MEDICARE "BANKRUPTCY"

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ABSTRACT

Medicare, the social insurance program for the old aged and disabled that is the backbone of the United States health care system, is once again facing insolvency. Spending from the program's hospital insurance trust fund is predicted to exceed the accumulated payroll taxes and other revenues that support the fund within the next five years, leaving Medicare unable to honor all its obligations. The program's four prior insolvency "crises" were averted only by the passage of bipartisan health reform legislation that seems unlikely today, and the past decade has seen Congress repeatedly fail to compromise on "must pass" legislation from sequester to shutdowns, with damaging results. Yet, what happens if and when Medicare actually becomes insolvent has not previously been explored in legal scholarship and is not addressed in statute or regulation—perhaps because scholars and policymakers worry they would make the possibility more real by acknowledging its plausibility. The Article argues that the opposite is true. It confronts for the first time the major legal questions that Medicare insolvency would present and explains that policymakers could by doing the same make insolvency less unfair, less harmful, less likely, and more effective as a tool to promote compromise and cost control in the program. In short, the Article argues for the establishment, by law, of rules to govern Medicare bankruptcy.

The Article's first-ever analysis of how an insolvent Medicare program would work reveals five unsettled legal questions, administrative and judicial resolution of which would determine insolvency's harms, who would pay them, and when: (1) the regulatory process through which Medicare would administer insolvency; (2) whether provider and insurer payments would be reduced pro rata *or delayed (outpatient and beneficiary payments would not be directly impacted); (3) whether some such claimants would be insulated from insolvency's harms; (4) whether disappointed claimants could be entitled to judicial relief; and (5) if so, whether the procedure for obtaining relief would be a prospective injunctive remedy in Federal District Court or a retrospective damages remedy in the Court of Federal Claims. All this uncertainty is a problem. Uncertainty surrounding the consequences of insolvency would be problematic from the* ex post *perspective of an actually-insolvent Medicare program because it would increase the unfairness and magnitude of the associated harms. Further, such uncertainty is already problematic from the* ex ante *perspective of a program in a five-decade cycle of insolvency that has once again come to the tipping point because it inhibits compromise and dilutes the effectiveness of the threat of insolvency in incentivizing Medicare's powerful industry constituents to use their influence in the regulatory and legislative processes to promote rather than undermine efforts to control health care costs. In developing this normative insight, the Article for the first time applies the structural,* ex ante *theoretical perspective developed in the municipal bankruptcy literature—and the accompanying focus on combatting moral hazard—to the law and political economy of a federal spending program.*

The Article concludes by addressing the roles of Congress, the Department of Health and Human Services ("HHS"), and courts in clarifying the consequences of insolvency in Medicare. Although a partial framework could and should be established by regulation in the short term, the Article suggests a Medicare bankruptcy provision ultimately be included as a failsafe in future legislation, if and when it comes, addressing the current crisis. Courts, for their part, should favor interpretive and doctrinal approaches that make the consequences of insolvency in Medicare more predictable. The open question of Chevron *deference to HHS interpretations of the Medicare statute would have important implications should the program become insolvent and illustrates the materiality of this predictability criterion.*

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INTRODUCTION

According to fable a frog tossed in boiling water will quickly hop out, but a frog placed in tepid water will remain, oblivious to the creeping threat, as the water is slowly warmed and the frog is boiled alive.[1] The United States is currently engaged in an unplanned, high stakes experiment to test the truth of this fable, with a slightly different setup. The frog is Medicare, the federal health care program for 61 million old aged and disabled Americans,[2] and the warming water is the program's approaching insolvency.

Medicare is projected to become insolvent within five years.[3] When that happens, the payroll taxes that primarily fund the program will be insufficient to pay the claims of the hospitals and insurers who meet the health care needs of the nation's elderly, and all reserves will run out. This is the fifth time in five decades that the program has faced insolvency within six years,[4] but the program has never been closer to insolvency than it is now.[5] Moreover, what once seemed unthinkable now seems increasingly plausible: Medicare may well actually go "bankrupt."[6] Four overlapping trends support that pessimistic conclusion,

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[1] *E.g.*, *What is the Fable of the Boiling Frog?*, DAILY MAIL (Mar. 4, 2019), https://www.dailymail.co.uk/sciencetech/fb-6769921/WHAT-FABLE-BOILING-FROG.html.

[2] Patricia A. Davis & Phoenix Voorheis, *Medicare Overview*, Congressional Research Service (2020), https://crsreports.congress.gov/product/pdf/IF/IF10885.

[3] The most authoritative predictions come from the Board of Trustees of the Trust Fund ("Trustees"), a group consisting of two presidential appointees (currently vacant) along with the Commissioner of Social Security and the Secretaries of Treasury, Labor, and Health & Human Services, that is required by statute to report annually on Medicare's financial status. 42 U.S.C. § 1395i. The Trustees' most recent estimate, issued August 31, 2021, predicted insolvency in 2026, which is consistent with a recent CBO baseline report. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: 2021 TO 2031 (2021), https://www.cbo.gov/publication/56970; Bds. of Trs., *2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*, FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS (Aug. 31, 2021), https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf

[4] *See* CONG. RSCH. SERV., RS20946, MEDICARE: INSOLVENCY PROJECTIONS 1, 4 (2020), https://fas.org/sgp/crs/misc/RS20946.pdf (indicating that insolvency was projected to be within six or fewer years in 1970–72, 1982, 1993, 1996–97).

[5] Richard G. Frank & Tricia Neuman, *Addressing the Risk of Medicare Trust Fund Insolvency*, 325 J. AM. MED. ASS'N 341, 341 (2021) ("Congress has addressed insolvency in the past but never on such a tight deadline.").

[6] It is common in health policy to object that an insolvent Medicare would not actually be "bankrupt." *E.g*, PAUL N. VAN DE WATER, CTR. ON BUDGET AND POL'Y PRIORITIES, MEDICARE IS NOT "BANKRUPT" 1 (2019), https://www.cbpp.org/sites/default/files/atoms/files/7-12-11health.pdf; THEODORE R. MARMOR, THE POLITICS OF MEDICARE 135 (2000) ("no precise analog to private bankruptcy exists in public programs like Medicare"). This objection is fair in the sense that even if insolvent the program would still have significant revenue and be able to pay most of its liabilities, and thus would not be "bankrupt" in that colloquial sense of the word that means "having no assets or revenue." It is also fair in the sense that insolvency would not change Medicare beneficiaries' entitlement to services from Medicare providers and insurers—it would instead impact reimbursement for those providers and insurers (with important but indirect effects on patients discussed *infra* Part III.A). But in legal parlance, one is bankrupt who is "without enough money to pay back what one owes," and "bankruptcy" itself refers to "[a] statutory procedure by which a . . . debtor obtains financial relief and undergoes a judicially supervised reorganization or liquidation of [their] assets for the benefit of creditors." *Bankruptcy*, BLACK'S LAW DICTIONARY (11th ed. 2019). In this sense, the Article explains, Medicare would indeed be "bankrupt" if it became insolvent, and the Article's central thesis is that an explicit "bankruptcy" framework for Medicare should be created before the program actually becomes insolvent. *Infra* Part III.

despite Medicare's traditional political sanctity. In Medicare itself, prior insolvency "crises" were resolved only by the passage of bipartisan health reform legislation that appear unlikely today,[7] especially given analysts' prediction that this time extending the program's life will require unprecedented changes in its financing structure.[8] In health law, Congress has increasingly failed to enact funding necessary to honor entitlements, thereby "disappropriating"[9] Tribal contract support costs,[10] the Children's Insurance Program,[11] and ACA subsidies.[12] In fiscal law, Congress has repeatedly failed to rise to the challenge of budgetary pressures and enact "must pass" legislation, often reverting to a series of short-term patches that eventually lead to impasse—as the debt ceiling debate looming once again at this writing illustrates.[13] And in politics, an era of "hardball" sees the party opposing the president look to seize any opportunity possible to use their influence in Congress to frustrate governance.[14]

Medicare's chances of bucking these trends are especially bad because, as serious as it would eventually be and as definitive as headlines make it sound, unless something is done the actual implications of insolvency in Medicare would be uncertain at the outset and slow

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[7] *See e.g.*, David Muhlestein, *The Coming Crisis for the Medicare Trust Fund*, HEALTH AFFS. BLOG (Dec. 15, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201210.997063/full/ (describing "major federal legislation" required to resolve past insolvency crises). Whether the approach of insolvency is properly understood as a "crisis" has been disputed, *see* MARMOR (describing insolvency as a "thermometer"), but that understanding is nonetheless pervasive and influential, so the Article employs it while seeking to develop a richer picture of how insolvency would work in Medicare that might supplant superficial understandings based only on rhetoric. *Cf.* JONATHAN OBERLANDER, THE POLITICAL LIFE OF MEDICARE 75 (2003) ("Trust find crises are political events whose solutions reflect contemporary partisan alignments, ideological commitments, and policy analysts' thinking about what represents the solution *du jour* in the health system.").

[8] *See e.g.*, PAUL N. VAN DE WATER, CTR. ON BUDGET AND POL'Y PRIORITIES, STRENGTHENING MEDICARE FINANCING: GENERAL REVENUES SHOULD BE PART OF THE SOLUTION 1 (2020), https://www.cbpp.org/sites/default/files/atoms/files/12-14-20health.pdf ("Phasing in spending cuts of [the] magnitude [of Medicare's projected deficit over a decade] would not be feasible.").

[9] "Disappropriation" is "the phenomenon of congressional failure to appropriate funds necessary to honor a government commitment." Matthew B. Lawrence, *Disappropriation*, 120 COLUM. L. REV. 1, 9 (2020).

[10] *Id.* at 24, 27–30 (describing how "Congress failed to appropriate sufficient funds to the Secretary of Interior to reimburse tribes" who "had elected to operate their own services under the [Indian Self-Determination and Education Act]").

[11] *Id.* at 37–39 (describing how, after "[t]he two-year appropriation for [the Children's Health Insurance Program (CHIP)] enacted in 2015 ran out," temporary funding measures were only enacted nearly twelve weeks later).

[12] *Id.* at 30–37 (describing how rider limiting "program management" appropriation's use for risk corridor payments left Health and Human Services without sufficient appropriations to pay insurers under the program, as the ACA required, and how Congress's failure to appropriate new funds for cost-sharing reduction payments led to the halting of such payments).

