



The Affordable Care Act:

Patients' Bill of Rights and Other Protections

The Patient Protection and Affordable Care Act (Affordable Care Act) offers you several new protections that are known as the "Patients' Bill of Rights." This brief explains what those rights and protections are, and how they can help you.

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Patients' Bill of Rights and Other Protections**

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This publication is available online at www.familiesusa.org

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Cover Design: Nancy Magill, Families USA



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Patients' Bill of Rights: Ensuring coverage for consumers with pre-existing conditions

An Overview

Under the Affordable Care Act, if you have a pre-existing condition, insurance companies will no longer be allowed to deny you coverage based on that condition. For children under the age of 19, this protection began on September 23, 2010. For adults aged 19 and older, it will begin on January 1, 2014. Insurers will have to accept everyone who wants to purchase a plan, regardless of their health status. In addition, health plans won't be able to exclude coverage of pre-existing conditions from their policies.¹ This means that health plans can't refuse to cover your treatment solely because you already had a health condition when you joined the plan.²

Your insurance company can still deny you coverage of a particular treatment if your plan does not offer coverage of that specific treatment to *anybody* enrolled in the plan. For example, some health plans do not cover particular prescription drugs. If your child's pediatrician recommends a particular drug to treat his ongoing condition, regardless of whether your child was enrolled in the health plan after his diagnosis or enrolled in the plan at birth, your plan would not cover treatment with this drug because coverage for the drug is not offered to any plan enrollee.

This new protection for children with pre-existing conditions will apply to everyone who gets coverage through work and to everyone who buys an individual or family plan after March 23, 2010. This new protection may not apply to those who stay in individual insurance plans that they bought before March 23, 2010, unless that plan has made major changes in its coverage or substantially increased cost-sharing or deductibles. (For more information, see the fact sheet on "grandfathered plans" starting on page 25.)

The following two examples help explain how this new protection works and when it goes into effect.



Mr. and Mrs. Wilson purchase a new family insurance plan in October 2010 and enroll themselves and their two children, 3-year-old Emma and 8-year-old Bob, in the plan. Emma has diabetes. Because the Wilsons have purchased a new plan, their family is protected under the new law. The plan is not allowed to exclude coverage of Emma's pre-existing condition; therefore, Emma will receive treatment for her diabetes as soon as their coverage begins.



Mrs. Y will begin a new job on November 1, 2010, and she will enroll herself and her 12-year-old daughter, Alice, in Sunny Insurance, the health insurance plan provided by her employer. Alice has severe allergies. In the past, Sunny Insurance had a pre-existing condition exclusion of 12 months that would have applied to coverage of Alice's allergy treatments. That means that, although her plan would have covered other care immediately, Alice would have had to wait a full year before it would cover treatment for her allergies.

Because of the new health reform law, this will change. Since Alice is in a plan that she gets through her mother's job, she will be protected under the new law as soon as the protection phases in. In this case, the protection will begin when her mother's employer renews its annual contract with the health plan. The employer's plan is renewed each year in June, and for Alice, this is when the new protection will begin. When the new plan year begins on June 1, 2011, Alice will receive coverage for her allergy treatments. However, from November 1, 2010, until June 1, 2011, the plan is still permitted to exclude coverage for treatment of her allergies.

Enrolling Children with Pre-Existing Conditions

For plan years beginning on or after September 23, 2010, insurers will have to cover *all children who apply for a plan*, regardless of their health status. However, insurance plans are not required to have new plans available for purchase year-round. Plans may choose to have "open enrollment periods" (that is, periods when they will take new applicants) for a month before the plan year starts again, for a few months in a row, or at several different times a year. Federal law permits limited open enrollment, but you should check with your state insurance department to see whether there are any state requirements about when plans have to take new applicants. While insurance companies in the individual market are not required to have a certain number of open enrollment periods for children, plans will be monitored to ensure that they are not deliberately limiting enrollment of children.

Conclusion

The new health reform law guarantees that all individuals who apply for coverage will be sold a policy regardless of health status, and it eliminates pre-existing condition exclusions in health plans. Instituting these protections for children marks a huge step forward for ensuring that all consumers get the comprehensive health care they need.

¹ The prohibition on excluding coverage of services for specific conditions (pre-existing condition exclusions) for children is taking effect at different times for different plans, starting on September 23, 2010. This is because plan years begin at different times, and this prohibition will take effect at the start of the new plan year. For example, if your plan year began in October, your child should have started to receive care for his or her pre-existing condition beginning in October 2010. If your plan year begins in July, your child will receive care for his or her pre-existing condition beginning in July 2011.

² In addition, health plans will not be able to charge consumers higher premiums due to a pre-existing condition. This protection and the elimination of pre-existing condition exclusions for people of all ages will take effect for plan years starting on or after January 1, 2014.



Patients' Bill of Rights: Ensuring the right to choose your doctor

Ensuring Choice of Doctors

Under the Affordable Care Act, if you have private health insurance, whether you have a plan offered through your employer or an individual plan you purchased directly from a health insurance company, you will have greater choice of, and better access to, health care providers. The protections we outline below were phased in beginning on September 23, 2010.¹ These protections apply to you if, after March 23, 2010, (1) you buy a new individual or family health plan in the individual market, or (2) your employer did not previously offer coverage and buys a new health plan to cover you and other employees. They also apply if you have coverage through your job and, since March 23, 2010, (1) your plan has significantly cut the benefits it covers, (2) your plan has substantially increased the amount you must pay in cost-sharing or deductibles, or (3) your employer has decreased the amount it pays toward your premiums by more than 5 percent. (For more information, see the fact sheet on “grandfathered plans” starting on page 25.)

Choosing a Primary Care Provider

Under the new law, if you are enrolled in a health plan that requires you to designate a specific primary care provider, you will be guaranteed the right to choose that doctor. You will have the choice of any primary care provider in the plan's provider network, as long as he or she is accepting new patients like you. The insurance plan or the employer is required to notify you of your new right to pick your primary care provider. Until you select your primary care provider, the health plan may select one for you. The following example illustrates this new protection:



Mr. Y enrolls in Best Insurance, a new plan offered through his employer. Mr. Y receives a notification from Best Insurance that explains how, under the new law, he may select one of the 800 primary care providers in the Best Insurance provider network as his primary care provider. If Mr. Y doesn't designate a primary care provider of his choice, Best Insurance will pick one for him.

