Where Do We Stand Now?

Learning Objectives

After completing this module and the accompanying exercises, you will be able to:

- discuss the main points of the Supreme Court decision on the Affordable Care Act (ACA),
- explain the most important ways the ACA will affect average people,
- explain the requirements for employer sponsorship of health coverage, and
- state when the most important ACA provisions become effective.

The Affordable Care Act (ACA) and the Supreme Court

After nearly a year of hearings, debate, and votes, Congress passed the Patient Protection and Affordable Care Act (as amended by the Health Care and Education Reconciliation Act). This comprehensive health care reform legislation, more commonly referred to as the Affordable Care Act (ACA), was then signed into law by President Obama in late March 2010.

Soon after its passage, the ACA became the subject of several lawsuits challenging its constitutionality, ultimately resulting in a hearing before the U.S. Supreme Court. Those opposing the ACA on constitutional grounds expressed the belief that its requirement that individuals either carry insurance or pay a penalty (the so-called individual mandate) was an overreach of federal authority. States also challenged the provisions of the ACA calling for the expansion of Medicaid.

On June 28, 2012, the Supreme Court issued a lengthy decision upholding most provisions of the ACA, including the individual mandate. Chief Justice Roberts, considered one of the more conservative members of the Court, sided with Justices Breyer, Ginsburg, Kagan, and Sotomayor, members of the Court’s liberal bloc, in a 5-4 decision upholding the individual mandate. The Court’s decision removed substantial legal uncertainties surrounding health care reform and paved the way for implementation of many but not all of key provisions of the ACA.

But the decision also contained a surprising twist—the Court ruled that the ACA’s Medicaid expansion was optional for the states. Equally surprising was that the Court reached this conclusion by a 7-2 majority, with Justices Breyer and Kagan siding with Chief Justice Roberts and Justices Kennedy, Scalia, Thomas, and Alito.
An Analysis of the Court Decision

The Supreme Court addressed four issues in *National Federation of Independent Business et al. vs. Sebelius*:

- Does the Anti-Injunction Act bar the lawsuit?
- Does the individual mandate to purchase private health insurance represent a constitutional exercise of Congress’s authority to regulate interstate commerce?
- Does the individual mandate to purchase private health insurance represent a constitutional exercise of Congress’s taxing authority?
- Does Congress have the authority to expand Medicaid eligibility without state consent?

**Applicability of the Anti-Injunction Act**

Under the ACA, individuals who fail to purchase health insurance (with some exceptions) must make a “shared responsibility payment.” Before addressing the merits of the case, the Court first had to decide whether this shared responsibility payment constituted a tax under the provisions of the Anti-Injunction Act. This Act basically requires that a person first pay a tax before suing for a refund. Therefore, if the shared responsibility payment were considered a tax under the Anti-Injunction Act, the lawsuit would be premature and a decision would have to wait until a future date when someone actually made the payment.

The Court examined the language of the ACA and found that it referred to the shared responsibility payment as a “penalty” imposed on those who forego insurance. Based on this rationale, the majority ruled that the shared responsibility payment was *not* a tax for purposes of the Anti-Injunction Act. Therefore, the case could proceed.

**The Individual Mandate and the Commerce Clause**

After making its determination regarding the Anti-Injunction Act, the Court proceeded to examine whether Congress had exceeded its power to regulate interstate commerce (granted to it by the Commerce Clause of the Constitution) by enacting the individual mandate. The Court found that Congress had indeed done so.

The Administration argued that Congress has the power to compel the purchase of insurance under the Commerce Clause because the failure to purchase insurance created cost-shifting from those without insurance to those with insurance. Chief Justice Roberts rejected the application of the Commerce Clause on the grounds that there must be activity to regulate—basically saying that the individual mandate compels activity rather than regulating activity already underway.
The Individual Mandate and Taxing Authority

The Court next examined whether the individual mandate could be upheld as a valid exercise of Congress’s taxing power under the Constitution. A majority, led by Chief Justice Roberts, upheld the individual mandate on this basis.

