National Association of Health Underwriters

Timeline of Health Insurance Reforms that Will Impact Private Health Insurance Coverage under H.R. 3590, the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010

April 1, 2010

Topic	Reform Provisions Contained in H.R. 3590, the Patient Protection and Affordable Care Act (Senate Bill), Enacted on March 23, 2010 and H.R. 4872, The Health Care and Education Affordability Reconciliation Act, Enacted on March 30, 2010	Effective Date
Grandfathered Health Plans	Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so if the only plan changes made were to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement. Even if a plan is grandfathered, some of the new market reform provisions will still be applicable including many that take effect within six months. These are noted by provision elsewhere in this summary.	**Immediately.** Grandfathered status is available for plans in effect on date of enactment.
Small Employer Tax Credits	Makes available tax credits for qualified small employer contributions to purchase coverage for employees. In order to qualify, the business must have no more than 25 full-time equivalent employees, pay average annual wages of less than $50,000 and provide qualifying coverage. The full amount of the credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000, and will phase out when those thresholds are exceeded. The average wage threshold for determining the phase-out of credits will be adjusted for inflation after 2013. Small employers will receive a maximum credit of up to 50% of premiums for up to 2 years if the employer contributes at least 50% of the total premium cost. The credit would phase out entirely for employers of more than 25 employees whose average annual salaries exceeded $50,000. Employers will not be eligible to use the credit for certain employees, including defined "seasonal workers," self-employed individuals, two percent shareholders of an S corporation (as defined by section 1372(b), five percent owners of a small business (as defined by section 416(i)(1)(B)(i)) and dependents or other household members. However, leased employees are eligible employees for the credit. Employers receiving credits will be denied any deduction for health insurance costs equal to the credit amount.	**Immediately.** Retroactive for premiums paid in taxable years beginning after December 31, 2009.
BCBS Plans	Limits the special deduction for Blue Cross Blue Shield organizations of 25% of the amount by which certain claims, liabilities, and expenses incurred on cost-plus contracts exceed the organizations' adjusted surplus. The special deduction will be available only to those otherwise qualifying BCBSA plans that expend at least 85% of their total premium on reimbursement for clinical services provided to enrollees.	**Immediately.** (Taxable years beginning after December 31, 2009).
Employer Subsidies of Medicare Part D Premiums	Elimination of employer deductible subsidy under Medicare Part D. This provision will have an immediate impact on employers' liability and income statements -- FAS 109 requires employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability.	**Immediate accounting impact** but applies to taxable years beginning after December 31,

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	Under ASC 740, the expense or benefit related to adjusting deferred tax liabilities and assets as a result of a change in tax laws must be recognized in income from continuing operations for the period that includes the enactment date. Therefore, the expense resulting from this change will be recognized in the first quarter of 2010 even though the change in law may not be effective until later years.	2012.
Grants for State Insurance Ombudsman Programs	Allows the Secretary of DHHS to award grants to States (or the Exchanges operating in such States) to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs to, in coordination with State health insurance regulators and consumer assistance organizations, receive and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law. $30 million is appropriated to fund these grants in FY 2010, but the Secretary of DHHS will have to request additional appropriations to fund the grant program in the out-years.	**Immediately.**
Rate Review	Establishes federal review of health insurance premium rates. The Secretary of DHHS, in conjunction with the states, will have new authority to monitor health insurance carrier premium increases beginning in 2010 to prevent unreasonable increases and publicly disclose such information. Carriers that have a pattern of unreasonable increases may be barred from participating in the exchange. In addition, $250,000,000 is appropriated for state grants to increase their review and approval process of health insurance carrier premium rate increases.	**Immediately.** (2010 plan year.)
Therapeutic Discovery Tax Credit	Creates a federal tax credit for businesses with 250 or fewer employees that make a qualified investment in acute and chronic disease research during 2009 or 2010.	Effective **immediately** and based on investments paid in taxable years beginning in 2009 or 2010.
Indian Health Benefits	Native Americans may exclude from gross income the value of qualified health benefits received directly or indirectly from the Indian Health Service or from an Indian tribe or tribal organization.	Effective **immediately** for health benefits and coverage provided after the date of enactment.
Preexisting Condition Coverage for Individual Market Consumers	Creates high-risk pool coverage for people who have been uninsured for at least six months and cannot obtain current individual coverage due to preexisting conditions. This national program can work with existing state high-risk pools and will end on January 1, 2014, once the Exchanges become operational and the other preexisting condition and guarantee issue provisions take effect. It will be financed by a $5 billion appropriation and premiums will be capped. Employers are prohibited from putting individuals into the high-risk pool with associated fines.	Within 90 days of enactment.
Early Retiree Reinsurance program	Creates a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. This program would reimburse employers retrospectively 80% of claims between $15,000-90,000, which will be indexed for inflation. It will end on January 1, 2014 and be financed by a $5 billion appropriation.	Within 90 days of enactment.
Web-Based Information Portals	Requires the states and the Secretary of DHHS to develop information portal options for state residents to obtain uniform information on sources of affordable coverage, including an Internet site. Information must be provided on private health coverage options, Medicaid, CHIP, the new high-risk pool coverage and existing state high-risk pool options.	By July 1, 2010.
Excise Tax on Indoor Tanning	Ten percent excise tax on amounts paid for indoor tanning services, whether or not an individual's insurance policy covers the service. Service provider to assess tax on customer.	Services performed on or after July 1, 2010.