Choosing a Pediatrician

If you and your child are enrolled in a health plan that requires you to designate a primary care provider, you have the right to designate a pediatrician as your child's primary care provider, as long as there are pediatricians in your network available to take new patients. The insurance provider must notify you of your right to choose your child's pediatrician. Until you select a pediatrician as your child's primary care provider, the insurance company may choose a primary care provider for your child.

Direct Access to OB/GYNs

The new health reform law provides direct access to in-network OB/GYNs for women in health plans that require them to designate primary care providers. This means that, if you are a female, you can see an OB/GYN without prior authorization from the health plan or referral from another doctor, such as your primary care provider. The insurance company or employer must notify you of your right to see an OB/GYN within the provider network with no referral.² The following example illustrates this new protection:



Suzie Q enrolls in a new health plan from Healthy Life Insurance. Following the plan's requirements, Suzie Q selects her primary care provider from the Healthy Life Insurance provider network. Suzie Q then schedules an appointment with Dr. A, an in-network OB/GYN. Because Dr. A is in the Healthy Life Insurance network, Suzie Q does not need a referral from her primary care provider or prior authorization from the insurance company.

Conclusion

The new patient protections in the Affordable Care Act, including the choice of an in-network primary care provider and pediatrician and direct access to OB/GYNs, will ensure that you can obtain quality health care that is appropriate for your specific needs.

¹ These new protections in the Patients' Bill of Rights will go into effect at different times for different plans. This is because plan years begin at different times during the year, and the patient protections take effect at the start of the new plan year. For example, if your plan year began in October, you would have gained the protections beginning in October 2010. If your plan year begins in July, these protections begin in July 2011.

² Depending on the policies of your specific insurance plan, you may need prior authorization for specific obstetric or gynecological treatments, and your OB/GYN may still be required to inform your primary care provider of treatment decisions.



Patients' Bill of Rights: Ensuring fair treatment when you need emergency care

The New Protection for Medical Emergencies

Many people have health plans that encourage them to use “in-network” services: Usually, consumers must pay more if they use a doctor, health facility, or other provider that is not in their plan’s network. However, if you face a medical emergency, you may need to go to the nearest emergency room, even if it is not in your plan’s network. And even if you do use an in-network hospital, you may not be able to make sure you are treated by health care providers that are also in your plan’s network. The protections in the new law address these problems.

If you have an emergency medical condition—that is, if your symptoms are severe enough that you think that you would put your health in jeopardy or you might be seriously harmed if you don’t get immediate attention—then you can get emergency medical screening and treatment at a hospital.¹ Under the new law, your health plan *cannot* do the following:

- Require you to get preauthorization for emergency services;
- Make you go through extra administrative hurdles to get your out-of-network emergency services covered;
- Charge you higher copayments or co-insurance for out-of-network emergency services than it charges you for in-network emergency services; and
- Limit its coverage for out-of-network emergency care more than it would limit its coverage if you received care in-network.

Who Is Protected

The new protections for emergency services apply to you if, after March 23, 2010, (1) you buy a new individual or family health plan in the individual market, or (2) your employer did not previously offer coverage and buys a new health plan to cover you and other employees. They also apply if you have coverage through your job and, since March 23, 2010, (1) your plan has significantly cut the benefits it covers, (2) your plan has substantially increased the amount you must pay in cost-sharing or deductibles, or (3) your employer has decreased the amount it pays toward your premiums by more than 5 percent. (For more information, see the fact sheet on “grandfathered plans” starting on page 25.) The new protections for emergency service apply to people in private insurance, not people with public coverage such as Medicaid, Medicare, or veterans health benefits; other laws help protect people with public coverage from emergency charges.

Balance Billing

Unfortunately, if a health care provider is not in a plan's network, that provider may not accept the plan's payment rates for a service. He or she may want to bill you the difference between what the plan pays for the service and his or her charge for that service. So, even if the plan has not charged you a higher copayment, you might still get a bill from an out-of-network provider for other charges that were not paid by your health plan. This is called "balance billing."

Although the new law does not completely solve this problem, it does make some changes that are designed to minimize your bills for emergency care: It sets some standards for what health plans must pay out-of-network emergency providers, and when providers are paid adequately, they are less likely to balance bill.

Your plan must pay the emergency providers the *greatest* of these three amounts:

1. The amount it pays in-network providers;
2. A payment based on the same methods the plan uses to pay for other out-of-network services (for example, a percentage of usual and customary fees charged by other providers in your area); or
3. The amount Medicare would pay for that service.

Some states have even stronger laws to stop balance billing. You can check with your state insurance department to find out if there are additional laws to protect consumers in your state. Also, if you have Medicaid, you should not be balance billed.

If you have questions about a bill you have received for emergency services, you can talk to the health plan and the provider to find out how the plan set its payment rate and why the provider is charging more. If you think a bill is unfair, you may also want to talk to your insurance department, your state attorney general's consumer protection division, or a consumer assistance program that helps consumers with health insurance problems.

Finally, if you have the time to ask to see in-network providers without jeopardizing your health, do so. For example, if a hospital is assigning an anesthesiologist or another specialist to you or your loved one, find out if the hospital can help you locate someone who is in your health plan's network.

Conclusion

The new health reform law places new limits on what consumers who need emergency care can be charged for out-of-network care when they are not in a position to decide which hospital to go to or which health care providers to use. And by setting standards for what health plans must pay out-of-network emergency providers, it further protects privately insured patients.

¹ The law defines an emergency medical condition as one that manifests with "acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to . . . (1) [place] the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) [result in] serious impairment of bodily functions; or (3) [result in] serious dysfunction of any bodily organ or part."



Patients' Bill of Rights: Making sure your policy can't be canceled unfairly

What Are Rescissions?

One troubling health insurance industry practice that has gained attention recently is known as “rescission.” A rescission occurs when an insurer retroactively cancels an enrollee’s policy (usually when the enrollee needs expensive care), blaming it on an error that the enrollee made. For example, an insurer may rescind an enrollee’s policy based on incorrect information that was included in the enrollee’s application for coverage (even if the enrollee completed the application months or years ago). The errors in question can be as minor as forgetting to mention a particular doctor visit or a prescription drug taken in the past. Or, an insurer might rescind a policy if an enrollee forgets to notify an insurer when his or her employment status has changed from full-time to part-time. When an insurer rescinds a policy, it cancels the policy retroactively and it may demand that the enrollee pay back money for any medical bills that the insurer covered in the past. Rescissions blindside enrollees, leaving them to face medical bills with no insurance and no recourse.

The Affordable Care Act changes this. It includes new rights for consumers that stop insurance company abuses and protect consumers against unfair rescissions.

