

**Fact Sheet: The Affordable Care Act:
Protecting Consumers and Putting Patients Back in Charge of Their Care
July 22, 2010**

The Affordable Care Act will help support and protect consumers and end some of the worst insurance company abuses. For too long, consumers have been forced to fend for themselves in a health care system that did not provide them with the support and assistance they needed and deserved. Today, the Obama Administration is announcing new regulations that will allow consumers to appeal decisions made by their health plans and the availability of resources that will be used to help give consumers more control of their health care decisions. Today's announcements include:

- **New regulations that give consumers in new health plans in every State the right to appeal decisions, including claims denials and rescissions, made by their health plans.¹** The rules issued by the Departments of Health and Human Services, Labor, and the Treasury give consumers:
 - The right to appeal decisions made by their health plan through the plan's internal process,
 - For the first time, the right to appeal decisions made by their health plan to an outside, independent decision-maker, no matter what State they live in or what type of health coverage they have. States will work to establish or update their external appeals process to meet new standards, and consumers who are not protected by a State law will have access to a Federal external review program.

Next year, an estimated 31 million people in new employer plans and 10 million people in new individual plans will benefit from the new appeals rights announced today. The number of individuals in employer plans who will benefit is expected to rise to 78 million by 2013, for a total potential of 88 million Americans who will be guaranteed the right to appeal decisions made by their health plan.

- **A \$30 million grant program to establish and strengthen consumer assistance offices in States and Territories.** The new Consumer Assistance Grants Program will help States establish consumer assistance offices or strengthen existing ones. The new funds will be used to provide consumers with the information they need to pick from a range of coverage options that best meets their needs.

New Regulations To Help Consumers Appeal Decisions By Their Health Plans

¹ To help individuals who like the coverage they have keep it, some plans that were in effect on March 23, 2010, and that were not significantly modified thereafter will be "grandfathered." Grandfathered health plans are not subject to these regulations. For more information about the definition of a grandfathered plan, see http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

The new rules issued by the Departments of Health and Human Services, Labor, and the Treasury will standardize both an internal process and an external process that patients can use to appeal decisions made by their health plan.

Today, if your health plan tells you it won't cover a treatment your doctor recommends, or it refuses to pay the bill for your child's last trip to the emergency room, you may not know where to turn. Most health plans have a process that lets you appeal the decision within the plan through an "internal appeal" – but depending on your State's laws and your type of coverage, there's no guarantee that the process will be swift and objective. Moreover, if you lose your internal appeal, you may not be able to ask for an "external appeal" to an independent reviewer.

The rules issued today will end the patchwork of protections that apply to only some plans in some States, and simplify the system for consumers. And they will ensure that all consumers in new health plans have access to internal and external appeals processes that are clearly defined, impartial, and designed to ensure that, when health care is needed and covered, consumers get it.

Internal Appeals

The internal appeals process will guarantee a venue where consumers may present information their health plan might not have been aware of, giving families a straightforward way to clear up misunderstandings. Under the new rules, new health plans beginning on or after September 23, 2010 must have an internal appeals process that:

- Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
- Gives consumers detailed information about the grounds for the denial of claims or coverage;
- Requires plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;
- Ensures a full and fair review of the denial; and
- Provides consumers with an expedited appeals process in urgent cases.

External Appeals

If a patient's internal appeal is denied, patients in new plans will have the right to appeal all denied claims to an independent reviewer not employed by their health plan. External appeals have helped consumers get the care they deserve: one study found that – in States that had external appeals – consumers won their external appeal against the insurance company 45% of the time.²

While 44 States provide for some form of external appeal, the laws governing these processes vary greatly and fail to cover millions of Americans. The new rules will ensure that consumers with new health coverage in all States have access to a standard external appeals process that meets high standards for full and fair review.

² Kaiser Family Foundation, *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation*, 2002. <http://www.kff.org/insurance/externalreviewpart2rev.pdf>.

