



KNOW YOUR EMPLOYEE BENEFITS



Benefit and insurance issues important to you—brought to you by the insurance specialists at Holmes Murphy and Associates, Inc..

The Affordable Care Act's New Patients' Bill of Rights

A major goal of the Affordable Care Act – the health insurance reform legislation President Obama signed into law on March 23 – is to put American consumers back in charge of their health coverage and care.

Recently, a new Patients' Bill of Rights under the Affordable Care Act was issued. It will help children (and eventually all Americans) with pre-existing conditions gain coverage and keep it, protect all Americans' choice of doctors and end lifetime limits on the care consumers may receive.

Many of these plan protections apply to health plans with their next renewal. For the Atlantic School District plans these changes are effective July 1, 2011.

New Consumer Protections Start As Early As This Fall
The new Patients' Bill of Rights regulations detail a set of protections that apply to

health coverage starting on or after September 23, 2010. They are:

No Pre-Existing Condition Exclusions for Children Under Age 19.

The new regulations will prohibit insurance plans from denying coverage to children based on pre-existing conditions. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for a child with cancer because the child had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy for the child because of the child's pre-existing medical condition). These protections will apply to all types of insurance except for individual policies that are "grandfathered," and will be extended to Americans of all ages starting in 2014.

No Arbitrary Rescissions of Insurance Coverage. Right now, insurance companies are able to retroactively cancel

your policy when you become sick, or if you or your employer made an unintentional mistake on your paperwork.

Under the regulations, insurers and plans will be prohibited from rescinding coverage – for individuals or groups of people – except in cases involving fraud or an intentional misrepresentation of material facts. Insurers and plans seeking to rescind coverage must provide at least 30 days advance notice to give people time to appeal. There are no exceptions to this policy.

No Lifetime Limits on 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. This regulation prohibits the use of lifetime limits in all health plans and insurance policies issued or renewed on or after September 23, 2010.

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Restricted Annual Dollar Limits on Coverage. Annual dollar limits on what an insurance company will pay for health care will phase out over the next three years until 2014, when the Affordable Care Act bans them for most plans. However, employers who demonstrate that current annual limits are necessary to prevent a significant loss of coverage or increase in premiums will be allowed to delay complying with these rules. Limited benefit insurance plans – which are often used by employers to provide benefits to part-time workers — are examples of insurers that might seek this kind of delay. These restricted annual dollar limits apply to all insurance plans except for individual market plans that are grandfathered.

Protecting Your Choice of Doctors. Being able to choose and keep your doctor is a key principle of the Affordable Care Act. The new rules make clear that health plan members are free to designate any available participating physician as their primary care provider. The rules allow parents to choose any available participating pediatrician to be their children's primary care provider. These policies apply to all individual market and group health insurance plans except those that are grandfathered.

Removing Insurance Company Barriers to Emergency Department Services. Some insurers will only pay for health care provided by a limited number

or network of providers – including emergency health care. Others require prior approval before receiving emergency care at hospitals outside of their networks.

The new rules make emergency services more accessible to consumers and limit the amount of cost-sharing for emergency services received out of network.

The rules also set requirements on how health plans should reimburse out-of-network providers. This policy applies to all individual market and group health plans except those that are grandfathered.

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