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Varying Health Plan Rules Based on Salary	Requires all group health plans to comply with the Internal Revenue Section 105(h) rules that prohibit discrimination in favor of highly compensated individuals.	Either plan years beginning on or after six months after date of enactment (September 24, 2010), or six months from the date of enactment. However, grandfathered status applies.
Lifetime Benefit Limits	For fully-insured and self-insured group and individual health plans including health plans with grandfathered status, prohibits lifetime limits on the dollar value of benefits for any participant or beneficiary.	Plan years beginning on or after six months after date of enactment (September 2010)..
Annual Benefit Limits	For fully-insured group and self-insured group and individual health plans, including health plans with grandfathered status, annual benefit limits on coverage would be limited to DHHS-defined non-essential benefits for plan years beginning prior to January 1, 2014. (Annual limits would be prohibited entirely for subsequent plan years.)	Plan years beginning on or after six months after date of enactment (September 2010).
Increased Dependent Coverage	For fully-insured and self-insured group and individual health plans, including health plans with grandfathered status, increases the age of a dependent for health plan coverage to up to age 26. Dependents can be married, and the group health insurance income tax exclusion would apply to value of the benefits provided for these dependents. For grandfathered group health plans only, through 2014, coverage would only have to be extended to these dependents id they do not have another source of employer-sponsored health insurance.	Plan years beginning on or after six months after date of enactment (September 2010)..
Policy Rescissions	Prohibits rescissions of health plan coverage in all insurance markets including self-insured plans and those with grandfathered status,, except for cases of fraud or when enrollees make an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Coverage may not be cancelled without prior notice to the enrollee.	Plan years beginning on or after six months after date of enactment (September 2010)..
Coverage of Preventive Care	For fully-insured group and self-insured group and individual health plans,, mandates coverage of specific preventive services with no cost sharing. The services that must be covered at minimum include: • Evidence-based items or services with a rating of `A' or `B' in the current recommendations of the United States Preventive Services Task Force; • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; • For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. • For women, additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. • For women, the recommendations issued by the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009. The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.	Plan years beginning on or after six months after date of enactment (September 2010) Grandfathered status applies.