[13] *See e.g.*, Katie Dmitrieva, *Treasury to Start Special Measures to Avoid Breaching Debt Limit*, BLOOMBERG, (July 30, 2021) ("Congress still lacks a clear plan for avoiding default later this year."), https://www.bloomberg.com/news/articles/2021-07-30/treasury-to-start-special-measures-to-avoid-breaching-debt-limit.

[14] Joseph Fishkin & David E. Pozen, *Asymmetric Constitutional Hardball*, 118 COLUM. L. REV. 915, 980–86 (2018) ("[g]reater use of constitutional hardball . . . tend[s] to increase even further the use of constitutional hardball . . . as members of both parties successively shred cooperative norms, shrink the space for bipartisan policy solutions, and make governance more difficult"). There is an argument about whether this phenomenon is asymmetric—perhaps more common among, or more useful to, Republicans—but even skeptics of hardball's asymmetry do not deny its growing prevalence. *See, e.g.*, David E. Bernstein, *Constitutional Hardball Yes, Asymmetric Not So Much*, 118 COLUM. L. REV. 207, 212–222 (2018) (arguing that constitutional hardball is not more common among Republicans than Democrats).

to develop. The question what would actually happen to hospital and insurer reimbursement[15] if the Medicare program reaches insolvency has not previously been explored in any public forum,[16] not even in the robust legal literature focused on the program's finances.[17] But the Article's first-ever analysis of what administering insolvency would entail reveals that the advent of insolvency in the program would be more like a slow-rising boil than a "jump or die" event. Specifically, the Article isolates and analyzes five key open legal questions facing the Department of Health and Human Services ("HHS") and courts, the answers to which could take years to emerge and would determine the harms of insolvency, who would bear those harms, when they would materialize, and the "deadline" to avoid them.[18] Hence the Article's thesis, that HHS or preferably Congress should establish Medicare bankruptcy rules in advance in order to make insolvency less unfair, less harmful, less likely, and, as a tool for controlling cost and promoting quality in health care, more effective.[19]

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[15] Reimbursement for outpatient care and prescription drugs through Medicare is not dependent on the Hospital Insurance Trust Fund, and so would not be directly disrupted in in the event of insolvency. *Infra* nn. 38-42 and accompanying text.

[16] The author is unaware of any treatment of the subject, public or private. A Congressional Research Service report on Medicare insolvency projections is illustrative of this gap. In a section titled "What Would Happen if the Fund Became Insolvent," the report simply notes that "[t]here are no provisions in the [Medicare statute] that govern what would happen if insolvency were to occur." Patricia S. Davis, *Medicare: Insolvency Projects* at 8, Congressional Research Service (May 29, 2020), https://fas.org/sgp/crs/misc/RS20946.pdf. As Part II elaborates, that is not quite true; there are no *explicit* provisions of law addressing insolvency in Medicare (the Article argues there should be), but HHS's administration of insolvency would be subject to many generally-applicable legal requirements in the U.S. Constitution, the Medicare statute, and the Administrative Procedure Act. Some treatments do address the distinctive question what might happen if the Social Security Trust Fund—which reimburses beneficiaries directly, not through intermediaries as does Medicare—were to run out. *E.g.* JOHN HARRISON, NEW PROPERTY, ENTRENCHMENT, AND THE FISCAL CONSTITUTION, IN FISCAL CHALLENGES: AN INTERDISCIPLINARY APPROACH TO BUDGET POLICY 404 (Elizabeth Garrett, Elizabeth A. Graddy, and Howell E. Jackson, eds., 2008 (discussing lack of clarity surrounding implications of insolvency in Medicare).

[17] A growing literature discusses the Medicare program in general and the program's financial situation in particular, but has not addressed the question what would actually happen should the program become insolvent. *E.g.*, Mark A. Lemley, Lisa Larrimore Oullette & Rachel Sachs, *The Medicare Innovation Subsidy*, 95 NYU L. REV. 75 (2020) (discussing interaction between Medicare reimbursement and pharmaceutical innovation); Isaac Buck, *Furthering the Fiduciary Metaphor: The Duty of Providers to the Payers of Medicare*, 104 CAL. L. REV. 1043, 1064 (2016) (giving providers fiduciary duty to payers would "better protect the fiscal health" of the Medicare program); Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L. J. 519 (2013); Jacqueline Fox, *The Hidden Role of Cost: Medicare Decisions, Transparency and Public Trust*, 79 U. CIN. L. REV. 1 (2010); Jill R. Horwitz, *The Virtues of Medicare*, 106 MICH. L. REV. 1001 (2008); David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165 (2003). As Part III.C explains, the question what would happen in the event of insolvency in Medicare is itself an upstream, *ex ante* determinant of the program's policies, finances, and performance that operates whether or not the insolvency point is actually reached.

[18] *See infra* Part II (exploring questions (1) when and how to promulgate Medicare policy addressing administration in the event of bankruptcy; (2) whether to pay claims in full but subject to an increasingly-long delay or to pay all claims as usual but reduced *pro rata*; (3) whether to insulate some claimants from insolvency's effects; (4) whether shorted providers could obtain recovery from the Judgment Fund; and (5) whether any such recover would come through prospective injunctions in federal district courts or retrospective damages orders in the court of federal claims).

[19] The Article focuses on the benefits of clarity, all else being equal, but it is important to note that those benefits could be outweighed if the clarification adopted by Congress or HHS was itself problematic. *See infra* Part III.C (describing possibilities); Part IV (recommending particular clarifications).

That it would be good to make insolvency less unfair, less harmful, and less likely presumably goes without saying, but the idea of making insolvency a more effective tool requires elaboration. The establishment of rules for Medicare bankruptcy would offer an opportunity to address a problem in Medicare's political economy that scholars have noted contributes to the program's underlying cycle of insolvency.[20] Medicare's political economy encourages concentrated lobbying interests—including hospitals, insurers, pharmaceutical companies, and beneficiaries—to use their influence to steer the program's policy toward greater spending between solvency crises (for better or worse), and they do so effectively (though not always successfully) in the administrative process, the legislative process, and the judicial process.[21] This is one reason that solutions to prior Medicare insolvency crises have inevitably proven temporary, and that the nation has consistently failed to control health care costs, in Medicare and beyond.[22]

The *threat* of insolvency has a potentially salutary role to play in this dynamic interaction between politics and law—even if Medicare actually never becomes insolvent. The threat of Medicare bankruptcy could mitigate the biasing influence of providers, insurers, and pharmaceutical companies by altering their incentives—changing not their ability to exert influence (which may be impossible) but the ends to which they put that influence. As municipal bankruptcy literature teaches,[23] making it clear that the most powerful constituents have skin in the game (so to speak) of Medicare's solvency would combat their moral hazard and encourage them to use their clout to protect, and not just undermine, the program's long-term fiscal health—perhaps even by promoting long-term population health. Clear Medicare bankruptcy rules, established *ex ante* rather than *ex post*, could change the program's political economy to give powerful interests reason to direct Medicare away from the boiling pot, rather than into it.

The stakes are so large, and numbers in the Medicare program so big, they can sometimes begin to seem more technical than human. But Medicare's insolvency would touch the lives of almost every American and carry the potential to transform the country's health, welfare, and governance. The program is the linchpin of our health care system, and of many communities. Its 61 million beneficiaries depend on it for medical care, the nation's 6,023 hospitals, 15,000 nursing homes, and nearly 5,000 hospice facilities depend on it to remain afloat, and the communities they serve depend on it for the jobs and economic lifeline Medicare providers bring.[24] Medicare insolvency would eventually impact all those who rely on Medicare and, as the Article explains, the legal and policy choices made in operationalizing insolvency if and when it comes will determine who among these groups pays, and how much.

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[20] *See infra* nn. 62 to 78 and accompanying text (describing law and political economy problem). On the concept and field of law and political economy, *see generally* Jedediah Britton-Purdy, David Singh Grewal, Amy Kapczynski & K. Sabeel Rahman, *Building a Law-and-Political-Economy Framework: Beyond the Twentieth-Century Synthesis*, 129 YALE L.J. 1784 (2020).

[21] *Id.*

[22] *Id.*

[23] David Schleicher, *Hands On! Part I: The Trilemma Facing the Federal Government During State and Local Budget Crises*, YALE L. SCH. PUB. L. & LEGAL THEORY RSCH. PAPER SERIES (forthcoming 2021) (manuscript at 6), https://ssrn.com/abstract=3649278 (discussing federal government's options in avoiding state debt crises).

[24] CTRS. FOR MEDICARE & MEDICAID SERVS., MDRC PROVIDERS 1, MEDICARE PROVIDERS: NUMBER OF MEDICARE CERTIFIED INSTITUTIONAL PROVIDERS, CALENDAR YEARS 2014-2019 (last modified Apr. 15, 2020), https://www.cms.gov/files/document/2019cpsmdcrproviders1.pdf.

What's more, trust fund insolvency would have transformative ramifications beyond Medicare itself. Across the health care system, disruptions in Medicare reimbursement would trigger hospital consolidation, cuts to charitable care, private sector insurance premium increases, and more vigorous medical bill collection activity.[25] All of these effects would reduce affordability and increase inequity in a health care system that is already unaffordable and deeply inequitable.[26] In politics, insolvency would support an argument and perception—justified or not—that government-sponsored health care is financially unsustainable.[27] Medicare's existing cycle of insolvency is already cited as an argument against "Medicare for All" or other expanded government programs[28]—actually reaching insolvency would supercharge such arguments. In fiscal law, where inter-generational, inter-class, and inter-sector fights about how the nation should direct its scarce resources play out,[29] the choices made by Congress, courts, and HHS in administering insolvency would determine whether Medicare continues to have a privileged status or instead must compete directly going forward with those seeking higher wages, profits, or spending on social programs such as public health and education.[30] Finally, the threat of insolvency in Medicare shapes the very political economy of health care. The formulation of insolvency rules, if done carefully, thus offers a rare chance to address the role that wealth plays in shaping health policy in the United States.[31]

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[25] Medicare subsidizes care for the indigent, for undocumented immigrants, and for all others who slip through the cracks of our health care system to become "uninsured." It is through Medicare that hospitals are required to treat any patient, regardless whether they have insurance, and through Medicare that hospitals that disproportionately serve such uninsured patients are reimbursed for doing so. 42 U.S.C. § 1395dd(b)(1) (requiring medical screening from hospitals regardless of whether or not the individual is eligible for Medicare); § 1395ww(d)(5)(F)(i)(I) (authorizing additional payments for providers "which serve[ ] a significantly disproportionate number of low-income patients . . . ."). Disrupted reimbursement due to insolvency in Medicare would prompt hospitals to cut these services, along with other impacts listed above. *Infra* Part III.A.