Your New Rights

Under the Affordable Care Act, an insurance company will be able to rescind your health plan only if you (or someone you’ve authorized to represent you on a health insurance application, including your employer) commits fraud—that is, knowingly and willfully misrepresents or omits a piece of information that is relevant to your health plan. This means that insurance companies will no longer be able to take your insurance away from you if you forgot to mention something minor in your medical history on your application for coverage, or if you did not understand that a piece of information (such as a change in your employment status) was relevant to your health plan.

Details of this new right include the following:

- The new protection against unfair rescissions will apply to you on or after September 23, 2010—whenever your health plan year starts again. If you have job-based coverage, your plan year will begin on the date that the policy is renewed or the date that your employer buys a new policy. If you’ve purchased a policy on your own in the individual market, the policy year may begin on the anniversary date of when you bought the policy, the date that the plan begins calculating your annual expenses to meet a deductible, or the beginning of the calendar year.

- This new protection will apply to you whether you stay in the same plan you've had or buy or enroll in a new insurance plan.
- The new protection applies to you if your insurance plan tries to rescind a policy that covers you alone, a policy for your whole family, or even a policy that covers you and your coworkers.
- If an insurer wants to rescind your coverage because it believes you have committed fraud, it must give you 30 days' advance written notice.
- If an insurer attempts to rescind your coverage, you have the right to appeal. To learn more about your appeal rights, see the the section on "Your Right to Appeal" on page 17.

When an Insurer Can Cancel a Policy

An insurer can *rescind* your policy if you intentionally misrepresent or omit a relevant piece of information on your application for coverage.

An insurer can *cancel* your policy if any of the following occurs:

- You stop paying your premiums;
- The insurer stops offering your insurance plan or leaves the insurance market in your area;
- You move away, and the location of your new residence is not in the insurer's service area; or
- You get your coverage through an association, and you end your membership in that association.

For More Information

If an insurer attempts to rescind your coverage, whether it appears to be breaking the new rules in the Affordable Care Act or if you just want more information on your rights, you can get more information from the following resources:

- U.S. Department of Labor website at www.dol.gov/ebsa;
- U.S. Department of Labor's benefit advisors, who can be reached by calling 1-866-444-EBSA (3272);
- Your state insurance department;
- The government's new health care website at www.healthcare.gov; or
- A consumer assistance program. Families USA lists some consumer assistance programs online at <http://www.familiesusa.org/resources/program-locator/>. An updated list may also be posted on www.healthcare.gov.



Patients' Bill of Rights: Ending Annual and Lifetime Limits

No More Annual or Lifetime Limits

Under the Affordable Care Act, insurance companies will no longer be allowed to set limits on the dollar amount of health benefits that they will cover in a single year or over the course of a person's lifetime. This means that you won't run out of coverage if you develop a health problem that is costly to treat.

The protection against annual and lifetime limits will take effect for you on or after September 23, 2010, depending on when your health plan year starts again. If you have job-based coverage, your plan year will begin on the date that the policy is renewed or the date that your employer buys a new policy. If you've purchased a policy on your own in the individual market, the policy year may begin on the anniversary date of when you bought the policy, the date that the plan begins calculating your annual expenses to meet a deductible, or the beginning of the calendar year.¹ The elimination of annual limits will happen gradually, until they are completely prohibited in 2014.

These protections apply to "essential benefits." Essential benefits include the following health care services: ambulatory care, such as doctor and specialist visits; emergency services; hospitalization; preventive and wellness services and chronic disease management; laboratory services; prescription drugs; maternity and newborn care; pediatric services; mental health and substance use disorder services; and rehabilitative and habilitative services and devices.

Annual and lifetime limits can still be applied to "nonessential benefits," both now and in 2014. For example, your plan could still limit how much it will cover for dental care each year or over your lifetime, because dental care for adults is considered a nonessential benefit.

Elimination of Lifetime Limits

Starting on or after September 23, 2010, insurers will no longer be allowed to stop paying for your care because you have reached a lifetime spending limit. This provision will protect you if you have insurance through your job, or if you purchase a plan directly from an insurance company for yourself or your family.

If you've already reached a lifetime limit in your health plan and your health coverage ended because of it, you may be able to reenroll when your plan year starts again on or after September 23, 2010. This option is available if you had coverage through your job and you still work for the same employer (and the employer still uses that health plan), or if your family is still enrolled in the plan you had before (if your family purchased it directly from an insurer). The insurance company or your employer is required to tell you on or before the first day of the new plan year that there are no longer lifetime limits on your plan and that you are eligible for coverage. The insurance company must give you at least 30 days to reenroll.

The example below helps explain this new provision:



Sally Smith was previously enrolled in HealthStar Insurance through her employer. Before the new law was passed, HealthStar Insurance had a lifetime limit of \$1 million. One year ago, Sally was diagnosed with cancer that was at an advanced stage. She needed chemotherapy and invasive surgery, as well as extensive follow-up treatments. In less than a year, Sally reached her \$1 million lifetime limit, and her insurance stopped covering her medical bills. Sally had to turn to friends and family to help her pay for the remainder of her cancer care.

Under the new law, HealthStar Insurance will be required to remove its lifetime coverage limit. The HealthStar Insurance new plan year begins on January 1, 2011. By that date, HealthStar Insurance must notify Sally that she can reenroll in her employer's plan, and it must give her at least 30 days to do so.

Gradual Elimination of Annual Limits

By 2014, insurers will not be allowed to place annual dollar limits on the amount of health benefits that any enrollee can use. Between 2010 and 2014, annual limits will be gradually eliminated. The dollar amount of annual limits will be regulated starting on or after September 23, 2010, as follows:

- For plan years beginning on or after September 23, 2010, but before September 23, 2011, plans with annual limits will be required to have limits of no less than \$750,000 per enrollee for essential benefits.²
- For plan years beginning on or after September 23, 2011, but before September 23, 2012, the annual limit amount rises to \$1.25 million.
- For plan years beginning on or after September 23, 2012, but before January 1, 2014, the annual limit amount rises to \$2 million.

These annual limit amounts apply on an individual basis, not on a family basis. This means that, for a family of four, if your child reaches the annual limit, the essential medical care that the other three members of your family get will still be covered by your health plan.

This protection will apply to everyone who gets coverage through their job, and to people who purchase a new individual or family plan after March 23, 2010.³ This protection may not apply to those who stay in individual or family insurance plans that were purchased before March 23, 2010, unless that plan has made major changes in its coverage or substantially increased cost-sharing or deductibles. (For more information, see the fact sheet on “grandfathered plans” starting on page 25.)