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Coverage of Emergency Services	For fully-insured group and individual health plans, and self-insured group health plans, mandates coverage of emergency services at in-network level regardless of provider.	Plan years beginning on or after six months after date of enactment (September 2010). Grandfathered status applies
Designating a Primary Care Physician	For fully-insured group and individual health plans, and self-insured group health plans, allows enrollees to designate any in-network doctor their primary care physician (including OB/GYN and pediatrician), if the plan requires the designation of a primary care physician.	Plan years beginning on or after six months after date of enactment (September 2010). Grandfathered status applies
Coverage Appeals	For fully-insured group and individual health plans, and self-insured group health plans, requires plans to have coverage appeals process.	Plan years beginning on or after six months after date of enactment (September 2010). Grandfathered status applies.
Preexisting Condition Coverage for Children	All group and individual health plans, included self-insured plans, will have to cover preexisting conditions for children 19 and under for plan years beginning on or after six months after date of enactment. Grandfathered group health plans must also comply with this requirement.	Plan years beginning on or after six months after date of enactment (September 2010). Grandfathered group health plans must also comply with this requirement.
Small Group Wellness Program Grants	Creates grants for small employer-based wellness programs. Appropriates $200 million in funding from fiscal years 2011-2015.	October 1, 2010
Minimum Loss Ratios	Minimum loss ratio requirements will be established for insurers in all markets. The MLR is 85% for large group plans and 80% for individual and small group plans (100 and below). The calculation is independent of federal or state taxes and any payments as a result of the risk adjustment or reinsurance provisions. Carriers will have to issue a premium rebate to individuals for plans that fail to meet the minimum MLR requirements. Allows the Secretary of DHHS to make adjustments to the percentage if it proves to be destabilizing to the individual or small group markets. The National Association of Insurance Commissioners (NAIC) is required to establish uniform definitions regarding the MLR and how the rebate is calculated by December 31, 2010.	Regulatory process with DHHS and NAIC begins in 2010, with the standards and any potential rebates to policy-holders being applied to the 2011 plan year.
Reporting on W-2s	Requires all employers to include on W-2s the aggregate cost of employer-sponsored health benefits for informational purposes only. If employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage, but exclude all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs.	Benefits payable during taxable years beginning after December 31, 2010.
HSA Distribution Tax Increase	Increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%).	Distributions made after December 31, 2010.
FSA Limit	Limits FSA contributions for medical expenses to $2,500 per year and indexes the cap for inflation.	Taxable years beginning after December 31, 2012.
OTC Drug Exclusion from Account-Based Plans	Changes the definition of medical expense for purposes of employer-provided health coverage (including reimbursements under employer-sponsored health plans, HRAs, and Health FSAs, HSAs, and MSAs) to	Taxable years beginning after December 31, 2010.

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	the definition for purposes of the itemized deduction for medical expenses. This means that account-based plans cannot provide nontaxable reimbursements of over-the-counter medications unless the over-the-counter medications are prescribed by a doctor. Prescribed medicines, drugs, and insulin will still qualify for nontaxable reimbursements from those accounts.	
Tax on Brand-Name Prescription Drug Manufacturers	Imposes a new annual nondeductible fee on pharmaceutical manufacturers and importers of branded prescription drugs (including certain biological products). The aggregate annual fees, based on market share, to be imposed on covered entities will be $4.8 billion, beginning in 2011.	Payable in 2011 with respect to sales in 2010.
Cafeteria Plan Safe Harbor for Small Employers	Small employers (generally those with 100 or fewer employees) will be allowed to adopt new "simple cafeteria plans." In exchange for satisfying minimum participation and contribution requirements, these plans treated as meeting the nondiscrimination requirements that would otherwise apply to the cafeteria plan.	January 1, 2011.
CLASS Act	Creates a new public long-term care program and requires all employers to enroll employees, unless the employee elects to opt out.	January 1, 2011.
Business Tax Reporting (1099 Forms)	Expands obligation of persons engaged in a trade or business to report on payments of other fixed and determinable income or compensation. Extends reporting to include payments made to corporations other than corporations exempt from income tax under section 501(a). Also expands the kinds of payments subject to reporting to include reporting of the amount of gross proceeds paid in consideration for property or services.	January 1, 2012.
Federal Study on Large-Group Plans	Mandates a federal study on the impact the market reforms in the bill will have on the large group market, particularly on whether or not they have encouraged groups to self-fund.	Within a year of enactment (March 2010).
Federal Study on Self-insured Plans	Mandates annual studies by the federal Department of Labor on self-insured plans using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500) begin. The studies will include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses).	Within a year of enactment (March 2010).