For this purpose, the Court majority used a different test than for the Anti-Injunction Act and looked beyond the labeling of the shared responsibility payment as a “penalty.” Instead, for purposes of constitutional analysis, the majority determined that it functioned as a tax. The majority based its interpretation on three key factors:

- For most Americans the amount of the shared responsibility payment would be far less than the price of insurance, and under the statute could never be more.
- While a penalty punishes an unlawful act or omission, the shared responsibility payment does not target wrongful behavior.
- The shared responsibility payment would be collected by the Internal Revenue Service (IRS), through the normal means of taxation.

Medicaid Expansion

The ACA, to extend health coverage to many of the uninsured (in particular, to low-income adults not old enough for Medicare), calls for the expansion of Medicaid. It requires states to provide Medicaid coverage to individuals younger than 65 with income at or below 133 percent of the federal poverty level (FPL). It provides federal funding for 100 percent of the cost of this additional coverage through 2016, to be gradually reduced to 90 percent in 2020 and thereafter. The ACA further stipulates that states failing to provide this expanded coverage may be penalized by losing existing federal Medicaid funding, not just the dollars earmarked for new recipients under the ACA. Many states, fearful of their budgets being overwhelmed by Medicaid obligations in future years, objected to the expansion despite the federal funding.

The Court faced a twofold issue:

- Does Congress have the authority to expand Medicaid?
- Does the Secretary of Health and Human Services (HHS) have the authority under the ACA to withhold existing Medicaid funding if a state does not expand coverage?

The Court ruled the Medicaid expansion to be a reasonable exercise of the federal government’s power under the Spending Clause of the Constitution. However, the Court stated that HHS could not force states to comply with the Medicaid expansion by threatening to withhold existing Medicaid funding. Under the Court’s ruling, states will have the option of expanding Medicaid eligibility as provided under the ACA, or they can
decline to do so and continue to operate their Medicaid programs under existing rules and with existing federal funding. And in the future, conditions on states must be more like contracts that are mutually agreed upon.

**Severability**

Before the Supreme Court took this case and during oral arguments, there was considerable discussion of whether the ACA was fully dependent on the individual mandate or whether portions of the Act could survive if the individual mandate was determined to be unconstitutional. In legal terms, could the individual mandate be severed from other provisions of the ACA? Some legal experts believed the ACA to be totally dependent on the constitutionality of the individual mandate, while others maintained that the mandate could be severed from the rest of Act. Still others contended that the individual mandate and ACA market reforms (such as the end of individual underwriting) were linked, but that the rest of the ACA was severable from these provisions.

In the end, because the Court’s decision upheld the individual mandate, there was no need to resolve the issue of severability. The ruling preserves the link between market reforms and universal coverage that is essential to avoiding significant cost increases and loss of choice for consumers and employers. The Court did briefly address severability in the context of Medicaid, concluding that Congress intended the rest of the ACA to remain in force despite the Court’s ruling in this area.

**The Dissent**

Justices Kennedy, Scalia, Thomas, and Alito joined in a lengthy written dissent, concluding that the entire ACA should be struck down. The dissent claimed that both the individual mandate and the Medicaid expansion were invalid and concluded that the rest of the law could not be severed from these “two pillars” of the ACA.

**Moving Forward**

**Medicaid Expansion**

Although the Supreme Court ruled that the federal government cannot withhold Medicaid funding as a way to force states to expand Medicaid coverage to those with income up to 133 percent of the federal poverty level, the Obama Administration has strongly encouraged states to do so. The Administration has pointed out that the federal government will pay the entire cost of this expansion for the first three years (2014 through 2016) and will cover most costs thereafter—gradually declining to 90 percent of extra costs in 2020 and thereafter. As of this writing, many states have decided to expand their Medicaid programs, and several additional states are seriously studying this option.
Establishment of Exchanges

The ACA calls for each state to establish a marketplace (exchange) for the purchase of health insurance by individuals and small businesses by January 1, 2014. If a state fails to take steps to establish an exchange, the federal Department of Health and Human Services (HHS) will operate an exchange in that state.

Currently HHS is working closely with the states to determine whether they will be ready to operate an exchange on their own or partner with the federal government in the operation of an exchange, or if they will have to rely fully on the federal government to run an exchange in the state. (For an in-depth discussion of exchanges, see Module 4.)