Waiver Option for Insurance Plans with Annual Limits

Some health plans now have annual limits that are far below \$750,000, and they claim that they would have to substantially increase their premiums or decrease their benefits significantly in order to comply with the new annual limit requirements. In these cases, health plans can apply to the Secretary of Health and Human Services for a “waiver” from these requirements. Group health plans that begin before January 1, 2014, that have annual limits below the amounts listed on page 10 may be able to get a waiver if they would have to significantly decrease benefits or raise premiums to comply with the new protections.

If your plan still has an annual limit and you want to know whether it has been given a waiver and is allowed to keep that limit, or if you have other questions about your rights, see the following resources:

- U.S. Department of Labor website at www.dol.gov/ebsa
- U.S. Department of Labor’s benefit advisors at 1-866-444-EBSA (3272)
- The government’s new health care website at www.healthcare.gov
- Your state insurance department

Conclusion

The elimination of lifetime and annual limits under the Affordable Care Act is a crucial step in ensuring that health coverage will work for people who need it. As a health care consumer, you will no longer have to worry that a serious illness or accident could leave you paying for health care on your own because your coverage has run out.

Endnotes

¹ These new protections will go into effect at different times for different people. This is because plan years begin at different times. For example, if your plan year began in October, your lifetime limit should have been eliminated in October 2010. If your plan year begins in July, your lifetime limit will be eliminated in July 2011.

² Plans can't count dollars spent on nonessential benefits toward the annual limits that are permitted until 2014. For example, the cost of adult dental services can't be counted toward a \$750,000 annual limit on essential benefits that your plan may impose for the coming year.

³ Health flexible spending accounts (FSAs) are exempt from this new provision.



Your Right to Preventive Care: Enhancing access to preventive services

Having access to appropriate and timely preventive medical care is key to Americans' well-being. People need preventive screenings and services to monitor their health and catch signs of illnesses that can be devastating and costly if they are not identified early. The Affordable Care Act includes vital protections for preventive services, which will make it easier for consumers with private insurance to obtain and afford critical preventive care.

Under the Affordable Care Act, new health insurance plans will be required to provide coverage for certain recommended preventive health services, and they will be prohibited from charging cost-sharing for those services. This means that people in new health plans will have access to recommended preventive care through their insurer without having to worry about any copayments, deductibles, or co-insurance.

When the New Protections Apply

These protections apply to you if, after March 23, 2010, (1) you buy a new individual or family health plan in the individual market, or (2) your employer did not previously offer coverage and buys a new health plan to cover you and other employees. They also apply if you have coverage through your job and, since March 23, 2010, (1) your plan has significantly cut the benefits it covers, (2) your plan has substantially increased the amount you must pay in cost-sharing or deductibles, or (3) your employer has decreased the amount it pays toward your premiums by more than 5 percent. (For more information, see the fact sheet on "grandfathered plans" starting on page 25.)

If you are in such a plan, these protections will apply to you on or after September 23, 2010, depending on when your health plan year starts again. If you have job-based coverage, your new plan year will start on the date that your policy is renewed or the date that your employer buys a new policy. If you've purchased a policy on your own in the individual market, your new policy year may start on the anniversary date of when you bought the policy, the beginning of the calendar year, or the date that the plan starts calculating your annual expenses to meet a deductible. Contact your employer or insurer if you are unsure of when your plan year starts.

Preventive Services that Are Covered

Under the Affordable Care Act, there are extensive guidelines that govern which recommended services must be covered with no cost-sharing (see below). Examples of recommended services that are included in the guidelines include the following:

- blood pressure screening for adults aged 18 and older;
- tobacco screening and cessation interventions;
- cancer screenings;
- hearing and vision screening for children and newborns; and
- immunizations, such as those for measles, mumps, and rubella (MMR); influenza (the flu); and hepatitis.

Under the more technical guidelines, the following services must be covered by new insurance plans with no cost-sharing:

- Preventive items or services that have a current A or B rating from the U.S. Preventive Services Task Force (USPSTF; note that the law currently requires insurers to cover breast cancer screening every one to two years for women over the age of 40, in keeping with the 2002 USPSTF guidelines);
- Vaccines recommended in the Immunization Schedules of the Centers for Disease Control and Prevention (CDC);
- Services recommended in the guidelines for preventive services for infants, children, and adolescents from the Health Resources and Services Administration (HRSA), which include the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Screening Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
- Services recommended in guidelines for women's preventive services supported by HRSA, which will be released by August 2011. (In the meantime, many women's preventive health services are included in the USPSTF recommendations.)

To see a full list of recommended services, visit www.healthcare.gov/center/regulations/prevention.html.

The expert guidelines described above include many more services than those mentioned in this fact sheet. Some of them are recommended only for people at certain ages or with certain health risks. For example, cholesterol screenings are recommended for all men aged 35 and older (and all women aged 45 and older) by the USPSTF, but they are also recommended for younger people if they are at increased risk for heart disease.

When the USPSTF, the CDC, or HRSA add new preventive services to their recommendations, those newly added services will be included among those that have to be covered by new insurance plans without cost-sharing. However, there will be a lag between when they are officially recommended by the expert body and when health plans are required to cover them: Insurers must cover newly recommended preventive services with no cost-sharing in the next insurance plan year that starts one year after the recommendation goes into effect.

If the expert bodies decide that a service they recommended should actually not be provided to a certain group of people anymore, or should not be provided at all based on new scientific evidence, they may remove it from their guidelines. In such a case, insurers will no longer have to cover the service without cost-sharing (or at all) under the Affordable Care Act. However, if an insurer previously covered a preventive service and decides to no longer do so, it must provide enrollees with 60 days' advance notice that the service will no longer be covered.

The best way to know which preventive services your plan must cover with no cost-sharing is to visit www.healthcare.gov/center/regulations/prevention.html. This site has an up-to-date list of recommended preventive services.

When Your Plan Can Charge Cost-Sharing

Under the new rules, there are still some times when you may face cost-sharing for recommended preventive services. To receive the recommended services with no cost-sharing, your plan can require you to see a provider who is in your plan's network. If you go to an out-of-network provider for a recommended preventive service, you may have to pay cost-sharing, or your health plan might not cover it at all, depending on the plan's rules.