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Non-Profit Hospitals	Non-profit hospitals must meet new requirements to satisfy tax exempt status.	Generally, the requirements apply to taxable years beginning after date of enactment, however, the community health needs assessment requirement applies to taxable years beginning two years after the date of enactment.
Summary of Benefits	Requires that all group health plans (including self-insured plans) and group and individual health insurers provide a summary of benefits and a coverage explanation to all applicants at the time of application, to all enrollees prior to the time of enrollment or reenrollment and to all policyholders or certificate holder at the time of issuance of the policy or delivery of the certificate. The summary must include specific information to be determined by the Secretary of DHHS in consultation with the National Association of Insurance Commissioners and can be provided in paper or electronic form. It must be no more than 4 pages in length with print no smaller than 12 point font written in a culturally linguistically appropriate manner. If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective. Employers and health plans that willfully fail to provide the information required can be fined up to $1,000 for each such failure. Each failure to provide information to an enrollee constitutes a separate offense.	DHHS/NAIC must develop the summary of benefits standards within one year of enactment (March 2011). Health Plans and employer groups must begin notifying enrollees within two years of enactment (March 2012).
Quality Information Reporting by Group Health Plans	Requires the Secretary of DHHS to develop quality reporting requirements for use by group health plan and group and individual health plans about their coverage benefits and health care provider reimbursement structures that improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors and implement wellness and health promotion activities. All group health plans (including self-insured plans) and group and individual health insurance carriers must annually submit to the Secretary of DHHS and to plan enrollees during the annual open enrollment period a report on whether the benefits under the plan or coverage include the specified components. The Secretary of DHHS will make the reports available to the public through an Internet website and can develop and impose appropriate penalties on employer groups and health plans for noncompliance.	Within two years of enactment (March 2012).
Tax on Group Health Plans to Fund Comparative Effectiveness Research	New federal premium tax on fully-insured and self-insured group health plans to fund comparative effectiveness research program begins. As financing mechanism to fund Patient Centered Outcome Research, imposes a fee on private insurance plans equal to $2 annually for each individual covered under a specified individual or group health insurance policy.	First plan year ending after September 30, 2012 but does not apply to policy years ending after September 30, 2019.

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Health Insurer Executive Compensation Limits	$500,000 deduction limitation on taxable year remuneration to officers, employees, directors, and service providers of covered health insurance providers.	Applies to current compensation paid during taxable years beginning on or after December 31, 2012, but will apply to deferred compensation earned in the taxable year beginning after December 31, 2009.
Tax on Medical Devices	New excise tax on medical device manufacturers equal to 2.3 percent of the price for which the medical device is sold. The tax will not apply to eyeglasses, contact lenses, hearing aids, and any other device deemed by the Secretary of DHHS to be of the type available for regular retail purposes.	January 1, 2013
Medicare Payroll Tax Increase	Beginning in 2013, additional 0.9 percentage Medicare Hospital Insurance tax (HI tax) on self-employed individuals and employees with respect to earnings and wages received during the year above $200,000 for individuals and above $250,000 for joint filers (not indexed). Does not change employer HI tax obligations. Self-employed individuals are not permitted to deduct any portion of the additional tax. In addition, there will be a new 3.8% Medicare contribution tax on certain unearned income from individuals with AGI over $200,000 ($250,000 for joint filers).	January 1, 2013.
Medical Expense Tax Deduction Limitation	The threshold for the itemized deduction for unreimbursed medical expenses would be increased from 7.5% of AGI to 10% of AGI for regular tax purposes. The increase would be waived for individuals age 65 and older for tax years 2013 through 2016 (Effective January 1, 2013).	January 1, 2013.
Employer Notice Requirement	Requires all employers provide notice to their employees informing them of the existence of an Exchange.	March 1, 2013.
Preexisting Conditions	Coverage must be offered on a guarantee issue basis in all markets and be guaranteed renewable. Exclusions based on preexisting conditions would be prohibited in all markets, including self-insured plans .	Plan years beginning on or after January 1, 2014 but, for enrollees under age 19, preexisting conditions are prohibited beginning plan years beginning on or after six months after date of enactment. Grandfathered group health plans must also comply with this requirement.
Tax on Private Health Insurance Premiums	Imposes annual taxes on private health insurers based on net premiums written after December 31, 2012? and third-party agreement fees received after December 31, 2012? The tax is phased in at. The fees would start at $8 billion in 2014, rise to $11.3 billion in 2015 and 2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018 the fee would be indexed to the annual amount of premium growth in subsequent years. Does NOT apply to self-insured plans and governmental entities (other than those providing insurance through the Act's community health insurance option). The bill's insurer tax provisions would also	January 1, 2014 based on net premiums written after December 31, 2012 and third-party agreement fees received after December 31, 2012.

