



# Non-Federal Governmental Plans: An Introduction



*Center for Consumer Information  
and Insurance Oversight*

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# Introduction

CMS is committed to providing Non-Federal Governmental Plan (Non-Fed) sponsors the resources, support, technical assistance, and information they need to ensure their plans are fully compliant with applicable Federal market requirements.

The purpose of this presentation is to orient you to CMS, give an overview of the Federal market requirements applicable to Non-Fed Plans, and introduce you to our resources to guide you in providing compliant plans to your enrollees.

# Roadmap

- ✓ What is a “Non-Federal Governmental Plan?”
- ✓ Who regulates Non-Federal Governmental Plans?
- ✓ Does the Affordable Care Act apply to Non-Federal Governmental Plans?
- ✓ How does CMS ensure Non-Federal Governmental Plans are compliant with the ACA?
- ✓ Resources and Compliance Tools
- ✓ Q&A

# What Is a Non-Federal Governmental Plan?

The Public Health Service (PHS) Act section 2791(d)(8)(C) defines a Non-Federal Governmental Plan (“Non-Fed plan”) as “a governmental plan that is not a federal governmental plan.”

*Examples include:*

- A municipal government group health plan
- A school district group health plan
- A fire department group health plan
- A fund created from the pooling of funds from a number of smaller municipalities

# Non-Fed Plans Are Further Characterized by Their Funding Mechanism:

- In **self-funded** Non-Federal Governmental group health plans, the non-Federal governmental employer assumes the risk for the claims.
- In **fully-insured** Non-Federal Governmental group health plans, the non-Federal governmental employer purchases group health insurance coverage from an issuer that assumes the risk for the claims.
- Non-Federal Governmental employers may also offer a **mixture** of self-funded and fully-insured products.

*Who bears the risk is important to the question of who regulates the plan.*

# Who Regulates Non-Fed Plans?

CMS enforces the provisions of the PHS Act applicable to “group health plans that are Non-Federal Governmental Plans” according to the PHS Act’s Enforcement statute and regulations (PHS Act section 2723 and at 45 C.F.R. § 150.301 *et seq.*)

- For **self-funded Non-Fed plans**, CMS is the primary regulator of the plan. Within CMS, the Non-Federal Governmental Plan Team (Non-Fed Team) within the Center for Consumer Information and Insurance Oversight (CCIIO) oversees Non-Fed compliance.
- For **fully-insured Non-Fed plans**, the Non-Fed Team within CCIIO regulates the group health plan, and the State Department of Insurance regulates the issuer.

# Does the Affordable Care Act Apply to Non-Fed Plans?

**YES:** Generally, Non-Fed plans are subject to the provisions of the Patient Protection and Affordable Care Act (also known as the Affordable Care Act or ACA) applicable to group health plans.

- ❑ The ACA collectively refers to the Patient Protection and Affordable Care Act, passed March 23, 2010, and the Health Care and Education Reconciliation Act enacted March 30, 2010.
- ❑ The ACA reorganized, added to, and amended provisions of title XXVII of the PHS Act (the federal market requirements).
- ❑ Many, but not all, of the ACA's provisions apply to Non-Fed plans. CMS is generally tasked with ensuring that enrollees in Non-Fed plans receive the benefits to which they are entitled under the law.

# Which ACA Provisions Apply?

The answer depends on whether a plan is “grandfathered” or not. A plan qualifies as a grandfathered plan if it meets all the following criteria (set out in ACA section 1251 and 45 C.F.R. § 147.140):

- It was in existence on or before March 23, 2010 when the ACA was passed;
  - At least one individual was enrolled on March 23, 2010;
  - At least one individual (not necessarily the same person) was continuously enrolled since March 23, 2010;
- AND
- *It has maintained grandfather status by meeting the criteria on the next slide (found in 45 C.F.R. § 147.140(g)).*



# Criteria for Maintaining Grandfather Status Under 45 C.F.R. § 147.140(g)

The plan HAS **NOT**:

