Affordable Care Act Basics
From: http://www.hhs.gov/healthcare/rights/

About the Law

The Affordable Care Act puts consumers back in charge of their health care. Under the law, a new “Patient’s Bill of Rights” gives the American people the stability and flexibility they need to make informed choices about their health.

Coverage

- Ends Pre-Existing Condition Exclusions for Children: Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
- Keeps Young Adults Covered: If you are under 26, you may be eligible to be covered under your parent’s health plan.
- Ends Arbitrary Withdrawals of Insurance Coverage: Insurers can no longer cancel your coverage just because you made an honest mistake.
- Guarantees Your Right to Appeal: You now have the right to ask that your plan reconsider its denial of payment.

Costs

- Ends Lifetime Limits on Coverage: Lifetime limits on most benefits are banned for all new health insurance plans.
- Reviews Premium Increases: Insurance companies must now publicly justify any unreasonable rate hikes.
- Helps You Get the Most from Your Premium Dollars: Your premium dollars must be spent primarily on health care – not administrative costs.

Care

- Covers Preventive Care at No Cost to You: You may be eligible for recommended preventive health services. No copayment.
- Protects Your Choice of Doctors: Choose the primary care doctor you want from your plan’s network.
- Removes Insurance Company Barriers to Emergency Services: You can seek emergency care at a hospital outside of your health plan’s network.

Young Adult Coverage

Under the Affordable Care Act, if your plan covers children, you can now add or keep your children on your health insurance policy until they turn 26 years old.

What This Means for You

Before the health care law, insurance companies could remove enrolled children usually at age 19, sometimes older for full-time students. Now, most health plans that cover children must make coverage available to children up to age 26. By allowing children to stay on a parent's plan, the law makes it easier and more affordable for young adults to get health insurance coverage.

Your children can join or remain on your plan even if they are:

- Married
- not living with you
- attending school
- not financially dependent on you
- eligible to enroll in their employer's plan

There is one temporary exception: Until 2014, grandfathered group plans do not have to offer dependent coverage up to age 26 if a young adult is eligible for group coverage outside their parent's plan.

Some Important Details

- Your plan is required to provide a 30-day period — no later than the first day of your plan's next play or policy year that begins on or after September 23, 2010 — to allow you to enroll your adult child. Your plan must notify you of this enrollment opportunity in writing.
- If you enroll your adult child during this 30-day enrollment period, your plan must cover your adult child from the first day of that plan year or policy year.

Plain Language Benefits Information

As of September 23, 2012 or soon after, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The new regulation is designed to help you better understand and evaluate your health insurance choices.

The new forms include:

- A short, plain language Summary of Benefits and Coverage, or SBC
- A uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment"

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for or enrolling in coverage or if you request a copy from your issuer or group health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan.

What This Means for You

It's not easy for consumers to know what they are buying when shopping for insurance. The new rules are a joint effort among the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. The SBC is designed after the Nutrition Facts label required for packaged foods which helps you make healthy and informed decisions about your diet. The SBC's standardized and easy to understand information about health plan benefits and coverage allows you to more easily make "apples to apples" comparisons among your insurance options. The measure brings more openness to the insurance marketplace for the more than 180 million Americans with private health coverage.

Some Important Details

- This provision applies to *all* health plans, whether you get coverage through your employer or purchase it yourself, beginning September 23, 2012.
- All health plans must provide an SBC to shoppers and enrollees at important points in the enrollment process, such as upon application and at renewal.
- The coverage examples give a general sense of how a plan would cover the normal delivery of a baby, and services to help a person control type 2 diabetes.

- If you don’t speak English, you may be entitled to receive the SBC and uniform glossary in your native language upon request.

Cancellation & Appeals

Curbing Insurance Cancellations

Insurance Companies can no longer cancel your coverage just because you made an honest mistake on your application.

Appealing Health Plan Decisions

You have the right to ask your plan to reconsider a denial of payment for services.

Lifetime & Annual Limits

The Affordable Care Act prohibits health plans from putting a lifetime dollar limit on most benefits you receive. The law also restricts and phases out the annual dollar limits a health plan can place on most of your benefits — and does away with these limits entirely in 2014.

What This Means for You

Before the health care law, many health plans set an annual limit — a dollar limit on their yearly spending for your covered benefits. Many plans also set a lifetime limit — a dollar limit on what they would spend for your covered benefits during the entire time you were enrolled in that plan. You were required to pay the cost of all care exceeding those limits.