Regulatory Clarification

Since many parts of the ACA are due to become effective in 2014, the Administration is in the process of releasing many regulations (often for comment before finalization) in order to clarify various aspects of the law. Recent proposed regulations have focused on:

- market reforms governing the sale, pricing, and renewability of private health insurance in the individual and small group markets (sold both inside and outside of exchanges);
- requirements on health insurance plans for essential health benefits, cost-sharing, and actuarial value;
- standards for wellness programs offered by employers who sponsor group health plans (such as discounts for meeting certain metrics); and
- shared responsibility mandates for individuals and large employers.

Possible Actions Outside the Administration

The Supreme Court decision is unlikely to end the battle over health care reform and the Affordable Care Act. While opponents were not able to overturn the entire law, some may challenge particular aspects of it. Funding of the ACA may come under scrutiny as Congress wrestles with the country’s exploding deficit. For example, tax subsidies available on a sliding scale to those with income up to 400 percent of the federal poverty level might be scaled back, or additional taxes may be proposed to fund the federal cost of Medicaid expansion.
Cost of Care and Affordability of Coverage

While many commentators believe that the ACA will succeed in expanding health coverage, many have raised doubts about the law’s ability to control the rising cost of care and make coverage more affordable. The ACA does contain some provisions designed to curb cost trends (for example, by promoting accountable care organizations (ACOs) for the Medicare population), but other provisions of the law will tend to increase the price of health insurance.

For instance, the ACA’s essential health benefits rules will require many health plans to add benefits. Another example is the rule that, in the individual and small group market, the oldest insureds can be charged no more than three times as much as the youngest. This is projected to raise premiums for younger, healthy individuals, and if coverage becomes too expensive, many of these people may opt to pay the shared responsibility payment rather than buy insurance.

What Does the Court’s Decision Mean to Me? Questions and Answers

How does the Supreme Court’s decision on the ACA affect average people? We will address different situations through questions and answers.

Parent of a Recent College Graduate

Q. My daughter, age 24, recently graduated from college and has not found a job. Will she be able to stay on my health insurance plan?

A. Yes. An adult child will remain eligible for insurance through his or her parents until the child reaches age 26.

Self-Employed Individual

Q. I am self-employed and make about $50,000 a year. Right now, I don’t have health insurance. Does this mean I will have to buy it?

A. Yes, starting in 2014. If you don’t buy insurance you will be subject to a tax penalty. In 2014 this penalty is rather low (capped at 1 percent of income above the tax filing threshold), but it will rise in future years.

Employee Presently Covered

Q. I work at a large company that offers me a benefit package including a comprehensive health insurance plan. Will I be required to drop my coverage and buy an individual plan?
A. No. You can keep your current coverage. In fact, for the foreseeable future most Americans who work for large companies will obtain health insurance through their employers.

**Low Wage Earner Currently Without Coverage**

Q. I earn low wages and am too young for Medicare. I work for a small retailer with fewer than 10 employees that does not offer health insurance. What does the ACA mean for me?

A. Starting in 2014 you will be able to obtain coverage through a health benefits exchange. If your household income is 400 percent or less of the federal poverty level, you will be eligible for subsidies to offset a portion of your health insurance costs.

**Individual with Preexisting Condition**

Q. I have had a bout of cancer that makes it difficult for me to obtain health insurance. Does the ACA do anything for me?

A. Yes. The ACA keeps in place the ACA market reforms, which will make it easier for individuals with preexisting conditions to obtain health insurance.

**High-Income Family**

Q. My husband and I are both professionals, and our income is substantial. How will the ACA impact us?

A. The amount you contribute to Medicare may rise. Employees currently pay 1.45 percent of their earnings to the Medicare payroll tax. Beginning in 2013 the ACA imposes an additional 0.9 percent on earnings in excess of $200,000 per year ($250,000 for married couples filing a joint return).

**Working Poor**

Q. I earn just above the federal poverty level. I live in a state that may opt not to expand Medicaid coverage up to 133 percent of the FPL. What does the Supreme Court decision mean for me?

A. The Court’s decision means that you may not be able to access health coverage through your state’s Medicaid program. However, you will likely be able to obtain premium subsidies through a health benefits exchange.

**Medicare Beneficiary**

Q. I am a Medicare beneficiary who participates in the Part D prescription drug program. What does the ACA mean for me?
A. The ACA will phase out the Part D coverage gap (the “donut hole”). If you reach the 
coverage gap in your Part D coverage, you will get a manufacturer’s discount on covered 
brand name drugs. And over the next several years you will pay a gradually lower 
portion of your drug costs during the coverage gap, until you pay no more than under 
regular coverage (in 2020). (For further discussion of Medicare Part D, see Module 8.)