- Eliminated all or substantially all benefits to diagnose or treat a particular condition;
- Increased any percentage cost-sharing requirement (such as co-insurance) measured from March 23, 2010;
- Increased any fixed-amount cost-sharing requirement other than a copayment (e.g., a deductible or out-of-pocket limit) if the total increase in the cost-sharing requirement measured from March 23, 2010, exceeds the maximum percentage increase;
- Increased a fixed-amount copayment, measured from March 23, 2010, to the date of the increase that exceeds the greater of:
  - \$5, adjusted for medical inflation, or
  - The maximum percentage increase determined by expressing the total increase in copayment as a percentage.
- Decreased the contribution rate paid by employers and employee organizations:
  - If the plan decreases its contribution rate based on cost of coverage by more than 5 percentage points below the contribution rate for the coverage period including March 23, 2010;
  - If the plan decreases its contribution rate based on a formula (for example, hours worked or tons of coal mined) toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percent below the contribution rate for the coverage period including March 23, 2010
- Changed its annual limits, including: the addition of a new annual limit after March 23, 2010, reduction in an annual limit after March 23, 2010, or addition of an overall annual limit to a plan that had an overall lifetime limit as of March 23, 2010;
- Complied with notice and document retention requirements.

# Which Provisions of the ACA Apply to Grandfathered Non-Feds?

Federal Citations	Provision	Overview of Provision
ACA section 1251; 45 C.F.R. § 147.140	Preservation of the Right to Retain Existing Coverage	The grandfather provision preserves the enrollee's right to maintain coverage existing as of March 23, 2010, as long as the plan meets certain criteria to qualify for and retain grandfather status. Only the following subset of title XXVII provisions apply to grandfathered plans.
PHS Act section 2704; 45 C.F.R. § 147.108	Prohibition of Pre-Existing Condition Exclusions	A plan may not impose any preexisting condition exclusions
PHS Act section 2708; 45 C.F.R. § 147.116	Prohibition on Excessive Waiting Periods	Plans shall not apply any waiting period that exceeds 90 days
PHS Act section 2711; 45 C.F.R. § 147.126	Prohibition on Lifetime & Annual Limits	Prohibits lifetime and annual dollar limits on EHBS
PHS Act section 2712; 45 C.F.R. § 147.128	Prohibition on Rescissions	Coverage may only be rescinded in the event of an act or omission that constitutes fraud or intentional misrepresentation of a material fact
PHS Act section 2714; 45 C.F.R. § 147.120	Dependent Coverage up to Age 26	If a plan provides coverage to dependents, it must be made available up to the age of 26 without certain requirements for eligibility (e.g., financial dependency or marital status)
PHS Act section 2715; 45 C.F.R. § 147.200	Summary of Benefits & Coverage (SBC)	Plans must provide this document explaining the benefits using standardized terms and formatting

# Which Provisions of the ACA Apply to Non-Grandfathered Non-Feds?

Federal Citations	Provision	Overview of Provision
PHS Act section 2704; 45 C.F.R. § 147.108	Prohibition of Pre-Existing Condition Exclusions	A plan may not impose any preexisting condition exclusions
PHS Act section 2705; 45 C.F.R. § 146.121	Prohibiting Discrimination Against Participants and Beneficiaries Based on a Health Factor	Prohibits discrimination against enrollees on the basis of enumerated health factors, including genetic information (GINA). Also prohibits discrimination in wellness programs
PHS Act section 2706 (No regulations)	Non-Discrimination in Health Care	Prohibits discrimination with respect to participation in the plan against providers who act within the scope of the providers' license or certification.
PHS Act section 2707(b); 45 C.F.R. § 156.130	Essential Health Benefits (EHBs)—Out of Pocket Maximum Limitations	Limits Maximum Out of Pocket (MOOP) spending on EHBs to a dollar amount as provided in section 1302(c)(1) of the ACA and adjusted each plan/policy year by the premium adjustment percentage.
PHS Act section 2708; 45 C.F.R. § 147.116	Prohibition on Excessive Waiting Periods	Plans shall not apply any waiting period that exceeds 90 days
PHS Act section 2709 (No regulations)	Clinical Trials	Imposes specific requirements for coverage of approved clinical trials for plans that cover "qualified individuals"
PHS Act section 2711; 45 C.F.R. § 147.126	Prohibition on Lifetime & Annual Limits	Prohibits lifetime and annual dollar limits on EHBs

