# A "Non-Grandfathered Plan" and its Implications under PPACA

If your plan is "Grandfathered", you have time (approx. 2 yrs.) to make mandatory changes per the new Patient Protection and Affordable Care Act (PPACA). However, if your plan has been deemed "Non-Grandfathered", you can be in the midst of planning changes to your health plan for your Plan Year that begins after September 23, 2010. In a letter sent from Blue Cross of NEPA directly to its contracted clients, the insurance provider advises its clients to consult with their legal counsel and/or benefits advisors in order to correctly classify its group health plan.

Depending on how the regulators craft final provisions, below are some of the mandated actions involved with a "Non-Grandfathered Plan".

**Coverage of Preventive Health Services** – A group health plan and a health insurance issuer offering group or individual health insurance coverage must, at a minimum provide coverage for and must not impose any cost-sharing requirements for the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
- With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, preventive care and screening provided by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

*Effective Date* for a "Non-Grandfathered" plan for Preventive Services is the anniversary of the Plan that renews on or after September 23, 2010.

**Nondiscrimination Rules for Fully-Insured Plans** – PPACA applies IRC nondiscrimination rules under section 105(h) to fully-insured plans. This is a good change for the self-funded industry and has been long overdue. Regrettably, not all fully-insured plans will need to comply, as plans that are "Grandfathered" plans will not be subject to the new rule. *Effective Date* – Plan years beginning on or after September 23, 2010.

**Reporting on the Quality of Care** – A group health plan and a health insurance issuer offering group or individual health insurance coverage must submit annually to the Secretary of HHS and to enrollees a report on whether the benefits under the plan and the provider reimbursement structures under the plan satisfy the following elements:

- Improve health outcomes through the implementation of activities, such as effective case management, care coordination, chronic disease management and medication and care compliance initiatives, including the use of the medical homes model;
- Implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by a health care professional.
- Implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage.
- Implement wellness and health promotion activities. A wellness and health promotion activity may not require the disclosure or collection of any information relating to the presence or storage of a lawfully possessed firearm or ammunition in the residence or on the property of an individual.

*Effective Date* for Reporting on Quality Care - Plan years beginning on or after September 23, 2010.

**More Reporting** – Plans must provide to the Secretary, the public and the State insurance commissioner the following information: claim payment policies and practices, periodic financial disclosures, data on enrollment, disenrollment, the number of denied claims, rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, information on participant rights, and other information as determined by the Secretary. *Effective Date* - Plan years beginning on or after September 23, 2010.

**Appeals Process** – PPACA imposes new requirements on group health plans and individual policies for an internal claims appeal process and an external review process. *Effective Date* - Plan years beginning on or after September 23, 2010.

**Clinical Trials** – If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to an individual who is eligible to participate in an "approved clinical trial", the plan may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with trial participation. The term "approved clinical trial" means a phase I, phase II, phase III, phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease and is either federally funded or is conducted under an investigational new drug application reviewed by the Food and Drug Administration. *Effective Date* – Plan years beginning on or after January 1, 2014.

**Emergency Services** – If a group health plan or a health insurance issuer covers benefits for emergency service in a hospital, the plan must cover these services without the need for any prior authorization, regardless of whether the health care provider is a participating provider, and at the same cost-sharing rules that apply to in-network services. *Effective Date* – Plan years beginning on or after September 23, 2010.