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# Patients' Bill of Rights

The Affordable Care Act (ACA) contains mandates for health plans regarding pre-existing condition exclusions, lifetime or annual limits, rescissions and other patient protections. These mandates are commonly referred to as ACA's Patients' Bill of Rights. Most of these requirements became effective for plan years beginning on or after **Sept. 23, 2010**, although some mandates will become effective in the future.

On June 28, 2010, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) issued **interim final rules** regarding these health plan coverage mandates.

**PRE-EXISTING CONDITION EXCLUSIONS**

ACA prohibits group health plans and group health insurance issuers, including those with grandfathered status, from imposing pre-existing condition exclusions on enrollees. This prohibition also applies to individual health insurance coverage, although it does not apply to grandfathered individual policies.

This prohibition generally is effective with respect to plan years beginning on or after **Jan. 1, 2014**. However, for enrollees who are under **age 19**, this prohibition took effect for plan years beginning on or after **Sept. 23, 2010**.

A "pre-existing condition exclusion" is a limitation or exclusion of benefits related to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Based on this definition, ACA prohibits both exclusions of coverage of specific benefits and complete exclusions from a plan or coverage based on a pre-existing condition.

Until these rules take effect for everyone, the rules regarding pre-existing condition exclusions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will continue to apply. The interim final rules do not change the HIPAA rule that an exclusion of benefits for a certain condition under a plan is not a pre-existing condition exclusion if the exclusion is not based on the date the condition arose.

**LIFETIME OR ANNUAL LIMITS**

ACA generally prohibits group health plans and group and individual health insurance issuers from imposing lifetime or annual limits on the dollar value of essential health benefits (EHBs), effective for plan years beginning on or after **Sept. 23, 2010**. Although annual limits are generally prohibited, "restricted annual limits" were permitted for EHBs for plan years beginning before **Jan. 1, 2014**.

***Restricted Annual Limits***

The interim final rules establish a three-year phased approach for restricted annual limits. Annual limits may not be less than the following amounts for plan years beginning before Jan. 1, 2014:

- **$750,000** for plan years beginning on or after Sept. 23, 2010, but before Sept. 23, 2011;
- **$1.25 million** for plan years beginning on or after Sept. 23, 2011, but before Sept. 23, 2012; and
- **$2 million** for plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014.

These are minimums for plan years; plans may use higher annual limits or impose no limits. The limits apply on an individual-by-individual basis, so that any annual limit on benefits applied to families cannot cause an individual to be denied the minimum annual benefit for the plan year.

In addition, the interim final rules allowed HHS to develop a temporary waiver program for plans that could demonstrate that complying with the restrictions would result in:

- A significant decrease in access to benefits; or
- A significant increase in premiums.

HHS granted a number of waivers and then closed the waiver program to new applications effective **Sept. 22, 2011**. Waivers and/or extensions received before that date could be effective until plan years beginning on or after Jan. 1, 2014, when all annual limits for EHBs are prohibited.

Waiver recipients must provide an **annual notice** informing each participant that the plan or policy does not meet the restricted annual limits for EHBs because it has received a waiver of that requirement, as well as annual updates to HHS regarding plan information and benefits. A model notice is available on the HHS website.

***Covered Plans***

The prohibition on lifetime and annual limits applies to both non-grandfathered and grandfathered group health plans. However, it does not apply to grandfathered individual policies. The restrictions on annual limits do not apply to account-based plans like health flexible spending arrangements (health FSAs), medical savings accounts (MSAs) and health savings accounts (HSAs).

***Essential Health Benefits (EHBs)***

ACA specifically provides that plans may impose annual or lifetime per-individual limits on specific covered benefits that are not EHBs. Each state will set its own definition of EHBs, but it must include at least the following general categories of items and services:

- 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, including chronic disease management; and
- Pediatric services, including oral and vision care.

Until a state benchmark is set, plans can use a good faith effort to comply with a reasonable interpretation of EHBs, and must apply it consistently.

