

Fact Sheet: The Affordable Care Act's New Patient's Bill of Rights

June 22, 2010

A major goal of the Affordable Care Act – the health insurance reform legislation President Obama signed into law on March 23 – is to put American consumers back in charge of their health coverage and care. Insurance companies often leave patients without coverage when they need it the most, causing them to put off needed care, compromising their health and driving up the cost of care when they get it. Too often, insurance companies put insurance company bureaucrats between you and your doctor. The Affordable Care Act cracks down on some of the most egregious practices of the insurance industry while providing the stability and the flexibility that families and businesses need to make the choices that work best for them.

Today, the Departments of Health and Human Services (HHS), Labor, and Treasury issued regulations to implement a new Patient's Bill of Rights under the Affordable Care Act – which will help children (and eventually all Americans) with pre-existing conditions gain coverage and keep it, protect all Americans' choice of doctors and end lifetime limits on the care consumers may receive. These new protections apply to nearly all health insurance plans.¹

How These New Rules Will Help You

- **Stop insurance companies from limiting the care you need.** For most plans starting on or after September 23, these rules stop insurance companies from imposing pre-existing condition exclusions on your children; prohibit insurers from rescinding or taking away your coverage based on an unintentional mistake on an application; ban insurers from setting lifetime limits on your coverage; and restrict their use of annual limits on coverage.
- **Remove insurance company barriers between you and your doctor.** For plans starting on or after September 23, these rules ensure that you can choose the primary care doctor or pediatrician you want from your plan's provider network, and that you can see an OB-GYN without needing a referral. Insurance companies will not be able to require you to get prior approval before seeking emergency care at a hospital outside your plan's network. These protections apply to health plans that are not grandfathered.

Builds On Other Affordable Care Act Policies

These new protections complement other parts of the Affordable Care Act including:

- **Reviewing Insurers' Premium Increases.** HHS recently offered States \$51 million in grant funding to strengthen review of insurance premiums. Annual premium hikes can put insurance out of reach of many working families and small employers. These grants are a down-payment that enable States to act now on reviewing, disclosing, and preventing unreasonable rate hikes. Already, a number of States, including California, New York, Maine, Pennsylvania and others are moving forward to improve their oversight and require more transparency of insurance companies' requests to raise rates.
- **Getting the Most from Your Premium Dollars.** Beginning in January, the Affordable Care Act requires individual and small group insurers to spend at least 80% and large group insurers to spend at least 85% of your premium dollars on direct medical care and efforts to improve the quality of care you receive – and rebate you the difference if they fall short. This will limit spending on overhead and salaries and bonuses paid to insurance company executives and provide new transparency into how your dollars are spent. Insurers will be required to publicly disclose their rates on a new national consumer website – HealthCare.gov.
- **Keeping Young Adults Covered.** Starting September 23, children under 26 will be allowed to stay on their parent's family policy, or be added to it. Group health plans that are grandfathered plans can limit this option to adult children that don't have another offer of employment-based coverage. Many insurance companies and employers have agreed to implement this program early, to avoid a gap in coverage for new college graduates and other young adults.
- **Providing Affordable Coverage to Americans without Insurance due to Pre-existing Conditions:** Starting July 1, Americans locked out of the insurance market because of a pre-existing condition can begin enrolling in the Pre-existing Condition Insurance Plan (PCIP). This program offers insurance without medical underwriting to people who have been unable to get it because of a preexisting condition. It ends in 2014, when the ban on insurers refusing to cover adults with pre-existing conditions goes into effect and individuals will have affordable choices through Exchanges – the same choices as members of Congress.

New Consumer Protections Starting As Early As This Fall

The new Patient's Bill of Rights regulations detail a set of protections that apply to health coverage starting on or after September 23, 2010, six months after the enactment of the Affordable Care Act. They are:

- **No Pre-Existing Condition Exclusions for Children Under Age 19.** Each year, thousands of children who were either born with or develop a costly medical condition are denied coverage by insurers. Research has shown that, compared to those with insurance, children who are uninsured are less likely to get critical preventive care including immunizations and well-baby checkups. That leaves them twice as likely to miss school and at much greater risk of hospitalization for avoidable conditions.
 - A Texas insurance company denied coverage for a baby born with a heart defect that required surgery. Friends and neighbors rallied around the family to raise the thousands of dollars needed to pay for the surgery and put pressure on the insurer to pay for the needed treatment. A week later the insurer backed off and covered the baby.²

The new regulations will prohibit insurance plans from denying coverage to children based on a pre-existing condition. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for a child with cancer because the child had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the family for the child because of the child's pre-existing medical condition). These protections will apply to all types of insurance except for individual policies that are "grandfathered," and will be extended to Americans of all ages starting in 2014.

