Pub. L. 110–343, div. C, title V, §512(g)(3)(B), Oct. 3, 2008, 122 Stat. 3892, added item 9812 and struck out former item 9812 ''Parity in the application of certain limits to mental health benefits''.

1997—Pub. L. 105–34, title XV, §1531(a)(4), Aug. 5, 1997, 111 Stat. 1081, added subchapter heading and analysis.

§ 9811. Standards relating to benefits for mothers and newborns

(a) Requirements for minimum hospital stay following birth

(1) In general

A group health plan may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a caesarean section, to less than 96 hours; or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) Exception

Paragraph (1)(A) shall not apply in connection with any group health plan in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

(b) Prohibitions

A group health plan may not—

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) Rules of construction

(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

(A) to give birth in a hospital; or

(B) to stay in the hospital for a fixed period of time following the birth of her child.

(2) This section shall not apply with respect to any group health plan which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this section shall be construed as preventing 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 newborn child under the plan, except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) Level and type of reimbursements

Nothing in this section shall be construed to prevent a group health plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(e) Preemption; exception for health insurance coverage in certain States

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (including a decision, rule, regulation, or other State action having the effect of law) for a State that regulates such coverage that is described in any of the following paragraphs:

(1) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a caesarean section.

(2) Such State law requires such 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 other established professional medical associations.

(3) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(Added Pub. L. 105–34, title XV, §1531(a)(4), Aug. 5, 1997, 111 Stat. 1081; amended Pub. L. 105–206, title VI, §6015(e), July 22, 1998, 112 Stat. 821.)

AMENDMENTS

1998—Subsecs. (e), (f). Pub. L. 105–206 redesignated subsec. (f) as (e).

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by Pub. L. 105–206 effective, except as otherwise provided, as if included in the provisions of the Taxpayer Relief Act of 1997, Pub. L. 105–34, to which such amendment relates, see section 6024 of Pub. L. 105–206, set out as a note under section 1 of this title.

EFFECTIVE DATE

Subchapter applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998,

see section 1531(c) of Pub. L. 105–34, set out as an Effective Date of 1997 Amendment note under section 4980D of this title.

§ 9812. Parity in mental health and substance use disorder benefits

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No lifetime limit

If the plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit

If the plan includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable lifetime limit''), the plan shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits

In the case of a plan that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits

In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No annual limit

If the plan does not include an annual limit on substantially all medical and surgical benefits, the plan may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit

If the plan includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable annual limit''), the plan shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits

In the case of a plan that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations

(A) In general

In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan, and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

The term ''financial requirement'' includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),[1]

(ii) Predominant

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

[1] So in original. The comma probably should be a period.