Employers and the ACA

Beginning in 2014, large businesses have to offer health coverage to their employees or 
pay a tax penalty. The rules in this area are entitled the Employer Shared Responsibility 
Provisions, but they are more commonly called the employer mandate.

Specifically, beginning in 2014 an employer will be subject to tax penalties if:

- it has 50 or more full-time employees (or the equivalent in combined full-time 
  and/or part-time employees);

- it does not offer health coverage to at least 95 percent of its full-time 
  employees, or it offers only coverage that is not considered adequate or 
  affordable; and

- at least one of its full-time employees receives a premium tax credit.

Let’s explain what each of these conditions means.

**What Is Adequate Coverage?**

Coverage is considered adequate if its actuarial value is at least 60 percent. This means 
that the health plan pays on average at least 60 percent of covered expenses, with the 
insured paying the rest in deductibles, coinsurance, and other cost-sharing. (For an 
explanation of actuarial value, see Module 5.)

**What Is Affordable Coverage?**

Employer-sponsored coverage is considered affordable if the cost of self-only coverage 
does not exceed 9.5 percent of an employee’s wages (as reported on IRS Form W-2). 
Where an employer offers several health plan options, the affordability test applies to 
the lowest-cost option that is considered adequate coverage.

**Full-Time Workers and Full-Time Equivalents**

For purposes of the ACA, a full-time worker is an individual employed on average at 
least 30 hours per week.

Even if an employer has fewer than 50 full-time employees, it is subject to the employer 
mandate if the total of its full-time workers and *full-time equivalents* is at least 50. The
number of full-time equivalents is calculated by adding up the hours worked by part-time employees for each month, then dividing by 120 (the minimum number of hours a full-time employee works in a month). No more than 120 hours can be counted per part-time worker.

**Example**: ABC Company has 10 full-time workers and 60 part-time workers who average about 15 hours a week. The monthly hours of the part-time workers total 3,600; 3,600 divided by 120 yields 30 full-time equivalents. 10 full-time workers and 30 full-time equivalents make 40, below the threshold of 50. So ABC is not subject to a penalty if it does not offer health coverage.

**Example**: XYZ Company has 40 full-time workers and 30 part-time workers who average about 15 hours a week. The monthly hours of the part-time workers total 1,800; 1,800 divided by 120 yields 15 full-time equivalents. 40 full-time workers and 15 full-time equivalents make 55, above the threshold of 50. So XYZ is subject to a penalty if it does not offer health coverage.

Under proposed IRS regulations, to determine if an employer is subject to the mandate for a year, full-time workers and full-time equivalents are counted for each month in the prior year, then the monthly count is averaged. For 2014 a special rule applies—employers can count only six months of 2013.

**How Much Do Employers Pay?**

How much do employers pay in tax penalties?

- **Employers not offering coverage**: $2,000 annually ($166.67 monthly) for every full-time employee above the first 30 (who are not counted).

- **Employers offering inadequate or unaffordable coverage**: $3,000 for every full-time employee receiving a premium tax credit, but the penalty cannot be greater than the penalty for not offering coverage at all ($2,000 annually for every full-time employee above the first 30).

**Example**: In 2014 HighTechCo employs 52 full-time workers but does not offer them health coverage. HighTech is subject to a penalty. The amount is calculated as follows:

   52 full-time employees minus the first 30 = 22

   $2,000 annually = $166.67 monthly

   22 X $166.67 = $3,667 (rounded) penalty per month
Summary

To recap, what employers do not have to make shared responsibility payments?

- Employers with fewer than 50 full-time employees or equivalents and
- Employers with 50 or more full-time employees or equivalents that offer at least 95 percent of their full-time employees affordable, adequate health coverage.

The IRS recently issued proposed regulations, along with a series of questions and answers, to help clarify the employer mandate rules. These proposed regulations:

- provide guidance on whether an employer has reached the 50-worker threshold, including a process that describes how to treat part-time workers as full-time equivalents; and
- promise a delayed effective date for large employers with fiscal year plans. For example, if a municipal government has always run its health plan on a July 1 – June 30 year, it will not be subject to the employer mandate until July 1, 2014.