[26] *See generally* Lindsay Wiley, Erin Fuse Brown, Elizabeth McCuskey, and Matthew B. Lawrence, *Health Reform Reconstruction*, U.C. DAVIS L. REV. (forthcoming 2021) (collecting sources describing inequity).

[27] THEDA SKOCPOL, SOCIAL POLICY IN THE UNITED STATES: FUTURE POSSIBILITIES IN HISTORICAL PERSPECTIVE 7 (Princeton 1994) ("Prior policies may be seen as models to be extended or imitated; or they may be seen as 'bad' examples to be avoided in the future.").

[28] *E.g.* Seth J. Chandler, *Medicare for All: The Need for a Long Approach*, 20 HOU. J. HEALTH L. 1, 10 (2020) ("[i]t might . . . be more persuasive to expand Medicare to a much larger population right away if that particular program were financially stable"); *see* Susan Adler Channick, *Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market, and Culture*, 28 LAW & INEQ. 1, 35 (2010) ("That Medicare . . . is perpetually on the verge of insolvency makes a universal social insurance system predictably frightening to legislators and voters alike.") Marmor, *supra* nn. 6 at 137 (trust fund financing is "one of the greatest political vulnerabilities" of Medicare and "the nominal foundation to support the attacks of the program's harshest critics"). In the Democratic presidential primary, the aspect of "Medicare for All" that proved pivotal—for the program and for its proponents, especially Senator Warren—was questions about its financing. *See* Peter Sullivan, *Warren Takes Fire From Rivals on Cost of 'Medicare for* All', THE HILL (Oct. 15, 2019), https://thehill.com/policy/healthcare/465979-warren-takes-fire-from-rivals-on-cost-of-medicare-for-all.

[29] *See* Matthew B. Lawrence, *Covid-19 Reveals the Fiscal Determinants of Health*, *in* COVID-19 AND THE LAW (I. GLENN COHEN, ABBE GLUCK, KATHERINE KRASCHEL, AND CARMEL SHACHAR, EDS.) (forthcoming, Cambridge University Press) (surveying role of fiscal law in health law and policy).

[30] *See* Matthew B. Lawrence, *Subordination and Separation of Powers*, 131 YALE L. J. ___ (forthcoming 2021) (describing privileged status of Medicare *vis a vis* other health programs in current fiscal arrangements); *infra* Part II.D, IV.A (describing how question of Judgment Fund availability would determine whether Medicare would continue to enjoy privileged status post-insolvency).

[31] *See* Britton-Purdy *et al.*, *supra* nn. 20, at 1829-32 (describing stubbornness of economic power and difficulty of curbing its influence through law).

The Article's contribution is descriptive, normative, theoretical, and prescriptive. Its descriptive contribution is to detail and analyze the key questions the Medicare program will face if it reaches insolvency and the provisions of Medicare law, administrative law, and constitutional law governing those choices. Its normative contribution is to explain that advance resolution of these questions by law would predictably reduce the likelihood Medicare would actually become insolvent and the harms and unfairness that would result if it did. Its theoretical contribution is to develop the possibility that the threat of insolvency could play a more effective role in health policy—if it must play any role at all—if insolvency's consequences were clarified to combat the moral hazard of the powerful economic interests who influence the program's policy between solvency crises. And its prescriptive contribution is to recommend specific actions that HHS, Congress, and courts should take to clarify the consequences of insolvency in Medicare before it is too late.

The Article proceeds in four parts. Part I is background. It describes the Medicare program and its ongoing cycle of insolvency. It also describes reasons for skepticism that Congress will enact legislation that addresses the program's solvency on more than a short-term basis, if it even does that.

Part II addresses how an insolvent Medicare program might be administered under current law. Recent congressional failures to appropriate funds necessary to honor commitments in Affordable Care Act and Medicaid programs reveal that the harms of such failures depend very much on the details.[32] Building on these precedents, Part II systematically isolates and analyzes the key choices posed by Medicare bankruptcy—the administrative process by which to set insolvency policy, whether to delay payments or reduce them *pro rata*, whether to insulate some claimants (such as hospitals that serve many indigent patients), whether courts could order shorted providers reimbursed through the "Judgment Fund," and, if so, which courts and when.

Part III develops the Article's thesis, that the consequences of insolvency in Medicare should be clarified in advance. From the *ex post* perspective of an insolvent program, clarity would reduce the unfairness and harms of Medicare bankruptcy. And from the *ex ante* perspective of a program in the midst of another insolvency crisis, rules established in advance could reduce the likelihood the insolvency point is reached in the short term (by facilitating compromise in Congress) and help break Medicare free of its underlying cycle of insolvency in the long term (by combatting the moral hazard of the powerful economic interests that influence Medicare policy).

Part IV offers prescriptions for HHS, Congress, and courts. HHS could create significant value by establishing a Medicare bankruptcy framework by regulation, but the greatest potential lies in a legislative framework created by Congress. And although the role of courts is necessarily secondary, Part IV explains that courts would by emphasizing the value of predictability in interpreting the Medicare statute both further the goal of clarifying the consequences of Medicare insolvency and honor congressional intent. The question of *Chevron* deference in Medicare that the Supreme Court is scheduled to consider in OT 2021 illustrates the relevance of this prescription.[33] Finally, a brief conclusion summarizes the Article's contribution.

I. THE FAULT IN MEDICARE'S STARS

[32] *Disappropriation*, *supra* note 9, at 27.

[33] *See infra* Part IV.B (describing cases).

Medicare is a federal program that covers health care costs for the elderly and disabled, as well as those with end-stage kidney disease.[34] It covers eligible hospital costs, outpatient care, and pharmaceuticals costs, among other benefits.[35] Scholars rightly describe it as a "cornerstone" of social policy in the United States, and prominent health reform proposals make Medicare their centerpiece.[36] It was created in 1965 as part of President Johnson's "Great Society."[37]

The nation's elderly and disabled are the costliest groups to provide with health care. The resources through which Medicare does so have to come from somewhere. The heart of Medicare's financing is the "trust fund" system pioneered in Frances Perkins' Social Security program.[38] In Medicare's version of this system, a payroll tax is levied against the income of all Americans and deposited into a designated Treasury account labeled the "Hospital Insurance Trust Fund" ("trust fund") and separated from general revenues. Congress has appropriated this account, in turn, as the source of payment for about half of Medicare costs,[39] including payments to hospitals, skilled nursing facilities (nursing homes), hospice care, Medicare Advantage insurers (aka "Part C" insurers), and many others.[40] This structure contributes to the political legitimacy of Medicare and to its robust enrollment, as beneficiaries come to see the program not as government largesse but as an entitlement they "earned" through their payroll tax contributions.[41] That said, a plurality of Medicare costs

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[34] *What's Medicare?*, MEDICARE.GOV, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last visited Jul 5, 2021).

[35] Patricia A. Davis & Phoenix Voorheis, *Medicare Overview*, Congressional Research Service (2020), https://crsreports.congress.gov/product/pdf/IF/IF10885 (last visited Jul 5, 2021).

[36] *See* Isaac D. Buck, *The Meaning of 'Medicare-for-All'*, 20 HOUS. J. HEALTH L. & POL'Y 159, 161 (2020) ("the national narrative has focused on insurance access through 'Medicare-for-All'); William G. Dauster, *Protecting Social Security and Medicare*, 33 HARV. J. LEGIS. 461, 461 (1996) ("Medicare rests as the cornerstone of Lyndon Johnson's Great Society").

[37] *Medicare Signed Into Law*, U.S. SENATE, https://www.senate.gov/artandhistory/history/minute/Medicare_Signed_Into_Law.htm#:~:text=On%20July%2030%2C%201965%2C%20President,Harry%20Truman%20had%20proposed%20it. (last visited Jul 5, 2021).

[38] The Social Security program is ordinarily associated with President Franklin Delano Roosevelt, but Labor Secretary Frances Perkins, the first female cabinet secretary, was more primarily responsible for the program's development and implementation. *See Social Security Pioneers*, SOC. SEC. ADMIN., https://www.ssa.gov/history/fperkins.html (last visited Jul 5, 2021).

[39] *See* 42 U.S.C. § 1395i(b)(2) (requiring Trustees to issue "funding warning" if general revenues are expected to cover 45% or more of total Medicare costs).

[40] 42 U.S.C. § 1395ww(b), 1395cc(a) (hospitals); § 1395yy(h) (skilled nursing facilities); § 1395w-23(f) (insurers participating in Part C); § 1395ww(h) (graduate medical centers); §1395l(f) (Community health clinics); § 1395g(a)–(e) (Hospices); § 1395b-1(a) ("public or private agencies, institutions, and organizations . . . develop[ing] and engag[ing] in experiments and demonstration projects"); § 1395b-4 (states receiving grants under the State Health Insurance Assistant Program (SHIP) for "providing information, counseling, and assistance relating to the procurement of adequate and appropriate health insurance to individuals who are eligible to receive" Medicare benefits); § 1395b-6 (Medicare Payment Advisory Commission costs); § 1395b-8 (chronic care improvement organizations—which include "disease management organization[s], health insurer[s], integrated delivery system[s], physician group practice[s], a consortium of such entities, or any other legal entity that the secretary determines appropriate"); § 1395m(x) (rural emergency hospitals); § 1395w-27a(h) (essential hospitals); 1395mm(i) (health maintenance organizations); 1395yy(h) (skilled nursing facilities); 1395ddd (program integrity).