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	exempt: (1) nonprofit insurers that receive over 80 percent of their gross revenues from government programs like Medicare, Medicaid, and CHIP; and (2) voluntary employee benefit associations that are established by non-employers.	
Modified Community Rating Requirements	All individual health insurance policies and all fully insured group policies 100 lives and under (and larger groups purchasing coverage through the exchanges) must abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions to be defined by the states and experience rating would be prohibited. Wellness discounts are allowed for group plans under specific circumstances.	Plan years beginning on or after January 1, 2014.
Group Size	Redefines small group coverage as 1-100 employees. States may also elect to reduce this number to 50 for plan years prior to January 1, 2016.	January 1, 2014.
State-Based Exchanges	Requires each state to create an Exchange to facilitate the sale of qualified benefit plans to individuals, including the federally administered multi-state plans and non-profit co-operative plans. A catastrophic-only policy would be available for those 30 and younger. In addition the states must create "SHOP Exchanges" to help small employers purchase such coverage. Coverage in the Exchange will only be offered on a pre-tax basis if it is purchased through an employer. The state can either create one exchange to serve both the individual and group market or they can create a separate individual market exchange and group SHOP exchange. States can also apply for a modification waiver from DHHS.	January 1, 2014.
Employee Free Choice Requirements	An employer that provides and contributes to health coverage for employees must provide free choice vouchers to each employee who is required to contribute between 8% and 9.8% of the employee's household income toward the cost of coverage, if such employee's household income is less than 400% of FPL and the employee does not enroll in a health plan sponsored by the employer. Eight percent and 9.8% are to be indexed to the rate of premium growth. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount. The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the exchange) with respect to the plan to which the employer pays the largest portion of the cost.	January 1, 2014.
Essential Benefits	Establishes standards for qualified coverage, including mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%. Allows catastrophic-only policies for those 30 and younger. Employer-sponsored plans offered outside of the exchange do not have to provide essential benefits coverage.	Plan years beginning on or after January 1, 2014.
Tax Credits for Lower Income Individuals	Creates sliding-scale premium assistance tax credits for non-Medicaid eligible individuals with incomes up to 400% of FPL to buy coverage through the exchange. Beginning in 2019, a failsafe mechanism would be applied that reduces overall premium subsidies if the aggregate amount exceeds 0.504 percent of GDP.	January 1, 2014.
Medicaid Expansion	Medicaid eligibility level is increased to 133% FPL. The federal government will pay 100% of the cost of the new expansion population until 2016. Starting in 2017, all states except for the expansion states (including Nebraska), would then have to begin to have to pay a phased in amount of the cost of covering the expansion population, so that the federal government's match would be 90% in 2020 and the out-years.	January 1, 2014.

