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The Supreme Court and the Future of Medicaid

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guishing claims of conscience from other types of claims. Certainly, if abortion providers' conscience-based claims require scrutiny, so do conscience-based refusals, to ensure that refusals are indeed motivated by conscience and not by political beliefs, stigma, habit, erroneous understanding of medical evidence, or other factors.

Despite nearly four decades of debate about conscientious refusals, we have no clear path for operationalizing them — no standard curriculum to teach health care professionals how to humanely conscientiously object, and no clinical standard of care for conscientious refusals — although there are presumably good and bad, skillful and haphazard, safe and unsafe ways of carrying them out. Since we need both a standard curriculum and a standard of care, it is perhaps premature to introduce a whole new set of conscience claims. The terms used in the current debate, however, are inadequate and inaccurate.

Recognizing only negative claims of conscience with respect to abortion — or any care — is a kind of hemineglect. Health care workers with conflicting views about contested medical procedures might all be "conscientious," even though their core beliefs vary. Failure to recognize that conscience compels abortion provision, just as it compels refusals to offer abortion care, renders "conscience" an empty concept and leaves us all with no moral ground (high or low) on which to stand.

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The Supreme Court and the Future of Medicaid

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Perhaps the biggest of the many surprises found in the Supreme Court's June 28 decision on the Affordable Care Act (ACA) was the Court's conclusion that the law's Medicaid expansion scheduled for 2014 was unconstitutional.[1] Attention before June 28 was focused on whether the Court would uphold the individual mandate to obtain health insurance coverage, but in the wake of the Court's decision, focus has shifted to the question of whether states will refuse to participate in expanding the Medicaid program, given the Court's holding that the Secretary of Health and Human Services cannot enforce the expansion as a mandate.

Sommers et al. now provide in the *Journal* (pages 1025–1034) a glimpse of the impact of Medicaid expansion in New York, Maine, and Arizona. Medicaid expansion in these states was associated not only with improved health care coverage but also with reduced mortality. The question of whether the states will expand Medicaid, therefore, is not just a question of politics; it is a question of life, health, and death.

The expansion is one of several important Medicaid changes in the ACA. But as Justice Ruth Bader Ginsburg noted in her opinion, changes in Medicaid are not new. Medicaid itself was established in 1965 as an amendment to the preexisting Medical Assistance for the Aged program. Since then, Congress has amended Medicaid at least 50 times, mandating coverage of new categories of beneficiaries (e.g., low-income pregnant women in 1988) and dramatically expanding coverage for others (e.g., low-income children in 1989). Indeed, the Social Security Act has always reserved to Congress "the right to alter, amend, or repeal any provision" of the Medicaid statute.[2] The ACA's expansion of Medicaid to cover all nonelderly low-income persons with household incomes below 138% of the federal poverty level was the latest in a long line of evolutionary program reforms.

The 26 state challengers claimed that the ACA Medicaid amendments crossed a constitutional line. It is clear that Congress cannot force states to par-

ticipate in a federal program. The Court has long recognized, however, that the federal government can offer funding to the states conditional on their satisfying program requirements. The Court had speculated in earlier cases that a situation could arise in which "the financial inducement offered by Congress" was so coercive that "pressure turns into compulsion." But no federal court had ever held that a federal law failed this test, and the lower courts rejected the states' Medicaid claims.

Chief Justice John Roberts, joined by Justices Stephen Breyer and Elena Kagan and supported by a joint dissent from Justices Antonin Scalia, Anthony Kennedy, Clarence Thomas, and Samuel Alito, held that the ACA Medicaid expansion crossed this line. The Court claimed, moreover, that this "coercion" doctrine is fundamental to federalism and that brandishing federal funding to coerce states to participate in federal programs threatens the states' independent sovereignty.

Because the Medicaid expansion was established as a mandate, not an option, Medicaid law would allow the Department of Health and Human Services (HHS) to threaten to withhold all Medicaid payments from states not adopting it — a penalty that HHS has never imposed. In this case, however, the Court held that such a response was impermissible. Withdrawal of program funding would amount to unconstitutional coercion, given the program's size and the nature of the expansion. On average, Medicaid accounts for more than 20% of total state budgets and represents the largest single source of federal funding to the states. Furthermore, said Roberts, the ACA Medicaid expansion changed Medicaid fundamentally. Medicaid, he claimed, "is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage." Congress could not constitutionally force the states to implement a new program under the threat of losing existing program funding.

