Patient Protection and Affordable Care Act
Patient’s Bill of Rights – Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010 and amended by the Health Care and Education Reconciliation Act (HCERA), signed on March 30, 2010 contains various provisions establishing insurance enrollee protections.


Prohibition of Preexisting Condition Exclusions

This provision, which applies to all health plans/coverage with the exception of grandfathered individual polices, prohibits the exclusion of coverage of specific benefits associated with a preexisting condition as well as a complete exclusion from the plan/coverage if based on a preexisting condition.

A preexisting condition exclusion is defined as a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. This includes a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

For individuals under age 19, this provision applies to plan years beginning on or after September 23, 2010. For plan years beginning on or after January 1, 2014 the preexisting condition exclusions are eliminated for all ages. It should be noted that the existing rule under the Health Insurance Portability and Accountability Act (HIPAA) allowing an exclusion of benefits for a condition if the exclusion applies regardless of when the condition began relative to the effective date of coverage still applies.
Prohibition of Lifetime and Annual Limits

The lifetime limit portion of the provision, which applies to all health plans/coverage, is effective for plan years beginning on or after September 23, 2010 and prohibits the plan from imposing any lifetime limits on the dollar value of “essential health benefits.” The portion regarding the prohibition of annual limits applies to all health plans/coverage with the exception of grandfathered individual polices. For plan years beginning on or after January 1, 2014, no annual limits are permitted on “essential health benefits.” It sets up a transition period for plan years beginning before January 1, 2014 allowing “restricted” annual limits on “essential health benefits.” The allowable annual limits for this time period are as follows:

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

For plan years beginning before January 2014, the rule allows the Secretary of Health and Human Services to establish a program to waive the application of the transitional annual limits for limited benefit plans (“mini-meds”) if compliance with the new limits “would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage.” Guidance concerning this waiver program will be issued in the “near future.”

Regulations defining “essential health benefits” have not been issued yet; however, the PPACA includes these general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.

The rule also requires plans/insurers to provide written notice to plan participants that the plan’s lifetime dollar limits no longer apply. When an individual already has reached a lifetime maximum, plans must provide an opportunity to re-enroll in coverage. The re-enrollment period must extend at least 30 days and begin no later than the effective date of the requirement (January 1, 2011 for calendar year plans). The Department of Labor has issued a model notice which can be viewed here: [http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc](http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc)
Account based plans, such as flexible spending accounts (FSAs), health savings accounts (HSAs), medical savings accounts (MSAs) and retiree-only health reimbursement arrangements (HRAs) are exempt from the annual/lifetime limit prohibition.

**Rescissions**

A rescission is a cancellation or discontinuance of health coverage that has **retroactive** effect. A cancellation or discontinuance of coverage with only a prospective effect is not a rescission. This provision, which applies to all health plans/coverage, is effective for plan years beginning on or after September 23, 2010 and prohibits the rescission of health coverage except in the case of fraud or intentional misrepresentation of a material fact. In situations in which rescission would be allowed, plans/insurers must notify participants in writing at least 30 days in advance. State laws that are more protective of individuals would not be preempted by this Federal standard and would still apply.

**Patient Protections**

This provision applies to all non-grandfathered plans and is effective for plan years beginning on or after September 23, 2010.

**Choice of Health Care Professional**

A plan/insurer that offers a network of providers is required to allow an individual to choose any network provider as his/her primary care physician (PCP). In the case of a child, any network provider qualified to provide pediatric services must be allowed to be designated as the child's PCP. Also, a plan may not require a woman to get a referral or pre-authorization for coverage provided by a participating health care professional specializing in obstetrics or gynecology.

A plan that requires designation of a PCP must provide notice informing each participant of the plan terms regarding this designation, including the right to select a PCP, pediatrician or health care professional specializing in obstetrics or gynecology. The notice must be included with the summary plan description or other similar description of benefits under the plan. The Department of Labor has issued a model notice which can be viewed here: [http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc](http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc).

**Coverage of Emergency Services**

Plans that cover emergency services must do so without the need for prior authorization, even if the services are provided out-of-network, and without regard to whether the service is provided by an in-network provider. Also, if a copayment or coinsurance is required for emergency services, it must be the same for services received in and out-of-network. Other cost-sharing requirements, such as a deductible or out-of-pocket
maximum, can only be imposed for emergency services if the requirement applies generally to out-of-network benefits. In other words, the deductible for non-network emergency services must be applied as part of the general non-network deductible and the out of pocket costs for non-network emergency services must count towards any out of pocket maximums for general non-network services.

The rules permit out-of-network providers to balance bill patients for the difference between the provider’s charge and the amount the provider receives from the plan/issuer and the patient’s regular copayment/coinsurance amount. Plans/issuers must pay a “reasonable amount” to providers before a patient becomes responsible for the balance billing amount. This “reasonable amount” can be met if the out-of-network emergency services benefits provided are in an amount equal to the greater of three possible amounts:

1. The amount negotiated with in-network providers for such services;
2. The amount calculated using the method the plan normally uses to determine out-of-network services (such as usual, customary, and reasonable charges), but applying the in-network cost-sharing provisions; or
3. The amount Medicare would pay for the service.

For further information, contact AFSCME’s Department of Research and Collective Bargaining Services.

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