jane may have other non-HIPAA protections under state law. She should contact the Department of Insurance (DOI) for the state in which she resides and ask DOI if she is entitled to any additional protections.

7. Definition of an attending provider --- An attending provider is an individual who is licensed under 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. As long as the providers are individuals who are licensed under State law, any of the following can be attending providers: physicians; nurses; and midwives. For the purposes of the NMHPA, a provider is an individual; therefore, hospitals and other care facilities are not included in this definition of an attending provider.