



Patient's Bill of Rights FAQs

The Patient Protection and Affordable Care Act (“PPACA”) was enacted on March 23, 2010. It contains several provisions designed to afford individuals greater access to health care. These provisions will take effect beginning in September 2010. This FAQ discusses these protections which collectively are referred to by PPACA as the “Patient’s Bill of Rights”.

Pre-existing Conditions and Coverage for Children

The first protection for consumers is that health care plans are prohibited from denying coverage to children based on pre-existing conditions.

1. Q: What is a pre-existing condition?

A: A pre-existing condition is a condition a child had before getting insurance. Insurers or employer health plans may not refuse to pay for covered treatment of the pre-existing condition. For example, an insurer or employer health plan may not refuse to pay for chemotherapy for a child with cancer because the child had the cancer before getting insurance.

2. Q: Can an insurer refuse to offer a policy to a family that covers the child because of the child’s pre-existing medical condition?

A: No, the insurer may not deny coverage to the child because of a pre-existing medical condition. These protections will apply to children under age 19 in health plans or group or individual insurance for plan or policy years beginning on or after September 23, 2010. Group policies that are “grandfathered” will include this coverage but individual “grandfathered” policies are not required to. For individuals **age 19 and over**, this provision applies for plan years beginning on or after **January 1, 2014**.

3. Q: If I have a pre-existing condition, how can I get coverage this year?

A: Beginning September 1, 2010, you may be eligible to receive coverage through the new Ohio High-Risk pool. Please consult the High-Risk Pool FAQs <http://www.healthcarereform.ohio.gov/Documents/HighRiskPoolFAQs.pdf> to determine if you are eligible.

Rescissions

A second protection for consumers is that health care plans are prohibited from rescinding coverage in most circumstances.

1. Q: What is a “rescission” of health coverage?

A: A rescission is a cancellation or termination of coverage that has a *retroactive* effect, meaning that the coverage is cancelled back to the first day of coverage. It is as though the coverage had never existed.

2. Q: When can your coverage be rescinded?

A: In Ohio, health insurance companies have the right to cancel or terminate your health insurance coverage if you commit fraud or make a material misrepresentation or omission on your health application. When the insurer establishes that either of these events has occurred, it can void the policy as of the date it was first effective. This means that it will not pay any claims you have incurred.

Accredited by the National Association of Insurance Commissioners (NAIC)

Consumer Hotline: 1-800-686-1526

Fraud Hotline: 1-800-686-1527

OSHIP Hotline: 1-800-686-1578

TDD Line: (614) 644-3745

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3. Q: To what kind of plans do the new rescission laws apply?

A: This law applies to all rescissions, whether they occur in the group or individual insurance market, including grandfathered coverage and self-insured coverage.

4. Q. What does “material misrepresentation” mean?

A: It means information that, had the insurer known about at the time of application, the policy would either not have been issued or would have been issued at a higher premium.

5. Q: If I accidentally left a field blank on my health insurance application, can my coverage be rescinded?

A: No. Ohio law will not permit an insurer to terminate a health policy unless you commit fraud or intentionally misrepresent information that is material or important.

6. Q: How do the new federal rescission provisions differ from Ohio's existing law?

A: Ohioans have always had strong protection against unjustified rescissions. The new federal law will not have a large impact on Ohio consumers because Ohio law already provides consumers with these protections. The new federal law requires the insurer or health plan to provide 30 calendar days' advance notice of a rescission. This notice provision is a new protection for Ohioans and was not previously required under Ohio law.

7. Q: Does an insurer need to notify me before rescinding my health insurance plan?

A: An insurer must provide at least 30 calendar days advance notice to you before rescinding your coverage. This 30-day period will provide you with an opportunity to explore your rights to contest the rescission, or look for alternative coverage.

8. Q: If I receive notice that my policy is about to be rescinded, what can I do?

A: You can appeal the rescission decision through the insurer's internal appeal procedure and then to the Ohio Department of Insurance Consumer Services Division at <http://www.insurance.ohio.gov/Pages/ComplaintMain.aspx>; or call 1-800-686-1526.

Patient Protections

1. Q: What special requirements are included in the new federal health care law to protect patients?

A: The patient protections in the new federal law that go into effect on September 23, 2010 include:

- (1) choice of health care professional;
- (2) the ability to obtain health care from a professional who specializes in obstetrics or gynecology without a prior authorization; and
- (3) benefits with respect to emergency services.

2. Q: What does it mean to have a choice of health care professional?

A: If the plan requires insureds or enrollees to have a primary care provider, the new law requires the plan to allow the insured or enrollee to select his/her primary health care provider as opposed to the plan selecting the primary care provider. Parents may choose a pediatrician as their child's primary care provider.