# Which Provisions of the ACA Apply to Non-Grandfathered Non-Feds? (Cont.)

Federal Citations	Provision	Overview of Provision
PHS Act section 2712; 45 C.F.R. § 147.128	Prohibition on Rescissions	Coverage may only be rescinded in the event of an act or omission that constitutes fraud or intentional misrepresentation of a material fact
PHS Act section 2713; 45 C.F.R. § 147.130	Preventive Health Services	Plans must provide certain recommended preventive services to enrollees at \$0 cost-share, including contraceptive coverage
PHS Act section 2714; 45 C.F.R. § 147.120	Dependent Coverage up to Age 26	If a plan provides coverage to dependents, it must be made available up to the age of 26 without certain requirements for eligibility (e.g., financial dependency or marital status)
PHS Act section 2715; 45 C.F.R. § 147.200	Summary of Benefits & Coverage (SBC)	Plans must provide this document explaining the benefits using standardized terms and formatting
PHS Act section 2719; 45 C.F.R. § 147.136	Internal Appeals and External Review	Plans must comply with internal claims appeals and external review process requirements
PHS Act section 2719A; 45 C.F.R. § 146.138(a), (b)	Patient Protections	If the plan requires or allows for designation of a primary care provider (PCP), then the plan shall permit each individual to designate any participating primary care provider who is available to accept such individual. Also describes requirements for coverage of emergency services and direct access to OB/GYN care.

# Which Additional PHS Act Requirements Apply to all Non-Feds?

- ✓ Newborns and Mothers Health Protection Act (NMHPA): *PHS Act section 2725*
- ✓ Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): *PHS Act section 2726*
- ✓ Women's Health and Cancer Rights Act (WHCRA): *PHS Act section 2727*
- ✓ Michelle's Law: *PHS Act section 2728*
- ✓ HIPAA Opt Out Elections: *PHS Act section 2722(a)(2)*

# Overview of Additional PHS Act Provisions Applicable to Non-Fed Plans

Federal Citations	Provision	Overview of Provision
PHS Act section 2725; 45 C.F.R. § 146.130	Newborns and Mothers Health Protection Act	Plans must comply with standards relating to benefits for newborns and mothers.
PHS Act section 2726; 45 C.F.R. § 146.136	Mental Health Parity and Addiction Equity Act of 2008	If the plan provides mental health and substance use disorder benefits, prevents the plan from imposing less favorable limits on such benefits than on medical and surgical benefits. Non-Federal governmental health plans with <u>50 or fewer</u> employees (100 or fewer in some states) are exempt from MHPAEA requirements.
PHS Act section 2727; (No regulations)	Women’s Health and Cancer Rights Act	Requires coverage for reconstructive surgeries following mastectomies. The statute is self-implementing; there are no regulations.
PHS Act section 2728; (No regulations)	Michelle’s Law	Plans must provide coverage of students on a medically necessary leave of absence.
PHS Act section 2722(a)(2); 45 C.F.R. § 146.180	HIPAA Opt Out Elections	Sponsors of <b>self-funded</b> , non-Federal governmental plans are permitted to elect to exempt those plans (“opt out of”) from any of the above four provisions of title XXVII of the PHS Act if they follow certain requirements.

