DEPARTMENT OF HEALTH & HUMAN SERVICES

Center for Consumer Information and Insurance Oversight

200 Independence Avenue SW
Washington, DC 20201

Learn about…

New Consumer Protections Under the Affordable Care Act

Protecting Your Choice of Health Care Providers

The Affordable Care Act removes health plan barriers between you and your doctor.

Read more below and at www.HealthCare.gov.

How does the Affordable Care Act preserve my choice of doctors?

The Affordable Care Act provides important new protections in many plans. It guarantees that you can choose the primary care doctor or pediatrician you want from your health plan's provider network. It ensures that you can see an OB-GYN doctor (a specialist in obstetrical or gynecological care) without a referral from another doctor. The law also guarantees that you can seek emergency care at a hospital outside your plan's network without prior approval from your health plan.

The Affordable Care Act is the name given to the comprehensive health care reform law enacted on March 23, 2010.

What does this mean for me?

You select the doctor: The new rules permit you to choose any available participating primary care provider to be your primary care doctor. You can choose any available participating pediatrician to be your child's primary care doctor.

No barriers by your insurance plan to OB-GYN services: The new rules also prohibit health plans from requiring a referral before you can seek 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 network of providers or would require that you get your plan's prior approval for emergency care at hospitals outside of the network. This meant financial hardship if you got sick or were injured while away from home. The new rules generally prevent health plans from having higher copayments or coinsurance for emergency room services that are obtained outside of your plan's network.

The new rules also prohibit plans from requiring you to get prior approval before seeking emergency room services from a provider or hospital outside of your plan's network.

NOTE: While the health plan is required to reimburse the emergency room a reasonable amount, you may still 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.

Did you know?

People who have a regular primary care provider:

Are more than twice as likely to receive recommended preventive care;

Are less likely to be hospitalized;

Are more satisfied with the health care system;

Have lower costs.

Do these patient protections apply to my health plan?

These rules apply to all employment-based group health plans and to all individual health insurance policies that are created after March 23, 2010.

These protections **may not apply** to employment-based group health plans and individual health insurance policies that already existed on or before March 23, 2010, because these may be "grandfathered," or exempted from some provisions of the Affordable Care Act in order to ensure that people who like their current coverage can keep it. Your health policy or plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor (for consumers in employment-based group health plans) or the U.S. Department of Health and Human Services (for those with individual health insurance policies) for further information.

When do these protections take effect?

If your plan is not "grandfathered" (see above), these protections will affect you when you start a new "plan year" or "policy year" on or after September 23, 2010.

A **plan year** refers to a 12-month period of benefits coverage—which may not be the same as the calendar year. This period is called a **policy year** for individual health insurance policies. To find out when your plan or policy year begins, you can check your plan or policy documents or contact your employer or insurer. For example: if your plan has a calendar plan year, the new rules would apply to your coverage beginning January 1, 2011.

What other protections does the Affordable Care Act offer consumers?

The Affordable Care Act includes many other consumer protections that apply to most health coverage starting on or after September 23, 2010. These include rules that:

- Stop plans and insurance companies from denying coverage to children younger than 19 because of a pre-existing condition.
- Prohibit plans and insurers from taking away your coverage based on an unintentional mistake on an application.
- Allow consumers to add or keep children on their health plan or policies until age 26.
- Stop plans and insurers from putting annual and lifetime dollar limits on your coverage.

- Require plans to provide recommended preventive services without cost-sharing requirements for those services.
- Help you receive maximum value for your premium dollars.
- Ensure your right to appeal to an independent entity when your plan or insurer denies payment for a service or treatment.

Visit www.HealthCare.gov to learn more about the Affordable Care Act and how you can make the most of your expanding health care choices.