[41] Oberlander, *supra* note 7 at 83 (Medicare's "popularity can be attributed, in part, to its financial design. The Medicare payroll tax has created the sense of public entitlement that its architects anticipated.").

are not financed through this trust fund but instead from other sources. These include outpatient medical costs (whether incurred at a doctor's office or a hospital) and pharmaceutical costs, which are paid from a different account, the Supplemental Medical Insurance Trust Fund, that does not depend on payroll contributions (and so would be insulated from the direct impacts of insolvency).[42]

The trust fund financing structure means that Medicare (or, rather, HHS and Congress) must find a way to ensure that expenditures on hospital and related costs under the program do not exceed revenues through the Medicare payroll tax and other sources. This Medicare has repeatedly failed to do. In its history Medicare has not controlled the solvency of the program between solvency "crises," depleting the trust funds until it was within six years of insolvency.[43] Each time, the resulting Medicare insolvency "crisis" was resolved only through major bipartisan legislation restructuring health policy in the United States.[44] This included the Social Security Amendments of 1983 eliminating "reasonable cost" reimbursement for hospitals and creating the Inpatient Prospective Payment System ("IPPS")[45]; the 1997 Balanced Budget Act which included large cuts to Medicaid (which covers eligible low income individuals)[46] and set the stage for the rise of privatized Medicare coverage offered through private insurance companies ("Medicare Advantage" or "Medicare Part C")[47]; and the Affordable Care Act, supplemented by MACRA, which created "Accountable Care Organizations" and a system of advanced payment models.[48]

This cycle of near-insolvency and repair has been harmful to Medicare, to the project of health reform, and to the country. The controversy surrounding each insolvency crisis damages the legitimacy of Medicare, creating a (perhaps accurate) picture of a lack of fiscal control that has undermined political support for expanding public health insurance in the United States.[49] More practically, waiting until the programmatic "last minute" to develop and implement reforms to protect the solvency of Medicare dramatically limits the "menu" of reforms available to those with immediate, direct payoff, such as savings from cuts in

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[42] Juliette Cubanski et al., HOW IS MEDICARE FINANCED AND WHAT ARE MEDICARE'S FUTURE FINANCING CHALLENGES?, KAISER FAM. FOUND. (2015), https://www.kff.org/report-section/a-primer-on-medicare-how-is-medicare-financed-and-what-are-medicares-future-financing-challenges/ (last visited Jul 5, 2021).

[43] Oberlander, *supra* note 7 at 75 (describing "pattern of crisis and reform that has driven Medicare politics since the program's enactment").

[44] Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. LEE L. REV. 1095, 1121 (2003) (describing "the practices . . . of adopting Medicare reform as a part of large-scale fiscal legislation")

[45] Social Security Amendments of 1983, Pub. L. 98-23.

[46] The law came at a time when "the notion that Medicare was a program in crisis" had become "a staple of American politics." Oberlander, *supra* note 7 at 74. In exchange for changes that increased costs in the program, fiscal conservatives insisted on broad reforms to "control" spending in other health and welfare programs, including a $61 billion reduction in spending through the Medicaid program (which covers eligible low income individuals). ANDY SCHNEIDER, CTR. FOR BUDGET & POL'Y PRIORITIES, OVERVIEW OF MEDICAID PROVISIONS OF THE BALANCED BUDGET ACT OF 1997 (Sept. 18, 1997), https://www.cbpp.org/sites/default/files/archive/908mcaid.htm. The amendments also expanded states' ability to privatize their Medicaid programs. *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 448 (2011) (citing 42 U.S.C. § 1396u-2(a) (2005)).

[47] *Id.*

[48] Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 Fed. Reg. 2,8162 (May 9, 2016) (to be codified at 42 C.F.R. pt. 414, 495).

[49] *Supra* note 28 (collecting sources).

benefits, increases in beneficiary obligations, tax increases, and cuts in other programs.[50] This excludes many of the most meaningful, substantive means of reducing health care cost, such as by incentivizing the development of less expensive alternatives to current technologies or encouraging preventive care and care coordination.[51] Indeed, every year in their report on the program's solvency Medicare's Trustees suggest reforms that would both improve the program and reduce cost, but as the insolvency date draws nearer they are forced to warn that that the later solvency is tackled, the fewer such reforms will be possible.[52]

Relatedly, the cycle of insolvency has skewed the shape of health policy by ensuring that, when Congress legislates on health reform, it is within the narrative framework of "solving" the "cost problem" in health care,[53] or the "spending problem" in government.[54] Scholars such as Professor El Sabawi have documented how the way Congress defines a regulatory problem shapes the solutions it evaluates and implements,[55] and that has proven true when it comes to legislation responding to Medicare solvency crises.[56] Most recently, legislative debates about Medicare's solvency have framed the problem as inherent in a government-run health care program, motivating major legislative steps toward the privatization of the program to be run through a for-profit health insurance model.[57]

What explains this cycle of insolvency? Of course, any given Medicare insolvency is in a superficial sense "caused" by an arithmetical imbalance—either too much spending or too little revenue. Thus, demographic shifts and cost growth are appropriately blamed for particular insolvency crises, and legal scholarship addressing the program's solvency has focused rightly (albeit almost exclusively) on specific, substantive policy reforms to reduce spending, such as giving patients greater "skin in the game" of their health care costs through

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[50] Hyman, *Medicare Meets Mephistopheles*, *supra* note 20, at 1197 ("The consistent approach when attempting "reform" is to fix the short term and ignore the (far more problematic) long term.").

[51] *See, e.g.*, Neel U. Sukhatme & M. Gregg Bloche, *Health Care Costs and the Arc of Innovation*, 104 MINN. L. REV. 955, 957 (2019) (problematizing lack of incentives to innovate cost-effective treatments and preventive measures); William M. Sage, *Explaining America's Spendthrift Healthcare System: The Enduring Effects of Public Regulation on Private Competition*, *in* THE LAW AND POLICY OF HEALTHCARE FINANCING 17, 34–36 (Wolf Sauter et al. eds., 2019) (describing how "accreted health law" contributes to inefficiency and waste in health care system).

[52] *E.g.* Bds. of Trs., *2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*, FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS (APR. 22, 2020) [hereinafter "2020 Trustees Report"], https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.

[53] *E.g.*, Press Release, Dep't Health & Hum. Servs., Statement of Sec'y Schweiker (May 12, 1981) (introducing proposed reforms by explaining they would "keep the system from going broke"); Letter from Mike Crapo & Kevin Brady to Janet Yellen, *supra* note 3.

[54] *E.g.* Oberlander, *supra* note 44, at 1118 (explaining how political leadership developing 1997 Balanced Budget Act leveraged Medicare fiscal crisis to motivate sweeping cuts in spending programs; "the concern was not just that the Medicare trust fund would soon go bankrupt, but also that Medicare would soon bankrupt the government").

[55] *See* Taleed El-Sabawi, *What Motivates Legislators to Act: Problem Definition & the Opioid Epidemic, a Case Study*, 15 IND. HEALTH L. REV. 189, 190–91 (explaining how the way problem is defined shapes perceptions of available solutions).

[56] *See* Oberlander, *supra* note 44, at 1117 ("members of Congress who had long sought to reduce entitlement spending seized on the "trust fund shortfall . . . [as] a convenient problem to which [they] could attach the solution that they already had in mind.").

[57] CONG. BUDGET OFFICE, TRUST FUNDS: 2020 TO 2030, *supra* note 3.

cost sharing,[58] incentivizing individual providers to take costs into account at the bedside through fiduciary duties[59] or properly-incentivized hospital systems,[60] or allowing the program to ration treatments and services (but not patient care) based on their cost effectiveness.[61]

Conceptualizing Medicare insolvency as an arithmetical byproduct of demographics and the particular policies in place at any given moment fails to explain the program's cycle of insolvency, however.[62] Why do "fixes" never seem to last and why do the program's policies, as they develop, creep inexorably toward greater spending? Several scholars have pointed to a possible explanation: Medicare's underlying "problem" is, in part, an alignment of powerful interests who use their influence in the legislative and regulatory processes to steer the program to increase, not decrease, costs.[63] In a phrase, the problem is the program's political economy, in the sense of that term used in the field of law and political economy.[64] Whatever their individual incentives in a particular case, the concentrated, powerful interests who influence the program's development—hospitals (and other providers), health insurers, beneficiaries, and pharmaceutical companies—have every incentive to make Medicare more "generous" on the whole, not less.[65] So their lobbying dollars and political influence are directed toward shifting the program toward greater spending. This is true when it comes to the frequent under-the-radar legislative tweaks to the program that mark the periods

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[58] Brian Elbel & Mark Schlesinger, *Responsive Consumerism: Empowerment in Markets for Health Plans*, 87(3) THE MILBANK QUARTERLY 633–682 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881453/ (last visited Jul 5, 2021).

[59] Buck, *supra* note 17, at 1094.

[60] Bagley, *supra* note 17.

[61] Fox, *supra* note 17.

[62] Cf. Skocpol, *supra* note 27, at 5 ("moralists" and "technocrats" often develop analyses that "lack [] historical and political sensibility").

[63] OBERLANDER, *supra* note 7, at 76 (2003) ("Medicare financing is the single most important pattern in program politics . . . more than any other factor [it has] driven the direction and timing of program reforms."); Charles Silver & David A. Hyman, *There Is a Better Way: Make Medicaid and Medicare More Like Social Security*, 18 GEO. J. L. & PUB. POL'Y 149, 151-52 (2020) (discussing political opposition to Medicare reforms); Timothy Stoltfus Jost, *The Independent Medicare Advisory Board*, 11 YALE J. HEALTH POL'Y L. & ETHICS 20 (2011) (HHS and Congress "are [] driven by special interest politics"); *id.* ("Both Medicare payment formulas and coverage determinations often seem to be driven by political, rather than scientific or economic, considerations."); Clark. C. Havighurst & Barak Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW. & CONTEMP. PROBS. 7, 10 (2006) ("industry and other interests . . . manipulate people's thinking . . . as consumers and as voters"); David A. Hyman, *Getting the Haves to Come Out Behind: Fixing the Distributive Injustices of American Health Care*, 69 LAW & CONTEMP. PROBS. 265, 279 (2006) ("Provider capture of state and federal legislators is the rule"); David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165, 1181 (2003) (describing role of lobbying by device manufacturers in preventing cost cutting).

[64] *See* Britton-Purdy *et al.*, *supra* note 2031, at 1792 (in contrast to "political economy" in modern economics departments, "law and political economy" uses term in historical, radical sense that explores "the relation of politics to the economy, understanding that the economy is always already political in both its origins and its consequences").