In addition, the Affordable Care Act doesn't say how often you can receive a given preventive service or where the service can be provided, even if it's a recommended service that the plan must cover without cost-sharing. Your health plan may have rules about how often you can receive a recommended service or where you are allowed to receive it in order for you to obtain it with no cost-sharing. (If you feel that your health plan is making it difficult for you to get recommended preventive services without cost-sharing, contact the resources mentioned on page 16.)

Also, if you receive a recommended preventive service as just one part of a doctor's visit that has other purposes, too, you might still have to pay cost-sharing for the office visit overall or for the other services you receive during the visit. However, if you go to see your doctor and the main purpose of your visit is to receive a recommended preventive service, the doctor cannot charge you a copayment or other cost-sharing for the visit.

If a recommended preventive service, such as a screening, identifies a health problem that requires further treatment, you will most likely have to pay whatever cost-sharing your health plan usually requires for that treatment. For example, if you go to see your doctor to get a recommended cholesterol test, you won't be charged for the test itself. However, if the test reveals that you have an elevated cholesterol level, you may have to pay cost-sharing for any treatment your doctor recommends, such as cholesterol-lowering medication.

For More Information

If you would like to know more about your rights to preventive services in private insurance plans, or if you think that your health plan is unfairly denying you a recommended service without cost-sharing, the following resources may be able to help you:

- U.S. Department of Labor website at www.dol.gov/ebsa;
- U.S. Department of Labor's benefit advisors, who can be reached by calling 1-866-444-EBSA (3272);
- Your state insurance department; or
- The government's new health care website at www.healthcare.gov.



Your Right to Appeal: Ensuring your right to appeal health plan decisions

Before the Affordable Care Act was passed, people's rights to appeal decisions made by their health plans varied depending on where they lived, what type of health plan they had, and whether they bought insurance themselves or got it through their job. In some states, when people disagreed with their health plan's decision, they could appeal that decision outside of their health plan, and in other states, they had no appeal rights.

The new law changes this. Under the Affordable Care Act, if you disagree with your plan's refusal to pay for care, the plan will have to review its decision. And if you still are not satisfied, you will have the right to appeal that decision to an independent reviewer who is outside of the health plan.

These protections apply to you if, after March 23, 2010, (1) you buy a new individual or family health plan in the individual market, or (2) your employer did not previously offer coverage and buys a new health plan to cover you and other employees. They also apply if you have coverage through your job and, since March 23, 2010, (1) your plan has significantly cut the benefits it covers, (2) your plan has substantially increased the amount you must pay in cost-sharing or deductibles, or (3) your employer has decreased the amount it pays toward your premiums by more than 5 percent. (For more information, see the fact sheet on "grandfathered plans" starting on page 25.)

These new rights are important: Eventually, they are expected to cover 88 million people. And research shows that consumers who do appeal outside of their insurance companies win their cases about 45 percent of the time.¹

If it appears that your plan will not be subject to the new protections, check with your state insurance department, your employer, and your health plan to find out whether you have similar appeal rights.

The Kinds of Decisions You Can Appeal

You can appeal a plan's decision not to pay for a benefit, or to reduce or end a covered service, when the plan says any of the following: (1) the care is not medically necessary or appropriate, (2) you are not eligible for the health plan or benefit, (3) you have a pre-existing condition, or (4) the care is experimental or investigational. If the plan has told you any of these things and you disagree, you can appeal. You can also appeal when the plan rescinds your coverage (cancels your coverage retroactively). The plan must give you a notice when it denies payment or rescinds your coverage that explains both the reason and how to appeal.

When the New Appeal Rights Go into Effect

States, the federal government, and health plans are all putting the new appeal system in place over the coming years. It will be fully operational for plan years beginning after January 2012, but health plans and states have already made many of the following improvements in their appeals processes.

The Appeal Process

First, ask for an “internal review.”

You should receive a notice from your plan with instructions about how to request a review and the deadline for doing so.

- Other people in the health plan who were not involved in the plan’s original decision will review the case. They must consult with appropriate medical experts.
- You have a right to get the details of why the plan refused to pay for your care. You can review the plan’s file about your case, get the medical evidence the plan used, and get the plan’s guidelines about when it does and doesn’t pay for the type of care you requested. The plan cannot charge you for this information.
- You have a right to present testimony and more evidence for the plan to consider. You can respond to any evidence the plan uses. For example, you might want to submit letters from your doctors and information from medical journals about why a benefit is appropriate. Or, if the plan is rescinding coverage, you may want to submit testimony and evidence that any errors you made on your insurance application were unintentional, honest mistakes.
- You can ask a consumer assistance program or another representative of your choosing to help you.
- If you want, you can ask the plan to continue paying for your treatment until the appeal has been decided.
- The plan must expedite the review if the matter is urgent and you ask them to do so. For example, if your health would be in serious jeopardy or you would experience severe pain, the plan must conduct its review and make a decision within 72 hours, or sooner if necessary. If the matter is urgent, you can also request an “external appeal” from an independent reviewer immediately, at the same time that you ask for an internal review. You don’t have to wait for the plan’s internal review decision.
- When the plan finishes its internal review, it must give you a notice of its final decision and the reasons for it, and the notice must explain how you can appeal outside of the plan to an external, independent reviewer.

Second, if you are not satisfied with the decision or the matter is urgent, appeal to an independent reviewer who is not part of the health plan. This is called an “external appeal.”

- The notice you get from your plan should explain where to send your appeal request. For example, state insurance departments or health departments might handle appeal requests for some types of plans, and private, independent review organizations might directly handle appeals for other types of plans. In any case, these reviewers must be independent of the health plan and have no conflicts of interest—they must be able to make a fair and impartial decision.
- You have some time to gather evidence before you submit your appeal. After you receive the plan's internal review decision, you have at least four months to request an external review. (Of course, if you need treatment quickly, you will want to appeal much sooner.) This gives you some time to gather doctor statements, medical literature, and other evidence that you might want to submit with your request for an appeal.
- After you have submitted your request for an appeal, you will receive notice that you have another five business days to submit any additional information that you want considered. If the plan submits new evidence or information, you will have an opportunity to respond.
- The independent reviewer will make a decision within 45 days, but you can ask for an expedited review if the matter is urgent. In that case, the reviewer will decide on your case within 72 hours, or even sooner if necessary.
- The plan must follow the reviewer's decision. If the independent reviewer decides that the plan should cover your treatment, the plan must do so. The only time that the plan can continue to refuse payment is if the plan takes the matter to court.