Having found the Medicaid expansion unconstitutional, however, the Court did not strike the expansion, as the dissenters wanted. Instead, it simply prevented HHS from enforcing the expansion as a mandate. The practical effect is to turn it into an option, although the law remains on the books unchanged. At the same time, the Court made clear that Congress has the power to delineate the conditions under which the states can receive new expansion funding.

The Court's decision raises three key questions. First, which ACA Medicaid reforms are affected? The ACA makes many changes in the Medicaid program. In particular, the law contains a maintenance-of-effort provision barring states from rolling back Medicaid coverage until their health insurance exchanges are operational. It also requires other changes in coverage and enrollment. The states challenged ACA reforms beyond the expansion of eligibility, including the maintenance-of-effort requirement.[3] But Roberts's opinion focuses only on the expansion group, never mentioning the other reforms; presumably the Court considered them part of the existing program, subject to the program's normal enforcement tool for mandatory provisions. A July 10 letter from HHS Secretary Kathleen Sebelius makes clear that where Medicaid is concerned, the Roberts ruling is confined to newly eligible adults.[4]

Second, how far does the Court's new coercion doctrine go? The federal government conditions participation in many cooperative programs on state compliance with federal requirements. These joint efforts include not just health and social welfare programs but education, environmental, civil rights, and transportation programs. Are they all at risk of litigation? Have states now been given a vested right in the status quo? Roberts seemed particularly focused on the notion that the Medicaid expansion changes the program in "kind," not merely "degree," and on Medicaid's size. How big is big? Can a federal program be too big to change? And when does a program change in kind and not degree? It is hard to find limiting principles of the Court's holding.

Finally, how will the states respond? Several Republican governors have made a show of their adamant refusal to expand their Medicaid programs. But the Medicaid expansions are accompanied by 100% federal funding for the first 3 years, phasing down to 90% by 2020. The ACA offers no other means for covering adults with incomes below 100% of the poverty level. Resisting states effectively intensify the huge uncompensated care burden faced by their hospitals, deprive other health care industry players of important revenues, and keep their medically underserved communities from receiving an enormous economic infusion. Indeed, there is good evidence that overall, the changes in Medicaid will

save, rather than cost, money.[5] And residents of states that do not expand will still be paying federal taxes to cover the expansion in states that do expand.

Given the clear language of the Court's decision, the July 10 letter permits states to decide whether to accept funding to support the Medicaid expansion for newly eligible adults as a group or to reject it and with it hundreds of billions of dollars in much-needed federal assistance. But some states may press the administration to interpret the expansion as a simple state option, allowing them to cover some portion of the expansion group and not others. This approach has no support in the law and would invite states to leave the most vulnerable members of the expansion group — adults without children — exposed to the worst sort of discriminatory exclusion. The administration may be pressured to enter into negotiations with each state, using its waiver authority. The ACA specifically amended the Medicaid waiver process to ensure that it was used for genuine research, not political horse trading. One can only hope that the states will come to their senses and we all will be spared the spectacle of federal and state governments struggling over the lives and health of the poorest among us.

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Tattoo Ink–Related Infections — Awareness, Diagnosis, Reporting, and Prevention

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Tattoos have become increasingly popular in recent years. In the United States, the estimated percentage of adults with one or more tattoos increased from 14% in 2008 to 21% in 2012.[1] The process of tattooing exposes the recipient to risks of infections with various pathogens, some of which are serious and difficult to treat. Historically, the control of tattoo-associated dermatologic infections has focused on ensuring safe tattooing practices and preventing contamination of ink at the tattoo parlors — a regulatory task overseen by state and local authorities.[2] In recent months, however, reported outbreaks of nontuberculous mycobacterial infections associated with contaminated tattoo ink have raised questions about the adequacy of prevention efforts implemented at the tattoo-parlor level alone. The Food and Drug Administration (FDA) is reaching out to health care providers, public health officials, consumers, and the tattoo industry to improve awareness, diagnosis, and reporting (through the MedWatch program) in order to develop more effective measures for tattoo ink–related public health problems.

In late January 2012, the FDA was notified, through MedWatch adverse-event reports,[3] of a cluster of patients in New York who had contracted nontuberculous mycobacterial infections manifested by red papules on the gray-colored areas of recently acquired tattoos (see photo and the article by Kennedy and colleagues in this issue of the *Journal*, pages 1020–1024). The FDA collaborated with local and state health departments and the Centers for Disease Control and Prevention to investigate the outbreak. Efforts to identify additional cases nationwide revealed that there were other outbreaks of tattoo ink–related nontuberculous mycobacterial infection that were associated with multiple brands of ink, occurred in other states, and involved multiple species of mycobacteria (e.g., chelonae, fortuitum, and abscessus).

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