THE PATIENT'S BILL OF RIGHTS

The Affordable Care Act is designed to put you, not the health insurance companies, back in charge of your health care. The Patient's Bill of Rights in the Affordable Care Act will stop insurance companies from limiting the care you need and remove insurance company barriers between you and your doctor. These new protections in the Affordable Care Act go into effect for health plan years beginning on or after September 23, 2010.

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; so rescissions are now 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 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 and insurance policies.

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.

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 ensures that all consumers in new health plans have access to internal and external appeals processes that are clearly defined and impartial.

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. One survey found that three-fourths of the OB-GYNs reported that patients needed 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. These protections apply to all plans except "grandfathered" employer and individual market plans.

YOU HAVE THE RIGHT TO ACCESS TO 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. This protection applies to all plans except "grandfathered" employer and individual market plans.

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