3. Q: How will I know about the patient protection requirements in my health plan?

A: The group health plan or insurer will provide you with a notice that will tell you about these patient protections. The notice must be provided whenever the group health plan or insurer provides the participant with a summary plan description or similar description of benefits or provides the primary subscriber with a policy, certificate, or contract of health insurance.

4. Q: Can I make an appointment with an in-network health care professional who specializes in obstetrics or gynecology without obtaining preauthorization from my primary care provider?

A: Yes. The group health plan or insurer may not require authorization or a referral for obstetrical or gynecological care if the health care provider is part of the plan's network of providers.

5. Q: Who is considered a "health care professional who specializes in obstetrics or gynecology"?

A: An individual who specializes in obstetrics or gynecology and is authorized [licensed] under applicable state law to provide obstetrical or gynecological care. Note that the definition is not limited to a physician.

6. Q: Does my obstetrical or gynecological health provider still need to notify my primary care provider of treatment decisions?

A: Yes, but only if the group health plan or insurer requires the obstetrical or gynecological provider to notify your primary care provider or plan of treatment decisions.

7. Q: Can my health plan require prior authorization before I receive certain obstetrical or gynecological treatments?

A: Yes, plans may require prior authorization for specific treatments as long as the prior authorization does not restrict access to providers specializing in obstetrics or gynecology.

8. Q: Can my plan require prior authorization or cover fewer services if I receive emergency care from a hospital that is not in the plan's network?

A: No. The plan may not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive emergency care from a hospital that is not in your plan's network.

9. Q: How does the health plan determine what to pay for my out of network emergency care?

A: When there is no agreement on what the provider will be paid because the emergency room is not in the network, the federal law requires the plan to calculate what amount should be paid for the emergency care in three different ways and pay the greater of the three amounts. The three amounts are 1) the amount the plan has negotiated to pay to in-network providers for the same service; 2) the amount that would be paid for the service using the same method the plan generally uses to determine out of network services (such as the usual, customary or reasonable amount); or 3) the amount that would be paid under Medicare for the service. All three of these amounts are calculated before application of the copayments or coinsurance that generally applies to in network services under the plan.

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10. Q: Can you give me an example of what the law will require the plan to pay for out of network emergency care?

A: Yes. An individual receiving emergency care is responsible for 20% of the provider's charge and the plan will pay 80%. If the hospital emergency room is not in the plan's network, there is no contract specifying how much the plan and the individual will pay for the emergency care. The plan pays in-network providers \$110 for the service, it calculates the usual, customary and reasonable amount for the service to be \$80, and Medicare pays \$70 for the same service. The plan is required to pay 80% of the higher amount, \$110 (\$88) for the service received out of network.

11. Q: How much can a health plan charge me for out of network emergency care?

A: The federal law requires a plan to apply the same copayments and coinsurance for out-of-network emergency services as it requires for in-network emergency services. However, if you use an out-of-network emergency service provider, the provider may send you a bill for any balance remaining after your health plan has paid (called "balance billing"). There is nothing in the statute or regulations that prevent an out-of-network health care provider from balance billing.

12. Q. Can you give me an example of how balance billing works?

A: Yes. Using the numbers from the example above, the plan is required to pay 80% of \$110 or \$88 for the emergency service received out of network. You are responsible for the co-payment of 20% of \$110 or \$22. However, if the out of network provider's bill is \$200, you are also responsible for the balance of the total of the bill minus what has been paid (\$200-\$110=\$90). In this example, receiving emergency services from the out of network emergency room will cost \$22 for the copayment and \$90 for the balance bill, for a total of \$112.

Limits

1. Q: What *lifetime* limits can be placed on what insurers pay for my medical care?

A: For plan or policy years beginning on or after **September 23, 2010**, health plans and health insurance companies providing group or individual coverage, will be prohibited from placing lifetime dollar limits on what they will pay for your medical care. The plan must remove any contract provision that limits the lifetime dollar value for "essential" health benefits that may be in your coverage. If a benefit is not considered an "essential" health care benefit, the plan can impose a lifetime limit on that particular benefit. "Essential" health care benefits include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use 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, including oral and vision care.

2. Q: If I have already reached a lifetime limit on my coverage, am I eligible to re-enroll for coverage now?

A: Yes. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to re-enroll. You should receive a notice from your prior plan explaining this opportunity and providing you 30 days from when you receive the notice to enroll in the plan.

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3. Q: What *annual* limits can be placed on what insurers pay for my medical care?

A: For plan or policy years beginning on or after **September 23, 2010**, health plans and health insurance companies providing group or individual coverage will be allowed to set annual limits for “essential” health benefits no lower than \$750,000. This minimum limit will be raised to \$1.25 million beginning September 23, 2011, and to \$2 million beginning on September 23, 2012. For plan or policy years beginning on or after January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.

Employers and insurers that want to delay complying with these rules will have to win permission from the Federal government by demonstrating that their current annual limits are necessary to prevent a significant loss of coverage or increase in premiums. 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.