[65] Providers' stake in Medicare costs is not limited to their interest in Medicare reimbursement. Private insurance agreements often base provider payment amounts on a multiple of Medicare payment rates, meaning that any increase in Medicare rates means increased reimbursement for many providers even for patients who have private health insurance, not Medicare. *E.g.*, *Medicare Rates as a Benchmark: Too Much, Too Little or Just Right?*, ALTARUM HEALTHCARE VALUE HUB (Feb. 2020), https://www.healthcarevaluehub.org/advocate-resources/publications/medicare-rates-benchmark-too-much-too-little-or-just-right (describing "common approach" to base private payment rates on Medicare benchmark).

between solvency crises,[66] and it is true when it comes to HHS as it makes the myriad decisions implementing and adjusting the program.[67]

To be sure, advocates of greater spending do not have complete control, and suffer both wins and losses in their lobbying efforts. But although taxpayer groups and those concerned about effects on other federal priorities—not to mention the public interest—have a generalized interest in combatting efforts to expand wasteful spending through the program,[68] that counteracting influence is strongest in the midst of solvency crises, not in maintaining the program's finances when insolvency is many years away. [69]

The nature of judicial review compounds this bias in the political economy of the Medicare program against controlling costs long term. Courts have no involvement when HHS arguably spends "too much" on Medicare or takes steps that allow funds to flow that should not. Although the beneficiaries of other spending programs, younger generations, and taxpayers are injured when Medicare overspends the trust fund,[70] the Supreme Court has held that generalized pecuniary interests are insufficient to confer standing.[71] Meanwhile, any step that HHS takes to reduce spending through the program is certain to be met with legal challenge by whoever loses out, whether hospital,[72] insurer,[73] dialysis provider,[74] nursing

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[66] ZACK COOPER, AMANDA KOWALSKI, ELEANOR NEFF POWELL, & JENNIFER WU, POLITICS, HOSPITAL BEHAVIOR, AND HEALTH CARE SPENDING 10 (Nat'l Bureau of Econ. Rsch., Working Paper No. 23748, 2020) (citing Christopher Lee, *Medicare Bill Partly a Special Interest Care Package*, WASH. POST (Nov. 23, 2003)) (describing provisions added at the behest of home-state Senators)), https://www.nber.org/system/files/working_papers/w23748/w23748.pdf.

[67] *See* LAWRENCE R. JACOBS & THEDA SKOCPOL, HEALTH CARE REFORM AND AMERICAN POLITICS 160 (3d ed., 2016) (describing role of health care industry lobbyists in development of regulations implementing Affordable Care Act, and their focus on costs); Hyman, *supra* note 20, at 1181, 1183 n. 60 (describing efforts by providers and manufacturers); *see* Silver & Hyman, *supra* note 20, at 151-52 (as opposed to lobbying for Medicare reform, which would lengthen the Trust Fund's lifetime, providers are more interested in receiving greater reimbursements, which necessarily depletes the Fund).

[68] Timothy Stoltzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 78 (1999) (providers' influence is "counterbalanced" in Medicare by fiscal constraints and occasional conflict of interest between providers and beneficiaries or among providers).

[69] *See* Oberlander, *supra* note 20, at 147–48 (noting that major Medicare policy choices have been driven by solvency crises, when fiscal concerns dominant, but cumulatively-important minor choices have been driven by interest groups).

[70] Over-spending Medicare receipts harms either taxpayers (if the increased costs are made up by increased taxes), future generations (if the increased costs are paid by deficit spending or reducing Medicare's generosity in the future), or recipients of other spending programs (if such programs are cut to fund increases in Medicare spending). *Cf.* William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, J.L. MED. & ETHICS 434 (2020) (explaining how "tyranny of budget" can make spending zero-sum choice about increasing generosity of some programs by reducing generosity of others).

[71] *See* Flast v. Cohen, 392 U.S. 83, 105-06 (1968) (limitations on taxpayer standing).

[72] *E.g.*, Am. Hosp. Ass'n v. Hargan, 289 F.Supp.3d 45 (D.D.C. 2017) (suit challenging rule reducing pharmaceutical reimbursement rates for hospitals), *aff'd sub nom.* Am. Hosp. Ass'n v. Azar, 895 F.3d 822 (D.C. Cir. 2018).

[73] *E.g.*, Fox Ins. Co. v. Ctrs. for Medicare and Medicaid Servs., 715 F.3d 1211 (9th Cir. 2013) (suit challenging CMS's decision to terminate contract with insurance company and require repayment of prospective payments to insurance company).

[74] *E.g.*, Dialysis Clinic, Inc. v. Leavitt, 518 F.Supp.2d 197 (D.D.C. 2007) (suit challenging CMS's denial of reimbursement for certain "bad debts" of dialysis clinic).

home,[75] or beneficiary.[76] And courts often take a sympathetic view to such plaintiffs—the nature of judicial review means that the slighted party is before the court, telling their story and expressing their need.[77] Thus, the federal courts have acted as a one-way ratchet in the arc of Medicare policy, rejecting HHS administrative efforts to control costs in dozens of cases involving many billions of dollars,[78] but never once invalidating an HHS decision as spending too much.

In light of these forces, it is not surprising that Medicare is again facing insolvency in the short term, with insolvency predicted either just before or just after the next presidential election.[79] Should we expect Congress to step in with major health reform legislation to address Medicare's solvency, as it has in the past? In economic speak, is Medicare in an uncomfortable but reliable equilibrium of crisis, fix, crisis, or might it eventually divert from its current pattern into a new one: crisis, insolvency, fix? [80] Or, might Medicare become insolvent and stay that way—crisis, insolvency, insolvency?[81]

Although Congress has intervened to address Medicare's solvency in each past crisis, four overlapping trends indicate that the present situation is different, *i.e.*, that Medicare will actually face a period of insolvency in the near future. First, the imminence of insolvency. As the Trustees have been lamenting for years, the closer the program is to insolvency, the more dramatic—and potentially draconian—are the changes necessary to avoid it.[82] Health policy observers thus predict that this time around fixing Medicare will be an even heavier lift than in prior crises, requiring either cuts in benefits or eligibility or increases in revenue.[83] That influences political calculations, as it means that any legislative effort to preserve the program's solvency might well be cast either as gutting the program (if it cuts costs), raising taxes (if it increases revenue), or robbing Peter to pay Paul (if it diverts funds from other programs).[84]

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[75] *E.g.*, Blossom South, LLC v. Sebelius, 987 F.Supp.2d 289 (W.D.N.Y. 2013) (suit challenging HHS's termination of nursing home's provider agreement).

[76] *E.g.*, Kort v. Burwell, 209 F.Supp.3d 98 (D.D.C. 2016) (suit challenging Medicare beneficiaries' denial by HHS of treatment for certain cognitive treatments).

[77] *See generally* Jerry Kang et al., *Implicit Bias in the Courtroom*, 59 UCLA L. REV. 1124, 1152-68 (2012) (reviewing literature on judicial bias in civil cases).

[78] *E.g.*, Am. Hosp. Ass'n v. Azar, 410 F.Supp.3d 142 (D.D.C. 2019) (rejecting site-neutral payment policy in Medicare Part B), *rev'd*, 964 F.3d 1230 (D.C. Cir. 2020), *cert. denied sub nom*, Am. Hosp. Ass'n v. Becerra, No. 20-1113, 2021 WL 2637851 (June 28, 2021); Monmouth Med. Ctr. V. Thompson, 257 F.3d 807 (D.C. Cir. 2001) (ruling for hospitals in high-stakes reimbursement case); Cape Cod Hosp. v. Sebelius, 630 F.3d 203 (D.C. Cir. 2011) (same); Shands Jacksonville Med. Ctr. V. Burwell, 139 F. Supp. 3d 240 (D.D.C. 2015) (same).

[79] *See supra* nn. 3 (describing estimates).

[80] This was the path Medicaid's Children's Health Insurance Program followed in 2018. *Disappropriation*, *supra* note 9, at 37-38 (noting that there have been consistent funding extensions in past years, but that, in the most recent case, there was a lapse in funding for the program until long-term funding and contested issues were solved).

[81] This was the path the ACA's cost sharing reduction subsidies followed after their disappropriation. *Id.*

[82] *E.g.*, 2020 Trustees Report, *supra* note 52, at 41 ("The sooner solutions are enacted, the more flexible and gradual they can be.").

[83] VAN DE WATER, *supra* note 8, at 2, 4.

[84] *See Medicare for All: Higher Taxes, Fewer Choices, Longer Lines*, SENATE REPUBLICAN POL'Y COMM. (Dec. 4, 2018), https://www.rpc.senate.gov/policy-papers/medicare-for-all-higher-taxes-fewer-choices-longer-lines ("Proponents say 'free' health care for all would eliminate premiums, copays, and deductibles for

Second, in health law, Congress has in recent years failed multiple times to enact legislation necessary to honor entitlements, sometimes temporarily and sometimes indefinitely. Impacted programs have included the Supplemental Nutrition Assistance Program, Children's Health Insurance Program, the Indian Health Service, and the Affordable Care Act's individual market cost-sharing reduction subsidies. This has forced administrators to make previously "unthinkable" administrative choices about how to administer a disappropriated program, and given rise to blockbuster, billion-dollar lawsuits by disappointed claimants seeking judicial relief.[85]

Third, in fiscal law, Congress has repeatedly failed to rise to the challenge of budgetary pressures and address fiscal issues through regular order.[86] As Professor Louk and Professor Gamage explain, the recurrence of "game of chicken" negotiations in the "new fiscal politics" make bargaining failures almost inevitable.[87] And, as the return of the debt ceiling impasse looming at this writing illustrates, the new fiscal politics often sees Congress adopt a series of short-term patches that ultimately end in failure, rather than a long-term fix.[88] In Medicare, this could easily take the form of a one-time measure pushing the insolvency date off by a year or two along with a super-committee or other mechanism whose failure would set up eventual insolvency.

Fourth, in politics, an era of "hardball" sees the party opposing the president look to seize any opportunity possible to use their influence in Congress to frustrate governance. A vigorous scholarly debate continues about whether one political party or the other is more to blame for this era of "constitutional hardball,"[89] but regardless, prudence counsels that Medicare might well be the next battleground. The possibility that legislation in the current Congress could expand the program increases this risk, as such legislation is predicted to follow a partisan path that would create opportunities (even if unjustified) for the opposing party to blame the program's looming insolvency on that reform legislation rather than policy choices made in the past.[90]

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everything from major surgery to dental, vision, hearing, and mental health services. In reality, enormous tax increases for all would simply pre-pay whatever health care services the government chooses to provide."). *Cf.* Dena Bunis, *Older Americans Oppose Social Security, Medicare Cuts To Fix Federal Debt*, AARP (May 26, 2021), https://www.aarp.org/politics-society/advocacy/info-2021/survey-social-security-medicare-cuts.html (outlining AARP's opposition to passing legislation which would cut Medicare benefits to fix federal debt despite the elderly's interest in reducing federal debt).

[85] *See Disappropriation*, *supra* note 9, at 23, 28, 30-31, 41.

[86] *See* David Scott Louk & David Gamage, *Preventing Government Shutdowns: Designing Default Rules for Budgets*, 86 UNIV. COLO. L. REV. 181, 185 (2015) (describing "new fiscal politics").

[87] *Id.*

[88] *See Understanding the Sequester*, COMM. FOR RESPONSIBLE FED. BUDGET (Nov. 22, 2013), https://www.crfb.org/blogs/understanding-sequester (discussing the effects of sequestration in the years following the super-committee's failure to agree on a budget relief package).