You Can Get Help with Your Appeal from a Consumer Assistance Program

Many states are establishing consumer assistance programs to help consumers with appeals and to help them understand their health insurance rights. Notices from your insurer should give you contact information for the consumer assistance program in your state. You can also ask your state insurance department if there is a consumer assistance program, or you might be able to find a knowledgeable advocate to help you with your appeal by contacting a legal services program, your state bar association, or a disease association for people with your illness. If you are in a job-based plan, you can also get help through the U.S. Department of Labor's Employee Benefits Advisors by calling 1-866-444-EBSA (3272).

For More Information

For more information, see the following resources:

- U.S. Department of Labor website at www.dol.gov/ebsa
- U.S. Department of Labor’s benefit advisors, who can be reached by calling 1-866-444-EBSA (3272)
- The government’s new health care website at www.healthcare.gov
- Your state insurance department
- A consumer assistance program. Families USA lists some consumer assistance programs online at <http://www.familiesusa.org/resources/program-locator/>. An updated list is also available at www.healthcare.gov/consumerhelp.
- Health Insurance Assistance Team, U.S. Center for Consumer Information and Insurance Oversight, 888-393-2789

¹ Kaiser Family Foundation, *Assessing State External Review Programs and the Effects of Pending Federal Patients’ Rights Legislation* (Washington: Kaiser Family Foundation, 2002), available online at <http://www.kff.org/insurance/externalreviewpart2rev.pdf>; U.S. Department of Labor, *The Affordable Care Act: Protecting Consumers and Putting Patients Back in Charge of Their Care*, July 22, 2010, available online at www.dol.gov/ebsa/newsroom/fsaffordablecareact.html.



Patients' Bill of Rights: Ensuring young adult coverage under their parents' plan

The new health reform law gives new options to uninsured Americans under the age of 26. Health plans that provide dependent coverage for children must extend benefits to adult children who meet certain eligibility criteria. The right to stay on a parent's plan is especially helpful to young adults who are having difficulty finding or affording health coverage in the current economy.

This fact sheet is aimed at young adults (and their parents) and is designed to answer important questions about this new opportunity to keep (or obtain) health coverage.

Who qualifies?

Young adults have the right to stay in a parent's plan—or to get back into that plan—if they meet the following conditions:

1. **Their parent has coverage through an employer or buys family coverage in the individual market.**

Unfortunately, TRICARE enrollees do not have this right because a different set of laws governs TRICARE. Currently, young adults can stay on their parents' TRICARE coverage until the age of 21—or 23, if they are full-time students.



For more information:

TRICARE: http://www.tricare.mil/NHCB_QnA.aspx.

2. **Their parent's health plan provides "dependent coverage"—that is, it covers children, spouses, or other family members.**

In the past, some plans required children and young adults to be "dependents" for tax purposes before they could qualify for coverage on their parents' plans. Under the new law, this is no longer the case. Nor does it matter whether or not the young adult is a student, lives with the parent, or receives financial support from the parent.

3. **The young adult cannot have a job that offers coverage, unless the parent's plan is either a plan purchased in the individual market or a plan that the parent's employer purchased after March 23, 2010, offering coverage to workers for the first time.**

Young adults whose parents have newer employer plans—those established after March 23, 2010—or plans purchased in the individual market can stay on their parents' plans regardless of their coverage-offer status. Young adults with an offer of

job-based coverage can also stay on their parent's job-based plan if (1) the parent's plan has significantly cut the benefits it covers, (2) the plan has substantially increased cost-sharing or deductibles, or (3) the parent's employer has decreased the amount it pays towards worker premiums by more than 5 percent. (For more information, see the fact sheet on "grandfathered plans" starting on page 25.)

When does this provision apply to you?

The new right for young adults to stay on a parent's health plan went into effect for "plan years" (or "policy years" for policies purchased in the individual market) starting on or after September 23, 2010. This means that the exact date that it applies to young adults depends on their parent's plan year or policy year.

- For job-based coverage, the plan year begins on the date that the policy is renewed or the date that an employer buys a new policy. For example, if a young adult gets coverage through a parent's job and the employer renews coverage each October, the new right went into effect in October. If the employer renews coverage and offers an annual open enrollment period in August, the new right may not go into effect until August 2011.
- For a policy purchased in the individual market, the policy year may begin on the anniversary date of when the person bought the policy, or the date that the plan begins calculating the enrollee's expenses to meet a deductible, or at the beginning of the calendar year.

Young adults can learn the exact date that the provision applies to them from their parents' employer or health plan.

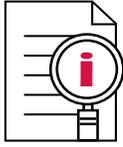
Getting Back into a Parent's Plan

Young adults who had already lost coverage before the law went into effect but who are not yet 26 will have a special one-time opportunity to re-enroll in their parents' plan. Their parents will receive notice of the opportunity at the beginning of the new plan year, and the young adults will have 30 days to enroll. The regulations explain that families may have some additional options during this special 30-day period when the law goes into effect, as follows:

- If the parent's employer offers several different benefit packages, the young adult and parent can switch to a different benefit package at that time if they wish to do so.
- If the parent had also dropped coverage when the young adult aged out of the plan, but the parent remained an employee, both the parent and the young adult have an option to re-enroll during this special 30-day period.

The regulations provide some examples of these situations.

For more information about young adults' right to stay on their parents' health plan, see the following resources on the Department of Labor website:



Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses, a fact sheet available online at <http://www.dol.gov/ebsa/newsroom/fsdependentcoverage.html>.



Text of the regulation, available online at <http://www.regulations.gov/search/Regs/home.html#documentDetail?R=0900006480aeca2b>.

FAQs, available online at <http://www.dol.gov/ebsa/faqs/faq-dependentcoverage.html>.

Might young adults have more rights under their state's law?

Some states already have laws that allow dependents to stay on their parents' plan up to a certain age. In general, if the state law would give young adults even more rights than the new federal law, the state law still applies. If the state law is less generous, the federal law applies. Young adults and their parents can check with their health plan or their state insurance department to learn more about laws in their state.

If a plan is not yet required to allow young adults to stay on their parents' coverage, what options do they have until then to maintain their coverage?

When young adults age out of their parents' plan, they may be able to get COBRA coverage or "state continuation" coverage. If the parent has a job-based health plan and the employer had *20 or more* employees, under the federal COBRA law, the young adult can elect to stay on the plan for 18 more months and pay the full cost of premiums (both the employee share and the amount that the employer paid). If the parent has a job-based plan and the employer had *fewer than 20* employees, the young adult may have a similar right under state law, called "state continuation" coverage or "mini-COBRA."

