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Final regulations address opt-out for non-federal governmental group health plans

The Department of Health and Human Services has issued final regulations which, among other things, modify the HIPAA opt-out process for self-funded, non-federal governmental group health plans. These final rules reflect the changes made to the opt-out provisions by the ACA and require that opt-out elections be submitted electronically. Non-federal governmental plan sponsors, such as state and local governments, should take note of these modifications and be prepared to file their opt-out elections electronically beginning in 2015.

Background

Prior to the enactment of the Affordable Care Act (ACA), sponsors of self-funded non-federal governmental plans could elect to opt out from complying with any of HIPAA's portability requirements (other than the obligation to provide certificates of creditable coverage). They could also elect to exempt themselves from requirements under the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, Michelle's Law, and/or the Mental Health Parity and Addiction Act. This election is commonly referred to as the "HIPAA opt-out." An opt-out election is generally effective for a single specified plan year; however, in the case of collectively bargained plans, the election will apply for the term of the collective bargaining agreement.

ACA eliminated the ability of self-funded, non-federal governmental plans to opt out of HIPAA's portability requirements effective for the first plan year beginning on and after September 30, 2010 (although such plans may still opt out of the other requirements described above). (See our October 7, 2010 *For Your Information*.)

Plans maintained pursuant to a collective bargaining agreement ratified prior to March 23, 2010 that had previously opted out of any of the HIPAA portability requirements could continue to do so for plan years beginning during the term of the agreement.

Thus, except to the extent that the special rule for collectively bargained plans still applies, self-funded, non-federal governmental plans now must comply with HIPAA's limitation on pre-existing condition limitations, requirements for special enrollment periods, and the prohibitions on discriminating against individual participants and beneficiaries based on health status.

In 2011, the Department of Health and Human Services (HHS) issued guidance that reflected the changes made by the ACA and provided updated model election documentation and notices to enrollees. (See our May 6, 2011 *For Your Information.)* This past March, HHS proposed amendments to existing regulations (addressing the treatment of non-federal governmental plans) that conform to the changes made by the ACA and also proposed opt-out elections be filed electronically.

Final regulations

HHS issued final regulations that provide the general terms and conditions necessary for a self-funded, non-federal governmental plan sponsor to make an opt-out election and reflect the amendments made by the ACA. These regulations are consistent with previously issued guidance and the proposed regulations. Of special note, the final regulations require the opt-out election to be made electronically and clarify the opt-out election process for a collectively bargained health plan.

Electronic filing

The final regulations specify that opt-out elections are to be filed electronically and adopt the CMS timing rules for electronic filings. Generally, if the filing date falls on a Saturday, Sunday, or state or federal holiday, CMS will accept filings submitted on the next business day. According to the preamble, CMS will continue accepting elections by mail or by fax until December 31, 2014.

Sponsors of multiple group health plans

The final regulations clarify how sponsors of multiple group health plans must make the opt-out election. A sponsor of multiple group health plans that are not subject to collective bargaining must file a separate election for each group health plan for which an opt-out is desired.

Sponsors of multiple group health plans subject to the same collective bargaining agreement may file one opt-out election, but must list each group health plan subject to the agreement in the opt-out election documentation. The final regulations also adopt the special effective date applied to collective bargaining agreements ratified before March 23, 2010 (the enactment date of the ACA). The regulations maintain that these collectively bargained plans can continue to be exempt from this ACA-narrowed opt-out provision (e.g., not having to comply with HIPAA's PECs, special enrollment, and nondiscrimination requirements) until the first plan year following the expiration of the agreement.

Permitted opt-outs

Self-funded, non-governmental plans can opt-out of any of the following:

- Standards related to benefits for newborns and mothers (NMHPA)
- Coverage for reconstructive surgery following mastectomies (WHCRA)
- Parity in mental health and substance use disorder benefits (MHPAEA)
- Coverage of dependent students on medically necessary leaves of absence (Michelle's law)

They cannot opt out of the Genetic Information Nondiscrimination Act (GINA).

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In closing

This opt-out election is available only for sponsors of self-funded, non-governmental health plans, and it is important for affected plan sponsors to be familiar with the opt-out election rules and procedures. While the procedures largely remain unchanged, the process for filing the election has changed. Plan sponsors must also consider whether or not there are advantages or gains to making this limited opt-out election. HHS posts opt-out election materials, as well as a model notice to enrollees.

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