[89] Joseph Fishkin & David E. Pozen, *supra* note 14.

[90] Reported reconciliation instructions would enable Congress to expand the program without facing a filibuster, but do not appear to leave room to replace or to fix the existing Trust Fund financing structure, or address the program's looming insolvency. *See* Jonathan Weisman et al., *Democrats Roll Out $3.5 Trillion Budget to Fulfill Biden's Broad Agenda*, N.Y. TIMES (July 14, 2021), https://www.nytimes.com/2021/07/14/us/politics/biden-social-spending-deal.html (describing instructions); Michael McAuliff, *Sen. Wyden: $3.5T Budget May Have To Trim but It Can Set a Path To 'Ambitious Goals*,' KAISER HEALTH NEWS (July 20, 2021), https://khn.org/news/article/senator-ron-wyden-interview-democrats-budget-ambitious-health-policy-goals/ (same).

Optimists might object that despite these overarching trends, Medicare is too culturally sacred and politically salient for Congress to let the program implode. This view wrongly assumes that insolvency in Medicare, on its present course, would entail a clear deadline and immediate consequences of the sort that would acutely threaten patients and, more importantly, force an "up or down" vote on preventive legislation. To the contrary, as the next Part explains, Medicare insolvency would not immediately impact patients, its impacts on providers and hospitals would be highly variable (though quite significant for some), and those impacts could emerge slowly and not be finally determined for years. Experience with the CHIP disappropriation, cost-sharing reduction disappropriation, and "debt ceiling" teaches that as insolvency approaches, expressions of uncertainty about the actual deadline and the consequences of missing it will grow.[91] With that rising uncertainty, pressure to act may well wain, not rise.[92]

All of this raises the questions: What would actually happen if Medicare became insolvent? And are there any steps that could be taken now, by HHS, Congress, or courts, to avoid, or at least mitigate, insolvency? The remainder of the Article takes up these questions.

II. ADMINISTERING INSOLVENCY

Prior scholarship has elaborated well the complicated public-private apparatus through which Medicare receives, processes, and pays billions of claims every year, as well as the legal framework of statutes, regulations, and guidance that defines and supports that apparatus.[93] For present purposes, and in the interest of space, it suffices to highlight that Medicare's administrative apparatus and the underlying statutes, regulations, and guidance assume solvency, that is, they say nothing specific about what to do if the program becomes insolvent.[94]

Yet, if Medicare became insolvent the Appropriations Clause of the U.S. Constitution would forbid spending beyond the Trust Fund (and the Antideficiency Act would render such spending a felony with a five-year statute of limitations).[95] Thus, if and when the statute's assumption of Trust Fund solvency becomes false, administering an

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[91] *E.g.* CTR. FOR CHILD. AND FAMS., WHEN WILL CHIP FUNDING RUN OUT? (Dec. 20, 2017), https://ccf.georgetown.edu/wp-content/uploads/2017/12/20171220_PressRelease_CHIP.pdf; Timothy Jost, *New Guidance On CSR Payments and Risk Adjustment: Answers … and More Questions*, Health Affs. (Aug. 11, 2017) https://www.healthaffairs.org/do/10.1377/hblog20170811.061514/full/ ("HHS may stop reimbursing insurers for reducing cost sharing for low income consumers at some undetermined point in the future—it has not yet decided. . . . Because of the uncertainty HHS has creates, some states have instructed their insurers to assume the payments will not be made and increase their rates accordingly."); Kate Davidson, *Capitol Hill Lacks Clarity on Debt-Ceiling Date*, Wall St. J. (June 11, 2017) https://www.wsj.com/articles/capitol-hill-lacks-clarity-on-debt-ceiling-date-1497193228 (bemoaning "[m]ixed messages and a dearth of details" regarding debt ceiling deadline and effect, arguing that this "[l]ack of clarity complicates the administration's efforts to convince lawmakers to raise the debt limit sooner rather than later").

[92] *See infra* Part III.B.

[93] Eleanor D. Kinney, *The Accidental Administrative Law of the Medicare Program*, 15 YALE J. HEALTH POL'Y L. & ETHICS 111 (2015); Bagley, *supra* note 17; Jost, *supra* note 22.

[94] *See* John Cubanski & Tricia Neuman, *FAQs on Medicare Financing and Trust Fund Solvency*, KAISER FAM. FOUND. (Mar. 16, 2021), https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/ ("[T]here is no automatic process in place or precedent to determine how to apportion the available funds or how to fill the shortfall.").

[95] *See generally Disappropriation*, *supra* note 9 (citing 31 U.S.C. § 1304).

insolvent Medicare program will force determination—by HHS, courts, and perhaps Congress—of five open legal questions: (1) How will administrative choices about how to administer an insolvent program be made?; (2) should payment of claims be delayed, or should all claims be paid on time but reduced *pro rata*; (3) would some claims or claimants be insulated from payment disruptions?; (4) would shorted claimants be entitled to judicial relief?; and (5) would litigation to decide that question proceed in the Court of Federal Claims or Federal District Court?

This Part discusses each choice, its determinants, and its implications for the likelihood and course of insolvency in Medicare. Subpart A addresses the administrative law question of the process for deciding how to administer insolvency in Medicare. Subpart B then addresses the substantive question whether to delay or reduce payments. Subpart C discusses the substantive question of insulating high-priority claimants. Subpart D addresses the $5 trillion dollar remedies question whether shorted providers could collect from the Judgment Fund through litigation. Subpart E addresses the procedural question of the path of such blockbuster litigation—whether through the Court of Federal Claims or through Federal District Court.

A. Process

An insolvent Medicare program will be unable to operate as required by the Medicare statute. (It is worth repeating, once again, that the outpatient coverage of Medicare Part B and pharmaceutical coverage of Medicare Part D are not funded through the Hospital Insurance Trust Fund and so are insulated from the direct impacts of insolvency.) Insolvency would force the agency to make substantive decisions discussed in the subparts that follow but also a first, primary decision about process: How should the agency make decisions about administration under conditions of insolvency? When should the agency make those choices, who should be involved, and what form should they take?

In prior disappropriations HHS has decided for itself what to do, without public consultation, announcing their approach in guidance documents.[96] One could certainly imagine HHS taking this path now—avoiding explicit advance consideration or public involvement in its decisions about how it would manage insolvency until the insolvency point was actually reached (itself a difficult date to pin down),[97] and then simply announcing its

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[96] *See* Notice of Method of Distribution of Fiscal Year 1994 Contract Support Funds, 58 Fed. Reg. 68,694, 68,694 (Dec. 28, 1993) (announcing, three months into fiscal year 1994, agency's approach for handling shortfall in fiscal year 1994 appropriations); CTRS. FOR MEDICARE & MEDICAID SERVS. & CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, RISK CORRIDORS AND BUDGET NEUTRALITY (APR. 11, 2014), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf (April 2014 guidance promising future guidance regarding risk corridors shortfall); GEO. UNIV. HEALTH POL'Y INST.: CTR. FOR CHILD. AND FAMS., WHEN WILL CHIP FUNDING RUN OUT? (Dec. 20, 2017), https://ccf.georgetown.edu/wp-content/uploads/2017/12/20171220_PressRelease_CHIP.pdf (describing confusion about how CHIP shortfalls would be administered in states).

[97] The trustees currently make an actuarial projection of the year at which the insolvency point will be reached, but the precise date would depend on payroll taxes "in" and claims made. There is not (yet) a mechanism to predict with certainty the month, week, or day within a given year on which the insolvency point would be reached. *Cf.* Howell Jackson, *The 2011 Debt Ceiling Impasse Revisited*, in IS U.S. GOVERNMENT DEBT DIFFERENT 55 (Franklin Allen, Anna Gelpern, Charles Mooney & David Skeel eds., 2012) (noting difficult of pinpointing day on which debt ceiling impasse would require extraordinary measures).

approach by fiat—or even simply implementing its insolvency plan and allowing the public to infer the substance.

Alternatively, HHS could, as a preemptive measure, opt to promulgate regulations setting forth how it would administer an insolvent Medicare program well in advance, by notice and comment rulemaking.[98] HHS is required by the Medicare statute annually to propose, seek comment on, and then finalize formal payment notices governing Medicare reimbursement for hospital and insurers for the upcoming year.[99] These notices routinely include a range of administrative changes and adjustments, big and small. Initial proposals must come in spring in the year ahead of the year to which they apply.[100] The agency could simply include its fallback insolvency plan in such a notice, along with a final deadline by which Congress would have to act to avoid triggering the fallback.

Though technical, this choice of process could prove pivotal. It would alter by months or even years the time it would take for courts to take up and resolve litigation by providers either challenging the agency's approach to administering insolvency or asking for an order for full payment.[101] The reason has to do with Medicare's jurisdictional channeling (aka exhaustion) provisions, which mean that "in most instances, judicial review is available only after the exhaustion of lengthy administrative processes."[102] The Medicare statute offers a path for expedited consideration of challenges to regulations through these processes, so a regulation dictating the agency's approach could be challenged directly in federal court soon (weeks or months) after its issuance.[103] By contrast, absent a regulation, providers would have to wait until their individual payments were actually impacted, then appeal those payments through a lengthy administrative process, and the Medicare statute's exhaustion provision would preclude judicial review until that process ran its course.[104]

Relatedly, proceeding by regulation would mean that Congress and all the entities with interests in Medicare would know precisely how the program's insolvency would impact them *before* the program actually became insolvent. This is because black letter administrative law (a principle known as the *Accardi* doctrine) binds the agency to follow its own

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[98] *See* 42 U.S.C. § 1395h (agency authority to act by rulemaking).

[99] 42 U.S.C. § 1395ww(d) (Part A payment notice); 42 U.S.C. § 1395w-23 (Part C payment notice).

[100] 42 U.S.C. § 1395ww(d) (final hospital payment notice must be published in Federal Register "on or before August 1 before each fiscal year," necessitating notice of proposed rule in spring); 42 U.S.C. § 1395w-23 (requiring advance notice and comment on changes in Medicare Advantage payment methodology "[a]t least 45 days" before final rule to be issued by "the first Monday in April before the calendar year concerned").

[101] The specifics of such litigation are discussed *infra* Part II.D.

[102] Jost, *supra* note 21, at 34; *see generally Shalala v. Illinois Council on Long Term Care*, 529 U.S. 1 (2000) (explaining exhaustion provisions).