- **No Arbitrary Rescissions of Insurance Coverage.** Right now, insurance companies are able to retroactively cancel your policy when you become sick, if you or your employer made an unintentional mistake on your paperwork.
 - In Los Angeles, a woman undergoing chemotherapy had her coverage cancelled by an insurer who insisted her cancer existed before she bought coverage. She faced more than \$129,000 in medical bills and was forced to stop chemotherapy for several months after her insurance was rescinded.³

Under the regulations, insurers and plans will be prohibited from rescinding coverage – for individuals or groups of people – except in cases involving fraud or an intentional misrepresentation of material facts. Insurers and plans seeking to rescind coverage must provide at least 30 days advance notice to give

people time to appeal. There are no exceptions to this policy.

- **No Lifetime Limits on Coverage.** Millions of Americans who suffer from costly medical conditions are in danger of having their health insurance coverage vanish when the costs of their treatment hit lifetime limits set by their insurers and plans. These limits can cause the loss of coverage at the very moment when patients need it most. Over 100 million Americans have health coverage that imposes such lifetime limits.
 - A teenager was diagnosed with an aggressive form of leukemia requiring chemotherapy and a stay in the intensive care unit. He reached his family's plan's \$1 million lifetime limit in less than a year. His parents had to turn to the public for help when the hospital informed them it needed either \$600,000 in certified insurance or a \$500,000 deposit to perform the bone marrow transplant he needed.⁴

The regulation released today prohibits the use of lifetime limits in all health plans and insurance policies issued or renewed on or after September 23, 2010.

- **Restricted Annual Dollar Limits on Coverage.** Even more aggressive than lifetime limits are annual dollar limits on what an insurance company will pay for health care. Annual dollar limits are less common than lifetime limits, involving 8 percent of large employer plans, 14 percent of small employer plans, and 19 percent of individual market plans. But for people with medical costs that hit these limits, the consequences can be devastating.
 - One study found that 10 percent of cancer patients reached a limit of what insurance would pay for treatment – and a quarter of families of cancer patients used up all or most of their savings on treatment.⁵

The rules will phase out the use of annual dollar limits over the next three years until 2014 when the Affordable Care Act bans them for most plans. Plans issued or renewed beginning September 23, 2010, will be allowed to set annual limits no lower than \$750,000. This minimum limit will be raised to \$1.25 million beginning September 23, 2011, and to \$2 million beginning on September 23, 2012. These limits apply to all employer plans and all new individual market plans. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.

Employers and insurers that want to delay complying with these rules will have to win permission from the Federal government by demonstrating that their current annual limits are necessary to prevent a significant loss of coverage or increase in premiums. Limited benefit insurance plans – which are often used by employers to provide benefits to part-time workers – are examples of insurers that might seek this kind of delay. These restricted annual dollar limits apply to all insurance plans except for individual market plans that are grandfathered.

- **Protecting Your Choice of Doctors.** Being able to choose and keep your doctor is a key principle of the Affordable Care Act, and one that is highly valued by Americans. People who have a regular primary care provider are more than twice as likely to receive recommended preventive care; are less likely to be hospitalized; are more satisfied with the health care system, and have lower costs. Yet, insurance companies don't always make it easy to see the provider you choose. One survey found that three-fourths of OB-GYNs reported that patients needed to return to their primary care physicians for permission to get follow-up care.

The new rules make clear that health plan members are free to designate any available participating primary care provider as their provider. The rules allow parents to choose any available participating pediatrician to be their children's primary care provider. And, they prohibit insurers and employer plans from requiring a referral for obstetrical or gynecological (OB-GYN) care. All of these provisions will improve people's access to needed preventive and routine care, which has been shown to improve the health of those treated and avoid unnecessary health care costs. These policies apply to all individual market and group health insurance plans except those that are grandfathered.

