



Date: September 21, 2010

From: Steve Larsen, Director, Office of Oversight

RE: Amendments to the HIPAA opt-out provision (formerly section 2721(b)(2) of the Public Health Service Act) made by the Affordable Care Act

I. Summary and Purpose

Prior to enactment of the Patient Protection and Affordable Care Act (Affordable Care Act) on March 23, 2010, sponsors of self-funded, nonfederal governmental plans were permitted to elect to exempt those plans from (“opt out of”) certain provisions of title XXVII of the Public Health Service (PHS) Act. This election was authorized under section 2721(b)(2) of the PHS Act. The Affordable Care Act made a number of changes, with the result that sponsors of self-funded, nonfederal governmental plans can no longer opt out of as many requirements of Title XXVII.

Prior to enactment of the Affordable Care Act, sponsors of self-funded nonfederal governmental plans could elect to “opt out” of all 7 of the following Title XXVII requirement categories:

1. Limitations on preexisting condition exclusion periods.
2. Requirements for special enrollment periods.
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status (but not including provisions added by the Genetic Information Nondiscrimination Act of 2008).¹
4. Standards relating to benefits for newborns and mothers.
5. Parity in the application of certain limits to mental health and substance use disorder benefits (including requirements of the Mental Health Parity and Addiction Equity Act of 2008).
6. Required coverage for reconstructive surgery following mastectomies.
7. Coverage of dependent students on a medically necessary leave of absence.

Once the PHS Act amendments affecting the opt-out provision become effective, the sponsor of a self-funded nonfederal governmental plan can no longer choose to exempt that plan from the first 3 requirement categories listed above, but may continue to exempt the plan from requirement categories 4 through 7. The opt-out elections for collectively bargained and non-collectively bargained self-funded nonfederal governmental plans that are affected by these amendments are explained below.²

¹ Plans could not, and still cannot, opt out of any of the genetic information protections, or the requirement to provide certificates of creditable coverage.

² Under section 1251(a)(2) of the Affordable Care Act, certain plans that existed before March 23, 2010, are “grandfathered,” and not subject to all of the requirements added by the new law. However, the opt-out election is not subject to the grandfathering provision. Even if a self-funded, nonfederal governmental plan is a grandfathered plan, it will no longer be able to opt out of the first 3 requirement categories described above.

The table below lists the provisions that plans could opt out of before the Affordable Care Act amendments, and what can be opted out of after those amendments take effect:

Provisions subject to opt-out for plan years beginning before 9/23/10	Provisions subject to opt-out for plan years beginning on or after 9/23/10
1. Limitations on preexisting condition exclusions	No
2. Requirements for special enrollment periods	No
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status	No
4. Standards relating to benefits for newborns and mothers	4. Standards relating to benefits for newborns and mothers
5. Parity in the application of certain limits to mental health benefits (including requirements of the Mental Health Parity and Addiction Equity Act)	5. Parity in the application of certain limits to mental health benefits (including requirements of the Mental Health Parity and Addiction Equity Act)
6. Required coverage for reconstructive surgery following mastectomies	6. Required coverage for reconstructive surgery following mastectomies
7. Coverage of dependent students on a medically necessary leave of absence (Michelle's Law)	7. Coverage of dependent students on a medically necessary leave of absence (Michelle's Law)

II. When and How the PHS Act Amendments Affect Opt-Out Elections

Section 2722(a)(2)(E) of the PHS Act, as amended by the Affordable Care Act, states categorically that the opt-out election for self-funded non-Federal governmental plans is not available with respect to the provisions in subparts I and II of Part A of title XXVII of the PHS Act. The Affordable Care Act amendments created two new subparts – subpart I and subpart II, but did not eliminate subpart 2. Accordingly, the self-funded non-Federal governmental plans can still opt-out of the provisions of subpart 2 (which contains provisions 4-7 above) for plan years beginning on or after September 23, 2010.

The impact on non-collectively bargained plans and collectively bargained plans is as follows:

A) Non-collectively bargained plans

Based on the Affordable Care Act's enactment date of March 23, 2010, for plan years beginning before September 23, 2010, the plan sponsor may elect to exempt the plan from any or all 7 requirement categories listed above. For plan years beginning on or after September 23, 2010, the plan sponsor may elect to exempt the plan only from the requirements in categories 4 through 7.

Example 1. A nonfederal governmental employer has elected to exempt its self-funded group health plan from all 7 requirement categories listed above. The plan year commences September 1 each year. The plan may continue to be exempted from all 7 requirement categories for the plan year that begins on September 1, 2010. However, the plan can no longer be exempted from the first 3 requirement categories beginning with the plan year that commences on September 1, 2011. Accordingly, for that plan year and any subsequent plan years, the plan sponsor may elect

to exempt its plan only from any or all of the requirement categories 4 through 7. The same conclusion applies if the plan is a grandfathered plan.

Example 2. Same facts as in Example 1, except the plan year commences October 1 each year. Beginning with the plan year that commences on October 1, 2010 and any subsequent plan years, the plan sponsor may elect to exempt its plan only from any or all of the requirement categories 4 through 7.

B) Collectively bargained plans

New section 2722(a)(2)(B)(ii) of the PHS Act (previously 2721(b)(2)(B)(ii)) continues to provide that an opt-out election made pursuant to a collective bargaining agreement remains in effect “for the term of such agreement.” Since this provision was not amended by the Affordable Care Act, it still has force and effect. Accordingly, a group health plan that is maintained pursuant to a collective bargaining agreement that was ratified before March 23, 2010, and that has been exempted from any of the first 3 requirement categories listed above, will not have to come into compliance with those provisions until the commencement of the first plan year following the expiration of the last plan year governed by the collective bargaining agreement. (See 45 CFR 146.180(b)(2), excluding clauses (i) and (ii).)

Example. A nonfederal governmental employer has elected to exempt its collectively bargained self-funded plan from all 7 requirement categories listed above. The collective bargaining agreement applies to five plan years, October 1, 2007 through September 30, 2012. For the plan year that commences on October 1, 2012, the plan sponsor is no longer permitted to elect to exempt its plan from the first 3 requirement categories listed above. Accordingly, for that plan year and any subsequent plan years, the plan sponsor may elect to exempt its plan only from any or all of the requirement categories 4 through 7.

III. Transition Period

Because of the timing of this guidance, HHS will not take any enforcement actions with respect to opt-out elections for plan years beginning prior to April 1, 2011 on the following provisions: limitations on preexisting condition exclusion periods, special enrollment periods, and the prohibitions against discriminating against individual participants and beneficiaries based on health status (provisions 1-3, above).

IV. Additional information

Responsibility for administration of Title XXVII of the PHS Act, including provisions that authorize sponsors of self-funded nonfederal governmental plans to elect to exempt those plans from certain requirements of Title XXVII, are in the process of being re-delegated from the Centers for Medicare & Medicaid Services to the Office of Consumer Information and Insurance Oversight (OCIIO), within the Department of Health and Human Services (HHS). OCIIO also is responsible for implementing other health reform provisions of Affordable Care Act.

Where to get more information:

If you have any questions, please contact OCIIO at (301) 492-4100.