[103] *See* 42 U.S.C. § 1395(f)(1)(providing for expedited judicial review when Provider Reimbursement Review Board determines that it "is without authority to decide the question"); 42 C.F.R. § 405.1842 (expedited review available if "legal question is a challenge . . . to . . . the substantive or procedural validity of a *regulation or CMS ruling*" (emphasis added); *e.g. Am. Hosp. Ass'n v. Azar*, 967 F.3d 818, 820-22 (D.C. Cir. 2020) (immediate lawsuit challenging regulation issued November 13, 2017 was dismissed for failure to exhaust, but exhaustion was completed and a new suit over which court had jurisdiction was brought, which district court resolved in hospitals' favor on December 27, 2018; D.C Circuit subsequently reversed), *cert. granted sub nom.* Am. Hosp. Ass'n v. Becerra, No. 20-1114, 2021 WL 2742784 (U.S. July 2, 2021).

[104] TIMOTHY JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 35 (2003) ("Attempts to obtain judicial review when it is not available by statute and precluded by 42 U.S.C. § 405(h) have generally been rejected by the Supreme Court, despite repeated attempts by the lower courts to find some jurisdictional foothold.").

regulations.[105] By contrast, if the agency does not regulate in advance than its approach would remain an open question during congressional deliberations, increasing the uncertainty in those deliberations about what would actually happen should Congress fail to act and about the deadline for congressional action.

Although somewhat more abstract, it is also important to note that the agency's choice of process would implicate important administrative process values including accountability, transparency, and participation. The Supreme Court recently emphasized, in *Allina Health Services v. Price*,[106] that the Medicare statute endorses these values through its mandate of rulemaking for changes in payment standards whether made in "substantive" or "interpretive" rules.[107] A process such as advance rulemaking, with notice and comment, would promote these values and align with the Medicare statute's endorsement.[108] Meanwhile, even if lawful because unavoidable in an emergency, last-minute decisionmaking by agency fiat would risk increasing controversy and confusion.[109]

Despite the fact that administrative law values favor advance rulemaking, the process decision would largely be in the discretion of HHS under current law. The Medicare statute's preference for rulemaking notwithstanding,[110] if the agency fails to address program insolvency in advance through regulation it would have no choice but to do so later without such formality in order to comply with the Appropriations Clause. And there is little possibility of courts forcing the agency to promulgate Medicare bankruptcy rules in advance. The administrative law doctrines governing whether courts will compel an agency to engage in rulemaking are weak and rarely-applicable, and the lack of an explicit statutory command that the agency make policy, let alone a deadline for one, would prove fatal under those doctrines.[111]

B. Delay or *Pro Rata* Reduction?

Whatever process it uses, the most fundamental substantive question facing HHS will be how to deal with its inability to make timely payment on all Medicare claims. Specifically, would the agency accommodate insolvency with a delay in processing full payments (the "delay" option) or, alternatively, by paying all claims on time but reduced *pro rata* in light of the shortfall (the "*pro rata* reduction" option)? Note, importantly, that each option assumes that Medicare beneficiaries would continue to incur claims by seeing providers, going to the hospital, and so on. This is because access to care from Medicare providers is structured as a clear entitlement for beneficiaries, so there do not appear to be

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[105] *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954).

[106] Azar v. Allina Health Services, 587 U.S. ___, 139 S. Ct. 1804 (2019) (interpreting 42 U.S.C. § 1395hh).

[107] *See generally* Graham Haviland, *Not So Different After All: The Status of Interpretive Rules in the Medicare Act*, 85 U. CHI. L. REV. 1511 (2016) (discussing statutory provisions).

[108] *Allina*, 139 S. Ct. at 1816 ("Notice and comment gives affected parties fair warning of potential changes in the law and an opportunity to be heard on those changes[.]").

[109] Abbe R. Gluck, Anne Joseph O'Connell, & Rosa Po, *Unorthodox Lawmaking, Unorthodox Rulemaking*, 115 COLUM. L. REV. 1789, 1839-40 (2015) (surveying possible democratic legitimacy impacts of emergency policymaking).

[110] 42 U.S.C. § 1395hh (requiring notice and comment rulemaking for "substantive" rules).

[111] *See* Sidney A. Shapiro, *Rulemaking Inaction and the Failure of Administrative Law*, 68 DUKE L. J. 1805, 1821-22 (2019) (describing difficulty of forcing agency action under current doctrine and importance of explicit statutory requirements and deadlines).

legal paths by which beneficiaries' eligibility for care could be circumscribed directly.[112] Rather, direct impacts would be on providers' and insurers' claims for reimbursement for having served Medicare beneficiaries.

The agency employed the "delay" option in administering the Affordable Care Act's risk corridors disappropriation: it committed to paying all claims in full eventually but, with insufficient funds, noted that it would need to delay payment of claims for which it lacked the necessary funds until they came in, resulting in an increasingly long backlog.[113] In the case of Medicare, that would mean payment delays on all claims payable from the Hospital Insurance Trust Fund, which includes hospital inpatient claims, skilled nursing facility claims, and the inpatient component of Medicare Part C plan payments, among others.[114]

The duration of delays in payment would begin small and gradually grow longer and longer unless and until Congress acted. Although specific delays would depend on real-time solvency projections and the logistics of different payment pathways,[115] generally speaking, based on CBO projections, the required delays before payment would be roughly two months in the first year of insolvency, roughly four months in the second, and eventually approach a year before stretching into multiple years as backlogs stacked up and the trust fund's shortfall increased.[116]

Alternatively, in the Tribal support cost disappropriation the agency employed the *pro rata* reduction approach, paying all claims as usual but reduced by a rate necessary to maintain overall solvency.[117] It is not hard to imagine how this would operate in Medicare, because payment rate adjustments for various purposes are common.[118] The agency would simply estimate, conservatively, the necessary adjustment for a given year and reduce payment rates by a corresponding percentage.[119] The amount of the needed downward adjustment in provider and insurer payment rates would be roughly equal to the amount of Medicare's anticipated shortfall, so approximately 17% in the first full year of insolvency, 18% in the second, and so on depending on the extent of the trust fund's anticipated shortfall each year.[120]

The choice between the delayed payment approach and a *pro rata* reduction would significantly impact the character of Medicare bankruptcy. Payment delays would come on gradually, without any clear "cliff." Moreover, such delays would not immediately affect hospitals' or insurers' anticipated revenues—just the timing of their reimbursement. By

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[112] *See* Timothy Jost, *Medicare: What Are the Real Problems? What Contribution Can Law Make To Real Solutions?*, 1 ST. LOUIS U. J. HEALTH POL'Y 45, 49 (2008) ("Medicare is an entitlement under federal law"); Jost, *Disentitlement*, *supra* note 104, at 31–32 ("The language of entitlement is deeply embedded in the Medicare . . . statute[] . . . . [The phrase] 'persons entitled to benefits' appears in [the Medicare statute as a reference to beneficiaries] over 100 times . . . ."); 42 U.S.C. § 426(a) ("Every individual who [is eligible] shall be entitled to hospital insurance benefits under part A.");

[113] CTRS. FOR MEDICARE & MEDICAID SERVS., RISK CORRIDORS AND BUDGET NEUTRALITY, *supra* note 96.

[114] *See supra* note 40 (listing payments paid through the HITF).

[115] *See supra* nn. 97 (raising logistical questions about insolvency date).

[116] *See infra* nn. 198 and accompanying text (discussing likely length of delays).

[117] Notice of Method of Distribution of Fiscal Year 1994 Contract Support Funds, 58 Fed. Reg. 68,694, 68,694 (Dec. 28, 1993).

[118] *E.g.*, Adirondack Med. Ctr. V. Sebelius, 740 F.3d 692 (D.C. Cir. 2014) (describing agency adjustment authority).

[119] If there were a surplus at year's end, the agency could roll it into the next year's adjustment.

[120] This estimate is based on the projections in CONG. BUDGET OFFICE, TRUST FUNDS: 2020 TO 2030, *supra* note 3.

contrast, a *pro rata* reduction would be implemented a year at a time in that year's payment rates.[121] This would create a clear annual deadline by which Congress would be required to act in order to avoid direct impacts on hospitals' and insurers' balance sheets. The presence or absence of such a clear deadline may prove determinative of whether Congress takes action to avert insolvency or not, as discussed *infra* Part III.B.

Just as significant, however, may be the implication of the choice between delayed payment and a *pro rata* reduction for the timing of litigation, and so of courts' involvement in Medicare bankruptcy. This is another choice, like the choice of process, that would have a significant impact on when and how litigation could proceed. The delayed payment option would mean a long wait before litigation due not only to exhaustion requirements applicable to Medicare claims,[122] but also limitations on the availability of judicial relief to force unlawfully withheld agency action,[123] as well as the ripeness doctrine.[124] By contrast, a *pro rata* reduction would avoid these threshold barriers.[125] This would shorten by months, and more likely years, the time it would take for providers to access federal court, and so to obtain any relief available there (discussed *infra* subparts D and E).[126]

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[121] *Supra* note 100.

[122] 42 U.S.C. § 405(h) (precluding ordinary federal question jurisdiction over claims "arising under" statute); 42 U.S.C. § 1395ii (applying § 405(h) to Medicare claims); Shalala v. Illinois Council on Long Term Care, 529 U.S. 1 (2000) ("section 405(h) prevents application of the 'ripeness' and 'exhaustion' exceptions . . . it demands the 'channeling' of virtually all legal attacks through the agency"); UnitedHealthcare Ins. Co. v. Price, 248 F. Supp. 3d 192, 197-98 (addressing explicability of exhaustion requirement to Medicare Advantage).

[123] *See* Shapiro, *supra* note 111, at 1821 (describing limited doctrines).

[124] Abbott Labs v. Gardner, 387 U.S. 136, 148 (1967) (describing "ripeness doctrine" through which courts exercise discretion to decline to issue injunctive and declaratory remedies depending on "fitness of the issues for judicial decision and . . . hardship to the parties of withholding court consideration").