Detailed compliance checklists summarizing federal laws applicable to non-grandfathered and grandfathered plans may be found at:  
<https://www.cms.gov/ccio/Resources/Forms-Reports-and-Other-Resources/index.html#Self-Funded%20Non-Federal%20Governmental%20Plans>

# HIPAA Opt Out Elections

- Self-funded Non-Fed plans may opt out of:
  - x Standards relating to benefits for newborns and mothers (NMHPA)
  - x Parity in the application of certain limits to mental health and substance use disorder benefits (MHPAEA)
  - x Required coverage for reconstructive surgery following mastectomies (WHCRA)
  - x Coverage of dependent students on a medically necessary leave of absence (Michelle's Law)
- Plan sponsors must submit opt-outs electronically via the Health Insurance Oversight System (HIOS) Non-Federal Governmental Plan module: paper opt-outs are no longer accepted.
- Requirements for providing notice to enrollees remain the same.
- See 45 C.F.R. § 146.180, the implementing regulations.
- See also our [sub-regulatory guidance](#) for electronic submissions and our [overview](#) of the process.

# How Does CMS Ensure Non-Feds Are Compliant with the PHS Act?

- We provide assistance to individuals who reach out to us with questions or concerns, including plan sponsors and administrators, consumers, and providers. This includes:
  - Technical assistance
  - Resources and information on our website
  - Connecting people with subject matter experts (SMEs) at CMS who can answer a question that requires particular specialized knowledge
- We initiate an enforcement action if we receive information indicating a plan may be non-compliant:
  - If we receive a complaint or inquiry from an enrollee or representative of an enrollee that a plan may be out of compliance with the PHS Act, we will review plan documents and request additional information from the plan as needed to determine whether there are any compliance issues.
  - The basis of and procedures for enforcement actions may be found in regulations at 45 C.F.R. 150.301 *et seq.*



# How Does CMS Ensure Non-Feds Are Compliant with the PHS Act (Cont.)?

If, during a review, we identify areas of non-compliance, we have several tools for enforcement:

- **Seek Corrective Action:** work with plan sponsors to implement a **corrective action plan (CAP) to correct areas of non-compliance and where necessary, compensate enrollees** who did not receive the benefits or processes to which they were entitled (45 C.F.R. § 150.307);
- **Call an Exam:** CMS has the authority to initiate a market conduct examination to investigate a plan sponsor's compliance with applicable federal market requirements (45 C.F.R. § 150.313); and
- **Impose Civil Money Penalties:** CMS is empowered to impose **civil money penalties (CMPs) of up to \$155 per day (adjusted annually for inflation), per responsible entity, per affected individual for each violation** (see 45 C.F.R. § 150.301 *et seq.*).

# What Does a PHS Act Corrective Action Plan Generally Entail?

- The Non-Fed Team reviews plan documents to determine if a complaint may be valid.
- If it appears there may be a violation of Federal requirements, a Non-Fed team member will reach out to plan sponsor to schedule a fact-finding call.
- The Non-Fed team member will alert plan sponsor to the complaint and any information identified supporting the complaint. Plan sponsors are welcome to offer any facts that might mitigate the compliance issue. Due to HIPAA privacy laws, Non-Fed team members will disclose the complainant's personal information only if they are authorized to do so by the complainant.
- If the facts of the situation indicate the plan is not compliant, CMS will do a full form review of all necessary plan documents and generate a notice identifying all compliance issues in addition to the issue that was the subject of the complaint.
- The Non-Fed team member will send the notice to plan sponsors identifying all areas of non-compliance and requesting the plan draft a corrective action plan.