ACA Phase-In

Several important provisions of the ACA had already been implemented at the time of the Supreme Court decision, including the following:

- the right of parents to include their adult children in their health coverage until the child reaches the age of 26;
- the coverage of preventive care services without cost-sharing;
- the prohibition of lifetime dollar limits on benefits for essential services (such as hospital care);
- medical loss ratio (MLR) rules requiring health insurance plans to spend at least a certain percentage of premiums collected on health care (85 percent for large groups, 80 percent for small groups and individual policies);
- stricter rules on the use of funds in flexible spending accounts (FSAs), health savings accounts (HSAs), and health reimbursement arrangements (HRAs) for over-the-counter drugs; and
- a higher tax penalty for using HSA funds for purposes other than health care.

Beginning August 1, 2012, health insurance plans that do not meet the medical loss ratio standards mentioned above have to pay rebates to policyholders. (In the group market,
rebates typically are paid to employers, and employers may have to use a portion of the rebate for the benefit of enrolled employees.)

Several ACA provisions are being implemented in 2013.

- Employee contributions to health care flexible spending accounts (FSAs) are limited to $2,500 per year.

- The Medicare payroll tax increases from 1.45 to 2.35 percent for earnings above $200,000 (individual) or $250,000 (married couple filing jointly).

The year 2014 marks a watershed for health care reform—many of the key components of the ACA are scheduled to be implemented.

- Individuals (with some exceptions) will have to have health insurance or pay a tax penalty. Larger businesses will have to offer health coverage that meets certain standards or pay a tax penalty.

- Health benefit exchanges, designed to help individuals access coverage and subsidies, will go into operation.

- For individual policies and fully insured group plans, coverage must generally be offered on a guaranteed issue basis (with no consideration of an individual’s health). In the individual and small group market different premium rates can be based only on a few factors and must be within certain limits.

Moving beyond 2014, ACA provisions designed to encourage the development of new ways of providing and paying for health care, such as accountable care organizations (ACOs) and bundled payments, are expected to have an impact. In addition, a tax on high-value health plans (“Cadillac” plans) will take effect in 2018, and the Medicare Part D coverage gap will be phased out by 2020. These ACA provisions are discussed in other modules of the Health Insurance Advanced Studies series.
### ACA Implementation Timeline

#### Began in 2010

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult children of insureds</td>
<td>For all group and individual health insurance plans, insureds have the right to include in their coverage their adult children up to age 26.</td>
</tr>
<tr>
<td>Preexisting conditions for children</td>
<td>A group or individual plan may not exclude or limit coverage of preexisting conditions for children 18 and younger.</td>
</tr>
<tr>
<td>Lifetime limits</td>
<td>A plan may not impose lifetime dollar limits on benefits for essential health services.</td>
</tr>
<tr>
<td>Small business tax credits</td>
<td>Small businesses that meet strict criteria are eligible for tax credits to help them pay health insurance premiums for employees.</td>
</tr>
<tr>
<td>Rescissions</td>
<td>Rescission of health coverage is prohibited except for cases of fraud or intentional misrepresentation.</td>
</tr>
<tr>
<td>Preventive care services</td>
<td>All plans must cover specified preventive care services without cost-sharing.</td>
</tr>
<tr>
<td>Appeals process</td>
<td>All plans must have a coverage appeals process.</td>
</tr>
</tbody>
</table>

#### Began in 2011

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical loss ratio (MLR)</td>
<td>Plans must spend at least a certain percentage of the money they receive in premiums on health care (80 percent for individuals and small groups, 85 percent for large groups).</td>
</tr>
<tr>
<td>Account funds for OTC drugs</td>
<td>Over-the-counter (OTC) drugs are no longer reimbursable from flexible spending accounts (FSAs), health savings accounts (HSAs), or health reimbursement arrangements (HRAs), unless prescribed by a physician.</td>
</tr>
<tr>
<td>HSA distributions</td>
<td>Health savings account (HSA) distributions for items other than qualified medical expenses are subject a tax penalty of 20 percent (increased from 10 percent), in addition to regular taxation.</td>
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</tbody>
</table>
CLASS Act frozen | HHS abandoned efforts to implement the Community Living Assistance Services and Supports (CLASS) Act because of actuarial concerns about the program design. The Act was later repealed in the American Taxpayer Relief Act of 2012, signed January 3, 2013. In its place a 15-person long-term care commission will be jointly appointed by the President and Congress.