These standards were established by the National Association of Insurance Commissioners (NAIC). States are encouraged to make changes in their external appeals laws to adopt these standards before July 1, 2011. The NAIC standards call for:

- **External review of plan decisions** to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- **Clear information** for consumers about their right to both internal and external appeals – both in the standard plan materials, and at the time the company denies a claim.
- **Expedited access** to external review in some cases – including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
- **Health plans must pay the cost of the external appeal** under State law, and States may not require consumers to pay more than a nominal fee.
- **Review by an independent body** assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
- **Emergency processes for urgent claims**, and a process for experimental or investigational treatment.
- **Final decisions must be binding** so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.

If State laws don't meet these standards, consumers in those States will be protected by comparable Federal external appeals standards. In addition, people in health plans that are not subject to State law – including new self-insured employer plans – will be protected by the new Federal standards.

New Consumer Assistance Grants

The Affordable Care Act provides consumers with significant new protections including the ability to choose a health plan that best suits their needs, to appeal decisions by plans to deny coverage of needed services, and to select an available primary care provider of their choosing. The new Consumer Assistance Grants program will provide nearly \$30 million in new resources to help States and Territories educate consumers about their health coverage options, empower consumers, and ensure access to accurate information. Grants will be made available to support States' efforts to establish or strengthen consumer assistance programs that provide direct services to consumers with questions or concerns regarding their health insurance.

All States and Territories may apply for these grants, which will help expand consumer assistance efforts on the State level, including:

- Helping consumers enroll in health coverage;
- Helping consumers file complaints and appeals against health plans;
- Educating consumers about their rights and empowering them to take action; and
- Tracking consumer complaints to help identify problems and strengthen enforcement.

Eligible applicants include State insurance departments, State attorneys general offices, independent State consumer assistance agencies, or other State agencies. States and Territories may also partner with non-profit organizations that have a track record of working with consumers. Applications are available now by visiting www.Grants.gov and searching for CFDA number 93.519.

What Will This Mean for You?

- Under these rules, if your health plan denies coverage of a test – for example an MRI – you and your doctor can appeal that decision to the plan and, if the plan still refuses to cover the test, to an external reviewer. If the external reviewer agrees with you, your plan must pay for the test.
- If your plan decides to rescind your coverage altogether based on the fact that information on your application for coverage was not accurate, you can appeal that decision. If your appeal is successful, the plan must reinstate your coverage.
- If you go to the emergency room and your plan won't pay the bill, you'll have the chance to provide information to the plan about why you needed emergency care – and take your request to an external reviewer if your appeal to the plan is denied.

Consumer Assistance Grants have the potential to benefit millions of Americans. These grants will fund programs that will support consumers both now as we transition to a more competitive, patient-centered health insurance marketplace in 2014 and once that new marketplace is established.

- If you learn that your employer is cancelling coverage, and you know it will be hard to find coverage for your family on the individual market, you may need someone to help explain your options. A State consumer assistance program will provide that support, helping you figure out what you need, describing ways you can get coverage, and ultimately helping you enroll in coverage.
- Just last year, one State's existing consumer assistance program helped nearly 3,000 residents and recovered over \$7 million in benefits on behalf of consumers. In another State, a similar program assisted about 13,000 residents and helped nearly 8,000 of them enroll in coverage.

Builds on Other Initiatives to Protect Patients' Rights

The rules released today build on a series of efforts under the Affordable Care Act to strengthen consumer and patient rights. Other actions include:

- **Prohibiting Insurance Companies from Rescinding Coverage.** In the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny coverage when he or she got sick. The new law makes this practice illegal.

- **Extending Coverage for Young Adults.** Under the new law, starting next year, young adults will be allowed to stay on their parent's plan until they turn 26 years old. (In the case of grandfathered group health plans, this right does not apply if the young adult has available health coverage at work.) Some plans have begun implementing this policy early. Check with your insurance company or employer to see if you qualify.
- **Eliminating Lifetime Limits on Coverage.** Under the new law, health plans will be prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays.
- **Regulating Annual Dollar Limits on Insurance Coverage.** Under the new law, health plans' use of annual dollar limits on the amount of insurance coverage a patient may receive will be restricted for new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans.
- **Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions.** The law prohibits insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition.