



Patient's Bill of Rights Under the Affordable Care Act: An Overview of the Rules on Consumer Protections

With the passage of the Patient Protection and Affordable Care Act (ACA), Congress set new standards for patient protections in health insurance which go into effect on September 23, 2010. The rules to implement these new standards are now out for public comment, and it's important that consumers provide input on the critical new protections affecting patients and their families. This overview provides a summary of the main provisions in the rules, as well as discussion about some ways to improve consumer protections.

The ACA's New Patient's Bill of Rights:

- Helps children with pre-existing conditions gain health insurance coverage
- Stops plans from retroactively cancelling policies when patients become sick
- Bans lifetime caps on coverage and restricts plans' ability to impose annual limits on benefits
- Protects consumers' choice of primary care doctor, and allows women to go directly to their OB/GYN without a referral
- Helps protect people from incurring medical debt in a time of emergency by requiring insurers to meet new cost-sharing requirements for emergency services

Requires plans to cover children with pre-existing conditions, so thousands of children will gain insurance coverage that they aren't able to get in today's marketplace.

The new rules:

- Require health plans to cover all children that apply — no matter what their health status
- Prohibit health plans from limiting benefits for kids who have pre-existing conditions (i.e. refusing to pay for chemotherapy because the child had cancer before getting insurance)
- Apply to all plans except individual policies that have been "grandfathered" — some families may need to change to a new plan to get their child covered

Discussion: The regulations are a positive step in guaranteeing that insurers offer coverage to children with pre-existing conditions, however it will not be effective if health insurance policies are prohibitively expensive for families. HHS should work with states to monitor the health insurance marketplace to ensure families are able to afford coverage for children with pre-existing conditions. Also, families must be able to enroll their children in health coverage when they need it and not rely solely on open enrollment periods. We recommend HHS allow families to enroll in coverage at any time during the first year of implementation of this rule, and create a waiver process for open enrollment periods after that.

Health plans will no longer be able to drop people from coverage when they become sick because they made an unintentional mistake on their application.

The new rules:

- Prohibit individual and group health plans from rescinding coverage unless they can show that the enrollee committed fraud or intentionally misrepresented important facts in their application.
- Require plans that rescind policies to give people at least 30 days advance notice so they have time to appeal.
- Provide for no exceptions — all plans, including grandfathered ones, need to comply with this policy.

Discussion: To ensure enrollees do not lose coverage based on an error, a third party review of the issue should be conducted before a carrier can rescind coverage to help protect consumers from losing coverage for a reason other than fraud.

The elimination of lifetime caps on coverage, and new rules restricting annual limits, will give thousands of families the peace of mind that coverage will be there for them in the event of a catastrophic illness or serious chronic condition.

The new rules:

- Stop insurance companies from setting any lifetime limits on “essential benefits”.¹ There are no exceptions — all plans, including grandfathered plans, must comply.
- Phases in a ban on annual coverage limits. In 2011 plans can have annual limits up to \$750,000, phasing up to \$2 million in 2013. By 2014, plans are prohibited from imposing any annual limits on essential benefits. Only grandfathered individual market plans are exempt from this new rule.
- Require most plans (except for grandfathered and self-insured plans) to cover a standard set of essential benefits. Because HHS will define those in a future regulation, the new rules governing lifetime and annual limits rely on plans’ “good faith” determinations of what will be covered in the essential benefits package.

Discussion: The current rules imply that prohibitions of lifetime and annual limits will only be based on dollar amounts. Insurers will likely try to circumvent this rule by maintaining annual limits on the number of visits or days of hospital care, which can cause families to not seek care when they need it or delay necessary services. The final rules should clearly prohibit annual or lifetime limits on “essential health benefits” by dollar amount and number of services that are easily translated into a dollar amount, allowed by enrollees.

¹ The ACA requires that the essential benefits package include, at a minimum, the following categories of benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care. HHS is charged with defining the specific items and services that will be covered within each category.

Ensuring that people can choose their own doctor and get emergency services without facing bureaucratic hurdles will help patients access care when and where they need it.

The new rules:

- Prohibit plans from imposing higher cost-sharing when a patient has to seek emergency care outside the plan's network
- Allow health plan members to designate any participating primary care provider as their provider, and allow parents to choose any available participating pediatrician.
- Prohibit insurance companies from requiring a referral for OB/GYN care.
- Apply to all plans except those that are grandfathered.

Discussion: While the rules limit cost-sharing by insurance carriers, they still expose families to undue risk of medical debt by allowing out-of-network providers to bill them for care not paid for by their health plan ("balance-billing"). The final rules should reflect fair standards for provider billing to ensure that consumers—even those with insurance coverage—pay only what they can afford and are not subject to unfair or overly aggressive pricing and billing practices. States with stronger consumer protections against balanced billing than the federal law for those who go out-of-network should not have its law pre-empted. Notification about how a consumer's plan paid an out-of-network provider should also be required so individuals can dispute any remaining charges. The rules should also prohibit balance-billing for all emergency services in network facilities.

While the rules on the Patient's Bill of Rights are strong and provide significant improvements for consumers in the insurance market, there are a number of areas where consumer protections can be improved. Health insurance companies and other interested parties are organized and pushing to relax some of the new requirements. By commenting on these regulations, consumer and patient organizations can ensure that the Patient's Bill of Rights rules fully meet the needs of individuals and families.