The young adult may also be allowed to "convert" his or her coverage to an individual policy that is offered by the same insurer. In this case, the insurer may offer an individual policy that has different benefits than the coverage that the young adult had before, but which does not exclude treatment of pre-existing conditions.

You or your parent should check with your state insurance department and health plan to see if you have a right to continuation coverage or a right to convert.

Young people can also shop for coverage on the individual market or look into student health plans, but they should check carefully about what is offered to them and whether pre-existing conditions are covered.

It is especially important for young adults to avoid breaks in coverage of 63 days or more, because such gaps in coverage strip people of protections against what are known as pre-existing condition exclusions. For more information on this topic, see *Your Guide to HIPAA Protections*, sections 7 and 8, online at <http://www.familiesusa.org/issues/private-insurance/legal-rights/guide-to-hipaa-protections.html>.



For additional information:

Families USA's state guides to finding health coverage, available online at <http://www.familiesusa.org/resources/resources-for-consumers/finding-coverage-2009.html>.



The Department of Labor also provides information for consumers online at http://www.dol.gov/ebsa/consumer_info_health.html.

The Department of Health and Human Services has established a web portal that will help consumers learn more about insurance options in their state, online at <http://www.healthcare.gov>.

Is the employer's contribution to the young adult's coverage considered taxable income?

No. The IRS has issued a bulletin explaining that job-based plans can continue to cover young people on their parents' plans until they turn 26, and then throughout the remainder of the plan year (which may be up until the young adult's 27th birthday), without tax consequences.



For more information:

IRS Notice 2010-38, available online at <http://www.irs.gov/pub/irs-drop/n-10-38.pdf>.



Patients' Bill of Rights: Understanding what protections apply under "Grandfathered Plans"

The Patient Protection and Affordable Care Act (Affordable Care Act) provides many new, important protections for consumers who have or who are seeking private health insurance. These protections will help make private coverage more accessible and affordable, and they will improve the quality of coverage for enrollees. However, many of these protections apply differently to health plans that existed on the day the law was enacted, known as "grandfathered plans," than they do to new plans. Grandfathered plans are exempt from requirements to comply with some of the new consumer protections that the law includes. Congress designed the law this way in order to make sure that people who like their health plans can keep the coverage they currently have.

This fact sheet explains the requirements that health plans must meet in order to maintain their status as grandfathered plans. It also outlines which protections in the Affordable Care Act apply to grandfathered plans and which do not.

The information in this fact sheet is based on the interim final rules for grandfathered plans, for the "Patients' Bill of Rights" (a collection of patient protections that was included in the Affordable Care Act), and for internal and external appeal processes under the Affordable Care Act that the Departments of Treasury, Labor, and Health and Human Services released in the *Federal Register* on June 17, 2010, June 28, 2010, and July 23, 2010, respectively (see additional resources on page 30). This fact sheet also includes information from an amendment to the interim final rules for grandfathered plans that was released on November 17, 2010. These preliminary regulations explain which health plans may be considered to be grandfathered and how several of the consumer protections in the law will be implemented in relation to grandfathered plans.

Grandfathered Status for Plans Sold in the Individual Market

Individual market health plans that covered individuals and families on the day that the Affordable Care Act was enacted, March 23, 2010, may be considered grandfathered plans. People who are enrolled in grandfathered individual market plans can add family members to their policies without the plans' grandfathered status changing. However, if an insurer in the individual market sells a plan to someone after March 23, 2010, the plan cannot be considered grandfathered for the new purchaser. This is the case even if the plan is considered to be a grandfathered plan for others who were enrolled in it on the day that the law was enacted.

In addition, a health plan that is sold in the individual market will lose its grandfathered status for people it covered on or before March 23, 2010, if it makes significant changes to its benefits package or its costs to enrollees. These changes are described on page 27.

Grandfathered Status for Job-Based (Group) Coverage

Job-based health plans that covered workers and their families on March 23, 2010, may be considered grandfathered plans. If qualifying new enrollees join a plan that their employer already provided on that date, the plan can maintain its grandfathered status. Employers with grandfathered plans can add newly hired employees, existing employees who were not previously enrolled, and employees' family members to their health plans and still maintain the plans' grandfathered status.

Under the amendment to the interim final rules for grandfathered plans that was released in November 2010, job-based health plans may also be considered grandfathered plans if they change the insurance companies they use for coverage and those changes went into effect on or after November 15, 2010.¹ However, such plans must still cover the same benefits at the same costs to enrollees as they did with the previous insurers.

If a job-based health plan makes significant changes to its benefits package or its costs to enrollees, whether it is providing coverage through its current insurer or starting a contract with a new health insurer, it will lose its grandfathered status. These changes are described on page 27.

Changes that Cause Plans to Lose Grandfathered Status

To maintain its grandfathered status, a plan in the individual or group (job-based) market cannot significantly increase copayments or deductibles, raise co-insurance, make annual limits more restrictive or add new annual limits, significantly decrease the share of premiums that employers contribute for their workers (in group plans), or eliminate covered benefits. If plans that existed on March 23, 2010, eliminate covered benefits that are necessary to treat or diagnose a condition, or if they significantly increase costs to enrollees, they will lose their grandfathered status and be subject to all applicable consumer protections in the health reform law. Table 1 on page 27 shows these disqualifying changes in more detail.

These protections against existing health plans making significant changes to benefits and costs will safeguard consumers from eroding coverage. They will also ensure that any health plans that decrease their quality or increase their costs for enrollees will have to meet the new consumer protection standards in the Affordable Care Act.

Table 1

Changes that Disqualify Plans from Grandfathered Status

Plan Element	Disqualifying Change*
Copayment	The greater of an increase of more than \$5 (adjusted for medical inflation since March 23, 2010) or an increase above medical inflation plus 15 percentage points.
Deductible	An increase above medical inflation (since March 23, 2010) plus 15 percentage points.
Out-of-Pocket Limit	An increase above medical inflation (since March 23, 2010) plus 15 percentage points.
Co-Insurance	Any increase in the co-insurance rate after March 23, 2010.
Annual Limit	Any decrease of an annual limit that was in place on March 23, 2010, disqualifies a plan. Adoption of a new annual limit for plans that did not have one on March 23, 2010, also disqualifies a plan.**
Employer Premium Contribution Rate (in group plans)	A decrease of more than 5 percentage points below the existing employer contribution rate as of March 23, 2010.
Benefits Package	The elimination of all or substantially all covered benefits to diagnose or treat a particular condition after March 23, 2010.