Effective for 2012 and 2013

<table>
<thead>
<tr>
<th>W-2 form reporting of coverage</th>
<th>Employers filing 250 or more W-2 forms in 2011 must include the cost of employer-sponsored health coverage on W-2 forms issued for tax year 2012 (early 2013 for those using calendar year reporting).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of benefits and coverage</td>
<td>Health plans have to provide a Summary of Benefits and Coverage (SBC) to each enrollee in accordance with detailed guidelines on content, format, etc.</td>
</tr>
<tr>
<td>Rebates</td>
<td>Health insurance plans not meeting the MLR requirements (see above) must pay rebates to policyholders (often employers).</td>
</tr>
<tr>
<td>FSA contribution limitations</td>
<td>Employee contributions to health care flexible spending accounts (FSAs) will be limited to $2,500 per year as of 2013. (Leeway is permitted for fiscal year plans—for example, a plan with a year running from October 1 will not have to adopt the stricter guideline until October 2013.)</td>
</tr>
<tr>
<td>Medicare payroll tax increase</td>
<td>The Medicare employment tax will increase from 1.45% to 2.35% for earnings above $200,000 (individual) or $250,000 (couple).</td>
</tr>
<tr>
<td>Medical deduction tightened</td>
<td>Currently a person can deduct unreimbursed medical expenses on her income tax return to the extent that they exceed 7.5 percent of her adjusted gross income. This threshold will be increased to 10 percent for people younger than 65, making it harder for them to deduct medical expenses. Those 65 and older are exempt from the tightened rule through 2016.</td>
</tr>
<tr>
<td>Health benefit exchanges</td>
<td>Enrollment starts in October 2013 for coverage beginning January 2014.</td>
</tr>
</tbody>
</table>
## Beginning in 2014

<table>
<thead>
<tr>
<th><strong>Health benefit exchanges (also called health insurance marketplaces)</strong></th>
<th>States are required to have exchanges running on or before January 1, 2014. For states that do not, HHS will establish and operate an exchange.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Market reforms</strong></td>
<td>Individual and fully insured group health plans must offer coverage on a guaranteed issue basis (without consideration of an individual’s current health, medical history, or family medical history). A plan may not exclude or limit coverage of preexisting conditions for adults (already prohibited for children as of 2010).</td>
</tr>
<tr>
<td><strong>Community rating</strong></td>
<td>Individual and fully insured small group plans must set premium rates using modified community rating (experience rating prohibited). Different premium rates can be based only on age, geographical area, family size, and tobacco use, and must be within limits.</td>
</tr>
<tr>
<td><strong>Annual limits</strong></td>
<td>Annual limits on benefits for essential health services are prohibited.</td>
</tr>
<tr>
<td><strong>Individual mandate</strong></td>
<td>Individuals (with some exceptions) are required to have health insurance or pay a tax penalty.</td>
</tr>
<tr>
<td><strong>Employer mandate</strong></td>
<td>Businesses with 50 or more full-time employees (or full-time equivalents) must offer health coverage that is considered affordable and meets a minimum standard. Coverage is considered affordable if the premium charged for self-only coverage is no more than 9.5 percent of an employee’s W-2 wages.</td>
</tr>
<tr>
<td><strong>Qualified coverage standards</strong></td>
<td>There will be standards for coverage including an essential benefit package.</td>
</tr>
<tr>
<td><strong>Tax credits</strong></td>
<td>Income tax credits will be available to individuals and families with incomes up to 400 percent of the federal poverty level (FPL) to help them pay health insurance premiums.</td>
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</table>

## Summary

In June 2012 the Supreme Court largely upheld the Affordable Care Act (ACA). The individual mandate was ruled constitutional based on Congress’s authority to tax, not its right to regulate interstate commerce. However, the Court ruled that the federal government could not compel states to expand their Medicaid programs.
As a result, ACA implementation will proceed and related regulations will continue to be rolled out. Some ACA provisions are already in effect, and more will become effective throughout 2013. But the key date will be 2014, when the individual mandate, employer mandate, health benefit exchanges, premium subsidies, and restrictions on underwriting and pricing all become effective.

References