(continued on next slide)

# What Does a General Corrective Action Plan Entail (Cont.)?

- The requested corrective action plan (CAP) should describe how the plan will fix the identified compliance errors, how the plan will identify individuals who have been affected by the compliance errors, and how the plan will make those individuals whole. The proposal should also include dates by which each item will be completed.
- CMS will review the CAP. CMS will collaborate with plan sponsors to assist with drafting the CAP letter (as may be necessary).
- Once the CAP is approved, CMS will work with the plan sponsors as they make changes to plan documents and processes to bring them into compliance. As the CAP is implemented, CMS will generate a notice describing compliance issues (if any) and how the plan can fix those issues.
- If necessary, CMS will connect plan sponsors with SMEs at CMS to provide additional technical assistance.
- CMS will also work with the plan as it drafts notices to enrollees and develops a process for retroactive compensation if necessary.
- Once plan documents and processes are fully compliant, and CMS has approved notices for enrollees and a method for compensation (if necessary, for both), CMS ends its engagement pending confirmation of any final steps by the plan (usually compensating enrollees).

# Example #1 of a Successful CAP

- **The Plan:** A self-funded Non-Fed plan in the Northwest with fewer than 50 enrollees.
- **The Complaint:** The plan self-reported that it lost grandfather status but did not come into compliance with all PHS Act requirements for non-grandfathered plans. This included requiring cost-sharing for preventive services and a non-compliant appeals process. It also imposed annual dollar limits on EHBs.
- **The CAP:** We worked with sponsor of the group health plan and its third party administrator (TPA) to update benefits and bring them into compliance with the ACA. Corrective actions undertaken included:
  - Updating all plan documents
  - Drafting a notice for enrollees back to 2011 to notify them they could resubmit claims that had been incorrectly denied or restricted
  - Creating a claim filing procedure for retroactive reimbursement
  - Reprocessing claims and reimbursing affected enrollees in total almost \$10,500 (estimated 19 members were impacted)

# Example #2 of a Successful CAP

- **The Plan:** A self-funded Non-Fed plan in the Southeast with approximately 300 enrollees.
- **The Complaint:** The plan imposed a prior-authorization requirement on outpatient mental health benefits after the 9<sup>th</sup> visit; a similar requirement was not imposed on medical/surgical benefits, implicating a mental health parity (MHPAEA) violation.
- **The CAP:** The plan provided data demonstrating that while it had imposed the prior authorization requirement 15 times in the past two years, no claims had been denied as a result.
  - The plan removed the prior authorization requirement going forward.
  - No remuneration of enrollees was required since no claims were denied.

# Resources and Compliance Tools

- ❖ Non-Fed Team website on CMS.gov: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/nonfedgovplans.html>
- ❖ PHS Act Requirements applicable to Non-Grandfathered Non-Fed Plans (compliance checklist): <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Market-Reforms-ACA-and-HIPAA-non-grandfathered-plan-provisions.pdf>
- ❖ PHS Act Requirements applicable to Grandfathered Non-Fed Plans (compliance checklist): <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Market-Reforms-ACA-and-HIPAA-Grandfathered-Plan-Provisions.pdf>
- ❖ User Manual— Instructions for HIPAA Opt Out Election module in HIOS (August 2018): <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-NonFed-UserManual.pdf>
- ❖ List of active HIPAA Opt-Out elections: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIPAAOptOuts06022017.pdf>
- ❖ HIPAA Opt-Out Overview: [https://www.cms.gov/CCIIO/Resources/Files/hipaa\\_exemption\\_election\\_instructions\\_04072011.html](https://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html)
- ❖ HIPAA Opt-Out Sub-regulatory Guidance: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/hipaa-exemption-guidance-7212014.pdf>
- ❖ Mailbox for questions, complaints, and concerns: [NonFed@cms.hhs.gov](mailto:NonFed@cms.hhs.gov)

# Topics for Upcoming Training Sessions

- ✓ The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- ✓ Internal Appeals and External Review Processes
- ✓ The Summary of Benefits and Coverage (SBC) Document– Guidance on Requirements and Avoiding Common Errors
- ✓ Market Conduct Examinations

# Q&A





# How to Contact us Directly

Non-Federal Governmental Plan Team Email Resource:  
[NonFed@cms.hhs.gov](mailto:NonFed@cms.hhs.gov)