* See the interim final rule on grandfathered plans listed under “Additional Resources” for information regarding exceptions to the March 23, 2010, date. Exceptions may apply to plans that had already filed pending changes at the time that health reform was enacted.

** If a plan had a lifetime limit but no annual limit on March 23, 2010, it may replace its lifetime limit with an annual limit while maintaining its grandfathered status, as long as the annual limit has a dollar value that is equal to or greater than the previous lifetime limit.

How Provisions in the Affordable Care Act Apply to Grandfathered Plans

Some provisions of the Affordable Care Act apply differently to grandfathered plans than they do to new plans. Table 2 on pages 28 and 29 shows which consumer protections apply to grandfathered plans and which do not, according to information available in the interim final rules for grandfathered plans, the Patients’ Bill of Rights, and internal and external appeal processes under the Affordable Care Act. Since some provisions apply differently to grandfathered plans that are purchased by individuals or families directly (in the individual market) than they do to grandfathered plans that are offered by employers (group plans), the plans are also broken down according to whether they are in the group or individual market.

The interim final rules on grandfathered plans, the Patients’ Bill of Rights, and internal and external appeal processes do not address all of the provisions of the Affordable Care Act that affect private insurance plans. Therefore, there is still some uncertainty regarding how other consumer protections in the law will apply to grandfathered plans in the group and individual markets. Future regulations will need to resolve these issues. Consumers will benefit from having as many protections as possible applied to grandfathered plans, as numerous provisions of the Affordable Care Act can be applied to such plans without disrupting the coverage that enrollees currently have.

Table 2

Which Affordable Care Act Provisions Apply to Grandfathered Plans?

Provision	Date It Goes into Effect	Does It Apply to Grandfathered Group Plans?	Does It Apply to Grandfathered Individual Market Plans?
Young adults can stay on their parents' health plans until age 26	Health plan years starting on or after September 23, 2010*	YES, with one exception: Until 2014, this provision applies only if a young adult does not have another offer of job-based coverage (excluding an offer from another parent's job-based plan).	YES
Prohibition of pre-existing condition exclusions for children under age 19	Health plan years starting on or after September 23, 2010	YES	NO
Preventive services covered with no cost-sharing	Health plan years starting on or after September 23, 2010	NO	NO
Restriction on annual limits in coverage	Health plan years starting on or after September 23, 2010	YES	NO
Prohibition of lifetime limits in coverage	Health plan years starting on or after September 23, 2010	YES	YES
Prohibition against unfair rescissions of coverage	Health plan years starting on or after September 23, 2010	YES	YES
Direct access to OB/GYNs without a referral; pediatricians can be classified as primary care providers; Enrollees must have choice of primary care providers	Health plan years starting on or after September 23, 2010	NO	NO
No higher cost-sharing for out-of-network emergency services (compared to in-network); no prior authorization requirements for emergency care	Health plan years starting on or after September 23, 2010	NO	NO
Right to internal and external appeals of insurer decisions	Health plan years starting on or after September 23, 2010	NO	NO

Table 2 (continued)

Which Affordable Care Act Provisions Apply to Grandfathered Plans?

Provision	Date It Goes into Effect	Does It Apply to Grandfathered Group Plans?	Does It Apply to Grandfathered Individual Market Plans?
Medical loss ratio requirements for fully insured plans: Insurers must spend a set share of premium dollars on medical care and quality improvements* *	2011	YES	YES
Development and use of uniform explanation of coverage documents and standardized definitions for health insurance terms	By March 23, 2011	YES	YES
Prohibition of pre-existing condition exclusions for enrollees of all ages	2014	YES	NO
Prohibition of annual limits in coverage	2014	YES	NO
Prohibition of waiting periods exceeding 90 days for coverage in job-based plans	2014	YES	N/A

Table Notes

* When this provision and others that take effect in health plan years starting on or after September 23, 2010, will actually apply for individual consumers depends on when their health plan starts its year. For example, some health plan years start in October, whereas others, such as the Federal Employees Health Benefits Program (FEHBP) plan year, do not start until January. After September 23, 2010, whenever an individual's health plan year starts again is when the provision will apply to him or her.

** Self-insured plans are exempt from this provision. Self-insured plans are those in which a large employer directly pays the costs of employee claims for medical care, instead of purchasing health insurance for its workers. Self-insured plans still usually collect premiums from employees and may contract with a health insurer to administer claims and coverage for employees, but the employer bears the risk of employee medical costs.

Conclusion

By creating a foundation of consumer protections, including many for grandfathered plans, the Affordable Care Act will ensure that health coverage is accessible and affordable for consumers. Strong requirements for existing plans to maintain their quality and affordability in order to remain grandfathered will protect consumers from thinning coverage, and new protections for plans that are not grandfathered will make sure that newly sold plans meet the needs of consumers and provide good value for their money.

¹ If job-based health plans changed insurance carriers after March 23, 2010, but before November 15, 2010, they may not retain their grandfathered status.

Additional Resources

For more on grandfathered plans, see the following resources:

- *Keeping the Health Plan You Have: The Affordable Care Act and “Grandfathered” Plans* (Department of Health and Human Services), available online at http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.
- *Amendment to Regulation on “Grandfathered” Health Plans under the Affordable Care Act (Fact Sheet)* (Department of Health and Human Services), available online at <http://www.hhs.gov/ociio/regulations/grandfather/factsheet.html>.
- *Interim Final Rule on Grandfathered Plans* (Departments of Health and Human Services, Labor, and Treasury, printed in the *Federal Register* on June 17, 2010), available online at <http://www.regulations.gov/search/Regs/contentStreamer?objectId=0900006480b03a90&disposition=attachment&contentType=pdf>.
- *Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act* (Departments of Health and Human Services, Labor, and Treasury, printed in the *Federal Register* on November 17, 2010), available online at <http://www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-28861.pdf>.
- *Interim Final Rule on the Patients’ Bill of Rights* (Departments of Health and Human Services, Labor, and Treasury, printed in the *Federal Register* on June 28, 2010), available online at <http://www.regulations.gov/search/Regs/contentStreamer?objectId=0900006480b0b97c&disposition=attachment&contentType=html>.
- *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act* (Departments of Health and Human Services, Labor, and Treasury, printed in the *Federal Register* on July 23, 2010), available online at <http://edocket.access.gpo.gov/2010/2010-18043.htm>.

Individual fact sheets on these protections and other resources can be found online at <http://www.familiesusa.org/health-reform-central/september-23/>

*For more about the health care act, visit
[Http://familiesusa.org/health-reform-central/](http://familiesusa.org/health-reform-central/)*



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