

Patient Protection and Affordable Care Act (“PPACA”)
Enacted March 23, 2010

Here is a list of some of the more important issues from the law in order of the year of implementation. Because the Federated group health plans renew on a calendar year basis the first benefit changes will be effective on January 1 each year. The 2010 benefit changes are effective the first renewal six months after the date of enactment so will be effective for Federated coverage starting January 1, 2011. Subsequent changes will be effective on January 1 of each year.

2010

- Small Employer health insurance tax credit
- Grandfather Plans - the health plans in force at time of enactment – not subject to some of the insurance and market reform provisions
- Tax code change in definition of dependents
- Automatic enrollment for employers of 200 or more full time employees
- Coverage available for dependents up to age 26
- Prohibition of lifetime limits and limitations on use of annual limits
- Limitations on rescissions of health coverage
- Requirement to provide coverage for preventive care services
- Requirement for insurers to maintain minimum loss ratios
- Insured health plan compliance with nondiscrimination rules
- Process for external appeals of coverage determinations and claims

2011

- Employers must disclose cost of health care coverage on employees W-2 form
- Over the counter medications not allowed in HSA or HRA plans
- Increase in excise tax on non-medical distributions from HSA plans
- New fees on insurers and drug manufacturers

2012

- Standardized summary of benefits and explanation of coverage

2013

- Free choice vouchers must be offered by employers to qualified employees
- Salary deduction for contribution to health plan FSAs limited to \$2500
- Increase in the threshold to claim itemized deduction for unreimbursed medical expense from 7.5% to 10.0% of adjusted gross income
- High income tax payers increase in Medicare tax of additional 0.9%

2014
And later

- Employers with 50 or more employees face assessments if they do not offer a qualified health plan
- Guaranteed availability and renewal in the individual and group markets
- Prohibition on preexisting condition exclusions
- Restrictions on premium rating
- Requiring minimum health coverage – essential benefits package
- Waiting periods may not exceed 90 days
- American Health Benefit Exchanges may offer only “qualified health benefit plans”
- Small Business Health Options Program (SHOP) Exchanges for individuals and employers of 100 or fewer employees
- Consumer Operated and Oriented Plan (COOP) – creation of non-profit qualified health insurance issuers for individuals and small groups
- Health insurance premium assistance credits
- Cadillac tax – a 40% excise tax on higher benefit plans above a certain threshold amount
- Require US citizens and legal residents to have qualifying health coverage or face a tax penalty

The U S Department of Health and Human Services website [The Affordable Care Act Overview.mht](#) provides more details on the health care reform law.