The interim final rules clarify that a plan can still exclude all benefits for a condition. This type of exclusion will not be considered an annual or lifetime limit as long as no benefits are provided for the condition.



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***Enrollment Opportunities***

The interim final rules included a transition rule for re-enrolling individuals who previously met a plan's lifetime limit. Eligible individuals who lost plan coverage as a result of a lifetime limit must have received an enrollment notice and an opportunity to re-enroll in the plan. The notice and enrollment opportunity must have been provided no later than the first day of the first plan year beginning on or after **Sept. 23, 2010**. Anyone who was eligible for the enrollment opportunity must have been treated as a special enrollee eligible to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

**RESCISSIONS**

ACA places limits on the ability of a group health plan or group and individual health insurance issuer to rescind health coverage. Effective for plan years beginning on or after **Sept. 23, 2010**, coverage may be rescinded only in the case of fraud or intentional misrepresentation of a material fact. Fraud may include an omission of relevant facts. This standard applies to all rescissions, whether in the group or individual market, and whether coverage is insured or self-funded. If a state law is more protective of individuals than the federal law, the state law will continue to apply.

A rescission is a cancellation or discontinuation of coverage that has a retroactive effect. For example, a cancellation that treats a policy as void from the time of enrollment is a rescission. Prospective and retroactive cancellations due to a failure to pay required premiums would not be considered rescissions.

The prohibition on rescissions applies whether the rescission is effective for an individual, an individual within a family or an entire group of individuals. The rules on rescissions also apply to representations made by the individual or by a person seeking coverage on behalf of the individual, such as the plan sponsor.

In addition to setting federal requirements for rescissions, ACA adds a new advance notice requirement when coverage is rescinded where still permissible. Group health plans and group health insurance issuers must provide at least **30 calendar days** advance notice to an individual before coverage may be rescinded. This 30-day period will provide individuals and plan sponsors with an opportunity to contest the rescission or look for alternative coverage.

The rules regarding rescission and advance notice apply to non-grandfathered and grandfathered health plans.

**PATIENT PROTECTIONS**

ACA imposes three new requirements on group health plans and group or individual health insurance coverage that are referred to as "patient protections." These patient protections relate to the choice of a health care professional and requirements relating to benefits for emergency services, and became effective for plan years beginning on or after **Sept. 23, 2010**. They do not apply to grandfathered plans. The rules regarding choice of health care professional apply only to plans that have a network of providers.

***Choice of Primary Care Provider***

If a group health plan or group or individual health insurer requires a participant to designate a primary care provider, the participant must be able to choose any participating primary care provider who is able to accept the participant as a patient. This rule includes the designation of a pediatrician as the primary care provider for a child. The plan must provide a notice informing each participant of the plan's terms regarding primary care provider designation. The notice should be included in the plan's summary plan description. The interim final rules include model language for this notice.

***OB-GYN Care***

Plans that provide coverage for obstetrical and/or gynecological care (ob-gyn care) and require the patient to designate an in-network primary care provider may not require preauthorization or referral for a female participant seeking such care. The plan must inform each participant of these rules and should include the notice in its summary



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plan description. Model language has been provided for plans to use. A plan may still require the ob-gyn provider to follow any policies or procedures regarding referrals, prior authorization for treatments and the provision of services.

***Emergency Services***

ACA places additional requirements on plans and health insurance issuers that provide hospital emergency room benefits. Plans and issuers must provide those benefits without requiring prior authorization, and without regard to whether the provider is an in-network provider.

Also, the plan or issuer may not impose requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network emergency services. Cost-sharing requirements, such as copayments or coinsurance rates imposed for out-of-network emergency services, cannot exceed the cost-sharing requirements for in-network emergency services.

Despite this rule, out-of-network providers may balance bill patients, as long as the plan or issuer has paid a reasonable amount for the services. The interim final rules provide guidance on determining whether the amount paid is reasonable. Also, other cost-sharing requirements, such as deductibles or out-of-pocket maximums, may be imposed on out-of-network emergency services if the cost-sharing requirement generally applies to out-of-network benefits.



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