- Under the law, *lifetime* limits on most benefits are prohibited in any health plan or insurance policy issued or renewed on or after September 23, 2010.
- The law restricts and phases out the *annual* dollar limits that all job-related plans, and individual health insurance plans issued after March 23, 2010, can put on most covered health benefits. Specifically, the law says that none of these plans can set an annual dollar limit lower than:
    - $750,000: for a plan year or policy year starting on or after September 23, 2010 but before September 23, 2011.
    - $1.25 million: for a plan year or policy year starting on or after September 23, 2011 but before September 23, 2012.
    - $2 million: for a plan year or policy year starting on or after September 23, 2012 but before January 1, 2014.
- No annual dollar limits are allowed on most covered benefits beginning January 1, 2014.

Some Important Details

- Be aware that plans can put an annual dollar limit and a lifetime dollar limit on spending for health care services that are not considered "essential."
- If the new rules apply to your plan, they will affect you as soon as you begin a new plan year or policy year on or after September 23, 2010. (For example, if your policy has a calendar plan year, the new rules would apply to your coverage beginning January 1, 2011).
- If you have a "grandfathered" individual health insurance policy, your health plan is not required to follow the new rules on annual limits. (A grandfathered individual health insurance policy is a plan that you bought for yourself or your family; that you did not receive through your employer; and that was issued on or before March 23, 2010.) If you're not sure whether your plan is grandfathered, ask your insurance company.
- The ban on lifetime dollar limits for most covered benefits applies to every health plan — whether you buy coverage for yourself or your family, or you receive coverage through your employer.
- Some plans may be eligible for a waiver from the rules concerning annual dollar limits, if complying with the limit would mean a significant decrease in your benefits coverage or a significant increase in your premiums.

Preventive Care

Under the Affordable Care Act, you and your family may be eligible for some important preventive services — which can help you avoid illness and improve your health — at no additional cost to you.

What This Means for You

If your plan is subject to these new requirements, you may not have to pay a copayment, co-insurance, or deductible to receive recommended preventive health services, such as screenings, vaccinations, and counseling.

For example, depending on your age, you may have access — at no cost — to preventive services such as:

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, andreducing alcohol use

- Regular well-baby and well-child visits, from birth to age 21
- Routine vaccinations against diseases such as measles, polio, or meningitis
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Flu and pneumonia shots - Visit Vaccines.gov to learn more

Some Important Details

This preventive services provision applies only to people enrolled in job-related health plans or individual health insurance policies created after March 23, 2010. If you are in such a health plan, this provision will affect you as soon as your plan begins its first new "plan year" or "policy year" on or after September 23, 2010.

Top things to know about preventive care and services:

- Grandfathered plans: If your plan is "grandfathered," these benefits may not be available to you.
- Network providers: If your health plan uses a network of providers, be aware that health plans are required to provide these preventive services only through an in-network provider. Your health plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.
- Office visit fees: Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.
- Questions: If you have questions about whether these new provisions apply to your plan, contact your insurer or plan administrator. If you still have questions, contact your state insurance department.
- Talk to your health care provider: To know which covered preventive services are right for you — based on your age, gender, and health status — ask your health care provider.

ER Access & Doctor Choice

The Affordable Care Act helps preserve your choice of doctors by guaranteeing that you can choose the primary care doctor or pediatrician you want from your health plan's provider network. It guarantees that you can see an OB-GYN doctor without needing a referral from another doctor. The law also ensures that you can seek emergency care at a hospital outside your plan's network without prior approval from your health plan.

What This Means for You

- **You select the doctor**: The new rules permit you to choose any available participating primary care provider as your doctor and to choose any available participating pediatrician as your child's primary care doctor.
- **No health plan barriers to OB-GYN services**: The new rules also prohibit health plans from requiring a referral from a primary care provider before you can seek coverage for obstetrical or gynecological (OB-GYN) care from a participating OB-GYN specialist.
- **Access to out-of-network emergency room services**: In the past, some health plans would limit payment for emergency room services provided outside of a plan's preselected network of emergency health care providers. Or they would require you to get your plan's prior approval for emergency care at hospitals outside its networks. This could mean financial hardship if you get sick or injured while away from home. The new rules prevent health plans from requiring higher copayments or co-insurance for out-of-network emergency room services. The new rules also prohibit health plans from requiring you to get prior approval before seeking emergency room services from a provider or hospital outside your plan's network.

Some Important Details

- These rules apply to all group health plans and individual health insurance policies created or issued after March 23, 2010.
- These rules do not apply to "grandfathered health plans."
- If your health plan or health insurance policy was created or issued after March 23, 2010, your plan will be affected as soon as it begins a new "plan year" or "policy year" on or after September 23, 2010.
- Please note that you still may be responsible for the difference between the amount billed by the provider for out-of-network emergency room services and the amount paid by your health plan.