The Patients' Bill of Rights

Ensuring fair treatment when you need emergency care

The Patient Protection and Affordable Care Act (Affordable Care Act) offers you several new protections that are known as the "Patients' Bill of Rights." This fact sheet explains how the Patients' Bill of Rights protects consumers who need emergency care.

The New Protections

Many people have health plans that encourage them to use "in-network" services: Usually, consumers must pay more if they use a doctor, health facility, or other provider that is not in their plan's network. However, if you face a medical emergency, you may need to go to the nearest emergency room, even if it is not in your plan's network. And even if you do use an in-network hospital, you may not be able to make sure you are treated by health care providers that are also in your plan's network. The protections in the new law address these problems.

If you have an emergency medical condition—that is, if your symptoms are severe enough that you think that you would put your health in jeopardy or you might be seriously harmed if you don't get immediate attention—then you can get emergency medical screening and treatment at a hospital.[1] Under the new law, your health plan *cannot* do the following:

- Require you to get preauthorization for emergency services;
- Make you go through extra administrative hurdles to get your out-of-network emergency services covered;
- Charge you higher copayments or co-insurance for out-of-network emergency services than it charges you for in-network emergency services; and
- Limit its coverage for out-of-network emergency care more than it would limit its coverage if you received care in-network.

Who Is Protected

The new protections for emergency services apply to you if, after March 23, 2010, (1) you buy a new individual or family health plan in the individual market, or (2) your employer did not previously offer coverage and buys a new health plan to cover you and other employees. They also apply if you have coverage through your job and, since March 23, 2010, (1) your plan has significantly cut the benefits it covers, (2) your plan has substantially increased the amount you must pay in cost-sharing or deductibles, or (3) your employer has decreased the amount it pays toward your premiums by more than 5 percent. (For more information, see the Families USA fact sheet, *Grandfathered Plans under the Patient Protection and Affordable Care Act,* available online at http://www.familiesusa.org/assets/pdfs/health-reform/Grandfathered-Plans.pdf.) The new protections for emergency service apply to people in private insurance, not people with public coverage such as Medicaid, Medicare, or veterans health benefits; other laws help protect people with public coverage from emergency charges.

Balance Billing

Unfortunately, if a health care provider is not in a plan's network, that provider may not accept the plan's payment rates for a service. He or she may want to bill you the difference between what the plan pays for the service and his or her charge for that service. So, even if the plan has not charged you a higher copayment, you might still get a bill from an out-of-network provider for other charges that were not paid by your health plan. This is called "balance billing."

Although the new law does not completely solve this problem, it does make some changes that are designed to minimize your bills for emergency care: It sets some standards for what health plans must pay out-of-network emergency providers, and when providers are paid adequately, they are less likely to balance bill.

Your plan must pay the emergency providers the *greatest* of these three amounts:

1. The amount it pays in-network providers;
2. A payment based on the same methods the plan uses to pay for other out-of-network services (for example, a percentage of usual and customary fees charged by other providers in your area); or
3. The amount Medicare would pay for that service.

Some states have even stronger laws to stop balance billing. You can check with your state insurance department to find out if there are additional laws to protect consumers in your state. Also, if you have Medicaid, you should not be balance billed.

If you have questions about a bill you have received for emergency services, you can talk to the health plan and the provider to find out how the plan set its payment rate and why the provider is charging more. If you think a bill is unfair, you may also want to talk to your insurance department, your state attorney general's consumer protection division, or a consumer assistance program that helps consumers with health insurance problems.

Finally, if you have the time to ask to see in-network providers without jeopardizing your health, do so. For example, if a hospital is assigning an anesthesiologist or another specialist to you or your loved one, find out if the hospital can help you locate someone who is in your health plan's network.

Conclusion

The new health reform law places new limits on what consumers who need emergency care can be charged for out-of-network care when they are not in a position to decide which hospital to go to or which health care providers to use. And by setting standards for what health plans must pay out-of-network emergency providers, it further protects privately insured patients.

---

[1] The law defines an emergency medical condition as one that manifests with "acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to . . . (1) [place] the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) [result in] serious impairment of bodily functions; or (3) [result in] serious dysfunction of any bodily organ or part."