

Making Progress and Moving Healthcare in America Forward, Not Backward

On March 30, 2010, President Obama signed the Affordable Care Act into law, putting everyday Americans—not the insurance companies—back in charge of their health care decisions. The Patient’s Bill of Rights in the Affordable Care Act will stop the worst insurance company abuses. I am pleased to pass along information on these new protections, which go into effect for health plan years beginning on or after September 23, 2010. Congressional Republicans already say they will repeal them.

I. For Plan Years Beginning On Or After September 23, 2010, Privately-Insured Consumers Will Have The Following Protections:

YOUR HEALTH COVERAGE CANNOT BE ARBITRARILY CANCELLED IF YOU BECOME SICK

Up until now, insurance companies had been able to retroactively cancel your policy when you became sick, if you or your employer had made an unintentional mistake on your paperwork.

Under the new law, health plans are now prohibited from rescinding coverage except in cases involving fraud or an intentional misrepresentation of facts. Due to pressure from Democrats in Congress and the Obama Administration, insurers agreed to begin implementing this protection early, this spring, making rescissions a thing of the past. This protection applies to all health plans.

YOUR CHILD CANNOT BE DENIED COVERAGE DUE TO A PRE-EXISTING CONDITION

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.

The new law prohibits insurance plans both from denying coverage and limiting benefits for children based on a pre-existing condition. This protection applies to all health

plans, except “grandfathered” plans in the individual market. **These protections will be extended to Americans of all ages starting in 2014.**

YOUR CHILD CAN STAY ON YOUR HEALTH PLAN UP TO AGE 26

Young people are the most likely to be uninsured. Currently one in three young people has no health coverage. One reason is that young people are less likely to be offered coverage through their jobs.

Under the new law, insurance companies are required to allow young people to remain on their parents’ insurance plan up to their 26th birthday, at the parent’s choice. This provision applies to all health plans. (For employer plans, only those young people not eligible for their own employer coverage receive the benefit, until 2014.)

YOUR HEALTH PLAN CANNOT PUT A LIFETIME LIMIT ON YOUR HEALTH 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. These limits can cause the loss of coverage at the very moment when patients need it most. Over 100 million Americans have coverage that imposes such lifetime limits. The new law prohibits the use of lifetime limits in all health plans.

YOUR HEALTH PLAN’S ANNUAL LIMITS ARE PHASED OUT OVER THREE YEARS

Even more aggressive than lifetime limits are annual dollar limits on what an insurance company will pay for health care. Annual limits are less common than lifetime limits – but 19% of individual market plans and 14% of small employer plans currently use them.

The new law phases out the use of annual limits over the next three years. For plan years beginning on September 23, 2010, the minimum level for the annual limit will be set at \$750,000. This minimum is raised to \$1.25 million in a year and \$2 million in two years. In 2014, all annual limits are prohibited. The protection applies to all plans, except “grandfathered” plans in the individual market.

II. Beginning September 23, 2010, Consumers Purchasing NEW Plans Will Have The Following Additional Protections:

YOU HAVE THE RIGHT TO KEY PREVENTIVE SERVICES WITHOUT DEDUCTIBLE OR CO-PAYMENTS

Today, too many Americans do not get the high-quality preventive care they need to stay healthy, avoid or delay the onset of disease, and lead productive lives. Nationally, Americans use preventive services at about half the recommended rate.

Under the new law, insurance companies must cover recommended preventive services, including mammograms, colonoscopies, immunizations and pre-natal and new baby care, without charging deductibles, co-payments or co-insurance.

YOU HAVE THE RIGHT TO BOTH AN INTERNAL AND EXTERNAL APPEAL

Today, if your health plan tells you it won't cover a treatment your doctor recommends, or it refuses to pay the bill for your child's last trip to the emergency room, you may not know where to turn. Most plans have a process that lets you appeal the decision within the plan through an "internal appeal" – but there's no guarantee that the process will be swift and objective. Moreover, if you lose your internal appeal, you may not be able to ask for an "external appeal" to an independent reviewer.

The new law provides the right to an impartial "internal appeal." Also, insurance companies will be prohibited from denying coverage for needed care without a chance to appeal to an independent third party.

YOU HAVE THE RIGHT TO CHOOSE YOUR OWN DOCTOR

Being able to choose and keep your doctor is highly valued by Americans. Yet insurance companies don't always make it easy to see the provider you choose. In one study, three-fourths of the OB-GYNs surveyed reported that their patients were forced to return to their primary care physicians for permission to get follow-up care.

The new law: 1) guarantees you get to choose your primary care doctor; 2) allows you to choose a pediatrician as your child's primary care doctor; and 3) gives women the right to see an OB-GYN without having to obtain a referral first.

YOU HAVE THE RIGHT TO ACCESS OUT-OF-NETWORK EMERGENCY ROOM CARE AT IN-NETWORK COST-SHARING RATES

Many insurers charge unreasonably high cost-sharing for emergency care by an out-of-network provider. This can mean financial hardship if you get sick or injured when you are away from home.

The new law makes emergency services more accessible to consumers. Health plans will not be able to charge higher cost-sharing for emergency services that are obtained out of a plan's network.

Please be assured that I will continue to fight to ensure people, not insurance companies, have control over their healthcare.

Sincerely,

John Olver
Member of Congress