- **Removing Insurance Company Barriers to Emergency Department Services.** Some insurers will only pay for health care provided by a limited number or network of providers – including emergency health care. Others require prior approval before receiving emergency care at hospitals outside of their networks. This could mean financial hardship if you get sick or injured when you are away from home or not near a network hospital.

The new rules make emergency services more accessible to consumers. Health plans and insurers will not be able to charge higher cost-sharing (copayments or coinsurance) for emergency services that are obtained out of a plan's network. The rules also set requirements on how health plans should reimburse out-of-network providers. This policy applies to all individual market and group health plans except those that are grandfathered.

Benefits of Consumer Protections

The new rules will bring immediate relief to many Americans and provide peace of mind to millions more who are only one illness or accident away from medical and financial chaos.

The new ban on lifetime limits would affect group premiums by 0.5% or less and individual market premiums by 0.75% or less. The restricted annual limit policy would affect group and individual markets by roughly 0.1% or less (grandfathered individual market plans are exempt). And, the prohibition of preexisting conditions exclusions for children would affect group health plans by just a few hundredths of a percent. For new plans in the individual market, this impact would be roughly 0.5% in many states. In states with community rating, (roughly twenty states), the impact could be up to 1.0%. These costs are before taking into account benefits.

In addition, the rules will achieve greater cost savings by:

- **Reducing the "hidden tax" on insured Americans:** By making sure insurance covers people who are most at risk, there will be less uncompensated care and the amount of cost shifting among those who have coverage today will be reduced by up to \$1 billion in 2013.
- **Improving Americans' health:** By making sure that high-risk individuals have insurance, the rules will reduce premature deaths.⁶ Insured children are less likely to experience avoidable hospital stays than uninsured children⁷ and, when hospitalized, insured children are at less risk of dying.⁸
- **Protecting Americans' savings:** High medical costs contribute to some degree to about half of the more than 500,000 personal bankruptcies in the U.S. in 2007.⁹ These costs borne by individuals might be assumed by insurance companies once rescissions are banned, annual limits are restricted, lifetime limits are prohibited, and most children have access to health insurance without pre-existing condition exclusions.
- **Enhancing workers' productivity:** Making sure that kids with health problems have coverage will reduce the number of days parents have to take off from work to care for family members. Parents will also be freed from "job lock," which occurs when people are afraid to take a better job because they might lose coverage for themselves or their families.¹⁰

¹ Limits on pre-existing conditions and annual limits will not apply to existing "grandfathered" plans offering individual coverage. For details, see the Fact Sheet and interim final regulations released on the topic on June 14.

² Jarvis, Jan, "Under Fire, Blue Cross Blue Shield of Texas Offers to Cover Medical Expenses for Crowley Baby," *Houston Star-Telegram*, (March 31, 2010).

³ Girion, Lisa "Health Net Ordered to Pay \$9 million after Canceling Cancer Patient's Policy," *Los Angeles Times* (2008), available at: <http://www.latimes.com/business/la-fi-insure23feb23,1,5039339.story>.

⁴ Murphy, Tom. "Patients struggle with lifetime health insurance benefit caps," *Los Angeles Times*, July 2008.

⁵ See "National Survey of Households Affected by Cancer." (2006) accessed at <http://www.kff.org/kaiserpolls/upload/7591.pdf>

⁶ See, for example, Almond, Doyle, Kowalski, Williams (2010), Doyle (2005), and Currie and Gruber (1996).

⁷ Keane, Christopher et al. "The Impact of Children's Health Insurance Program by Age." *Pediatrics* 104:5 (1999), available at: <http://pediatrics.aappublications.org/cgi/reprint/104/5/1051>.

⁸ Bernstein, Jill et al. "How Does Insurance Coverage Improve Health Outcomes?" *Mathematica Policy Research* (2010), available:

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http://www.mathematica-mpr.com/publications/PDFs/Health/Reformhealthcare_IB1.pdf

⁹ David Himmelstein et al, 2009.

¹⁰ Gruber, J. and B. Madrian. "Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature." (2001).

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