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	For expansion states (where the state is already covering these adults through their Medicaid programs), it would reduce the amount they are currently paying to cover this population by 50% in 2014 and gradually increase the amount of the federal share, so that by 2019, all states would be paying the same amount for the non-pregnant adult Medicaid population.	
Premium Assistance for Employer-Sponsored Coverage	Requires states to offer premium assistance and Medicaid wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored coverage if cost-effective to do so, under terms outlined already in current law.	January 1, 2014.
State-Level Subsidy Programs	Gives states the option of establishing a federally-funded non-Medicaid state plan for people between 133-200% FPL who do not have access to affordable employer-sponsored coverage and would otherwise be eligible for subsidized coverage through a state-based exchange. The funding for this program will come from the subsidy dollars.	January 1, 2014.
Employer Mandate	An employer does not have to offer coverage, but if they do not offer qualified coverage and employ more than 50 full-time equivalent employees (with an exception for seasonal workers) and one or more employees receives a premium assistance tax credit to buy coverage through an exchange, the employer must pay a fine of $2000 per year times the number of full-time equivalent employees. When determining whether an employer has 50 employees, part-time employees must be taken into consideration in the number of full-time equivalent employees based on aggregate number of hours of service. An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of $3,000 for each of those employees receiving a tax credit or $2000 for each of their full-time employees total. An individual with family income up to 400% of FPL is eligible for a premium assistance tax credit if the actuarial value of the employer's coverage is less than 60% or the employer requires the employee to contribute more than 9.5% of the employee's family income toward the cost of coverage.	January 1, 2014.
Employer Waiting Period for Coverage	Waiting periods in excess of 90 days are prohibited for all plans, including grandfathered plans.	January 1, 2014.
Auto-Enrollment by Employers	Requires employers of 200 or more employees to auto-enroll all new employees into any available employer-sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage.	**Effective date is unclear.**
Individual Mandate	Requires all American citizens and legal residents to purchase qualified health insurance coverage. Exceptions are provided for religious objectors, individuals not lawfully present and incarcerated, those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those who have received a hardship waiver, those with incomes below the federal income tax filing threshold and those who were not covered for a period of less than three months during the year. The penalty structure for noncompliance will be an excise tax of either a flat dollar amount per person or a percentage of the individual's income, whichever is higher. In 2014 the percentage of income determining the fine amount will be 1%, then 2% in 2015, with the maximum fine of 2.5% of taxable (gross) household income capped at the average bronze-level insurance premium (60% actuarial) rate for the person's family beginning in 2016. The alternative will be a fixed dollar amount that phases in	January 1, 2014.

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	beginning with $325 per person in 2015 to $695 in 2016.	
Coverage Documentation	Health plans, including self-insured employer plans and public programs, must also provide coverage documentation to both covered individuals and the IRS.	January 1, 2014.
Employer Wellness Plans	Codifies and improves upon the HIPAA bona fide wellness program rules and increases the value of workplace wellness incentives to 30% of premiums with agency discretion to increase the cap on incentives to 50%.	Plan years beginning on or after January 1, 2014.
Wellness Plans for the Individual Market	Establishes a 10-state pilot program to apply the rules to HIPAA bona fide wellness program rules the individual market in 2014-2017 with potential expansion to all states after July 1, 2017. It also calls for a new federal study on wellness program effectiveness and cost savings.	No later than July 1, 2014.
CHIP	Children's Health Insurance Program was extended through September 30, 2015, but then must be reauthorized.	Must be reauthorized by October 1, 2015.
State-Opt Out Provisions	Allows states to apply for a waiver for up to 5 years of requirements relating to qualified health plans, exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers, provided that they create their own programs meeting specified standards.	Plan years beginning on or after January 1, 2017.
Large Groups in the Exchanges	States may choose to allow large groups (over 100) to purchase coverage through the exchanges.	January 1, 2017.
Cadillac Tax	The 40% excise tax on employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage with higher thresholds for retirees over age 55 and employees in certain high risk professions/ Transition relief would be provided for 17 identified high-cost states. The tax would be indexed annually for inflation based on the consumer price index, but would also allow plans to take into account age, gender and other factors that impact premium costs. Value of health plans would include reimbursements from FSAs, HRAs and employer contributions to HSAs, as well as other supplementary health insurance coverage. Stand-alone dental and vision plans would be excluded from the calculation, The excise tax will not apply to accident, disability, long-term care and after-tax indemnity or specified disease coverage.	Taxable years beginning after December 31, 2017.