[125] Shands Jacksonville Med. Ctr. v. Azar, 959 F.3d 1113, 1115 (D.C. Cir. 2020) (provisions allow hospitals to "seek review of reimbursement rates"). A *pro rata* reduction would be agency action, so would not require litigation to force action. As for ripeness objections, a *pro rata* reduction would avoid these both by providing a concrete policy for courts to review and by guaranteeing a one-year change in rates, thereby avoiding arguments that claimants' challenge was not ripe because their injury would be contingent on Congressional failure to enact a fix in time. *See* Gardner v. Toilet Goods Ass'n, 387 U.S. 167, 171 (1998) (hardship prong considers whether withholding judicial review will have an "immediate and substantial impact" on the plaintiff); Systems Application & Techs., Inc. v. United States, 691 F.3d 1374, 1383 (Fed. Cir. 2012) (claim is not fit for review if it is "contingent upon future events that may or may not occur")

[126] The comparison of two recent Medicare litigations—one over a delay, the other over a payment reduction—is informative. It took seven years for the courts to conclude they could hear the delay case, the payment reduction case was heard almost immediately and resolved within about a year. Specifically: In Am. Hosp. Ass'n v. Sebelius, No. 1:2014cv00851 (D.D.C. 2018) the American Hospital Association sued HHS over delays in the processing of Medicare payment appeals. A rising flood of appeals saw Medicare begin to miss the statutory deadline of decisions within 90 days in 2011. *Average Processing Time By Fiscal Year*, OFFICE MEDICARE HEARINGS & APPEALS (Feb. 8, 2021), https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html. Hospitals did not even attempt to bring an unreasonable delay action until May of 2014. *See Litigation: AHA, Hospitals Sue To Require HHS To Meet Deadlines for Deciding Appeals*, AM. HOSP. ASS'N, https://www.aha.org/legal/litigation-aha-hospitals-sue-require-hhs-meet-deadlines-deciding-appeals (last visited July 28, 2021). The D.C. Circuit and District of Columbia District Court did not agree that such an action was proper until November 2018, at which time the delay in processing appeals had stretched to three years. OFFICE MEDICARE HEARINGS & APPEALS, *supra*. By contrast, in *Adirondack*, the agency promulgated a prospective reduction in payment rates for fiscal year 2012 (beginning October 1, 2011) in August of 2011.

The decision whether to implement a payment delay or reduce payments *pro rata* is more than likely up to the agency, both legally and logistically. As for the law, there is a strong argument that current law does not require the agency to make one choice or the other in accommodating insolvency.[127] As for logistics, Medicare's payment processes are certainly capable of accommodating a *pro rata* reduction, and more than likely could accommodate payment delays—but the latter option may pose administrative difficulties, especially to honor the statute's mandate of "equivalence" in the treatment of Medicare Part A and Part C.[128]

C. Triage?

It is easy enough for an academic to refer to a 17% reduction in Medicare payment rates, or months (eventually years) long delay in payments. For a health care provider trying to stay afloat in a challenging environment—especially an asset poor such provider or one particularly reliant on Medicare dollars—the reality of disrupted Medicare payment would be challenging, to say the least. Part III.A focuses on the market concentration, provider insolvencies, increased costs, and reduced access for patients that this disruption would eventually cause, as well as the skewed distribution of such harms.

The fact that even across-the-board reductions or delays in Medicare payment would impact different providers differently, posing a much greater challenge for some, raises an additional, substantive question HHS would have to address regardless whether it pursued the delayed payment approach or the *pro rata* reduction approach. In the Social Security context, Professor Harrison suggests that the costs of insolvency should be targeted towad wealthier beneficiaries.[129] This question is one of prioritization, namely, whether the agency could (as a matter of law) and would (as a matter of policy) differentiate among claimants seeking payment from the trust fund, insulating some from insolvency's effects. In medical parlance, could the agency "triage" among claimants, prioritizing those for whom (increasingly) scarce dollars would be most valuable, or would it be forced to employ a one-

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Adirondack Medical Center v. Sebelius, 891 F. Supp. 2d 36, 41 (D.D.C. 2012) (describing regulation). Plaintiffs immediately sought and obtained an "expedited judicial review" determination from the Provider Reimbursement Review Board and filed suit on October 15, 2012. *Id.* The Court ruled on the statutory interpretation question on which the case depended on September 17, 2012. *Id.*

[127] The statute both mandates payments to claimants, 42 U.S.C. § g(a) ("the provider of services shall be paid" the "amount which should be paid under this part"), and mandates that such payments be made in a certain timeframe, 42 U.S.C. § 1395(c)(2)(A) ("95 percent of all claims submitted" must be paid "within 30 days . . . after the date on which the claim is received"). Thus, insolvency would leave the Secretary no choice but to break one of these commands (or violate the Appropriations Clause and Antideficiency Act by spending despite the shortfall in appropriations, *see supra* nn. 95).

[128] Different claimants seek reimbursement through different processes, which themselves have different timeframes. As a result, if the agency chose the delayed payment route, it would have to take steps to operationalize it in a way that created equivalent delays across payment programs reimbursable through the hospital insurance trust fund to avoid differential treatment favoring some programs over others, as well as a significant administrative burden. *Cf. Shands Jacksonville Med. Ctr., Inc. v. Azar*, 959 F. 3d 1113, 1120 (discussing "significant administrative burden" avoided with prospective, across-the-board remedy to improper downward rate adjustment). Payment changes that systematically favored Part C (or Part A) would raise legal issues under the "actuarial equivalence" provision of the Medicare statute. *See infra* nn. 145 (describing provision).

[129] Harrison, *supra* note 16, at 407 ("Congress today could provide that, in the case of a cash shortgage, the reduction in payments would be means tested, with high-income recipients of benefits absorbing most or all of the reductions.").

size-fits-all approach?[130] For example, could Medicare prioritize payments for hospitals that serve a disproportionate share of low-income beneficiaries, or rural hospitals who would face a particularly acute risk of insolvency due to payment disruptions?

As a legal matter, it is difficult to predict with certainty whether courts would find the agency had discretion to insulate some claimants. Medicare reimbursement is "tremendous[ly] complex."[131] Just as no law specifically addresses what to do if the program is insolvent, the law is silent about how much discretion the agency has in such a case. That said, there is some agency precedent for the possibility of triage: Congress has for several years failed to appropriate the funds necessary for Medicare to hold hearings within the timeframe required by the Medicare statute.[132] This has led to a multi-year backlog in Medicare's appeals process,[133] in which the agency has triaged among claimants, allowing beneficiary claimants to cut the line.[134] While the backlog itself has been subject to extensive litigation, the agency's choice to triage in this way has not been challenge in that litigation.[135]

Despite the overarching uncertainty about this option, it is possible to draw some important lessons about HHS's discretion to triage among claimants in the event of insolvency. First, the extent of the agency's discretion—the laws and principles governing and perhaps limiting it—would depend to a significant extent on the process through which the agency made decisions about administering insolvency (the question confronted in subpart A). The best case for agency discretion to insulate some claimants from the effects of insolvency comes if the agency promulgates its policy in advance, through notice and comment rulemaking, and invokes its catchall authority to adjust Medicare payment rates via regulation.[136] That adjustment authority is broad and flexible,[137] so the agency would need only justify any prioritization by reference to underlying goals of the Medicare statute.[138] In such a case, the legality of the agency's prioritization choices would rise or fall with any challenge to its authority to implement a prospective solvency adjustment in the first place.

The legal case for agency discretion to prioritize becomes much more tenuous if HHS declines to invoke its statutory adjustment authority, and especially if it waits to announce its policy until it is too late to proceed through notice and comment rulemaking. The reason has to do with the nature of the agency's inherent authority to reduce (or delay) payments because forced to do so by insolvency. This authority is a byproduct of the Appropriations Clause and Congress' ability to command payment without appropriating

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[130] *See Triage*, Merriam-Webster Dictionary (11th ed. 2014) (in medicine, "triage" means "the sorting of and allocation of treatment to patients . . . according to a system of priorities designed to maximize the number of survivors").

[131] Cmty. Care Found. v. Thompson, 318 F.3d 219, 225 (D.C. Cir. 2003).

[132] Matthew B. Lawrence, *Procedural Triage*, 84 FORDHAM L. REV. 79, 86 (2015).

[133] *Id.*

[134] *Id.*

[135] The American Hospital Association and many hospitals have challenged the agency's delay in holding hearings, but not the agency's decision to prioritize patient claims for timelier hearings. *Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183 (D.C. Cir. 2016).

[136] 42 U.S.C. § 1395ww(d)(5)(I)(i) (authority to promulgate "such other exceptions and adjustments to [IPPD] payment amounts . . . as the Secretary deems appropriate"); *see also* 42 U.S.C. § 1395*l*(t)(2)(E) (authority to make "other adjustments as determined to be necessary to ensure equitable payments").

[137] *Adirondack Medical Center v. Sebelius*, 891 F. Supp. 2d 36, 41 (D.D.C. 2012) (upholding adjustment).

[138] For example, the agency might exempt DSH payments on the ground that DSH hospitals are the most vulnerable to funding shortfalls, pointing to the statutory concern for that fact in the very existence of DSH payments.

funds necessary to meet that command.[139] Unlike the agency's discretion under its statutory adjustment authorities, the extent to which the agency would have discretion in wielding this inherent authority to choose how to break the law is altogether unclear.[140] Courts might be sympathetic to arguments that a one-size-fits-all approach is compelled in such a case, for two reasons. First, a one-size-fits-all approach would plausibly minimize the extent of the breach from legal requirements. Second, the alternative would not carry any apparent limiting principle, leaving the agency unfettered discretion to decide where and how to honor statutory spending commands under conditions of scarcity, and so raising constitutional questions.[141]

Regardless, however, it is almost certain that courts would hold the agency, in administering insolvency, must honor all pre-existing laws that it is *possible* to honor.[142] This would include the statutory requirement that the agency make substantive changes in Medicare policy only through notice and comment rulemaking,[143] which would foreclose non-regulatory prioritization efforts that could be characterized as "substantive" within the meaning of the statute, a broad category.[144]

A last lesson for the agency's discretion to prioritize relates to the fact that the two biggest claimants from the trust fund—hospitals (paid through Part A) and insurers (paid through Part C) are reimbursed through very different formulae and processes. This could lead the agency to adopt an approach to administering insolvency that privileges one set of claimants or the other. Its authority to do so would be circumscribed, however, by a provision of the Medicare statute arguably commanding that the agency ensure that Part A and Part C reimbursements be "actuarially equivalent."[145] This provision could prove pivotal in ensuring that the agency does not administer insolvency in a way that hastens (by favoring insurers) or slows (by favoring hospitals) the long-term trend of increased privatization in the program.

D. The $5.3 Trillion Dollar Question

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[139] *See generally* Lawrence, *Disappropriation*, *supra* note 10.

[140] *See* Neil H. Buchanan & Michael C. Dorf, *How to Choose the Least Unconstitutional Option: Lessons for the President (and Others) from the 2011 Debt Ceiling Standoff*, 112 COLUM. L. REV. 1174 (2012) (discussing question of executive discretion forced by competing statutory commands).

[141] *Cf.* Clinton v. City of New York, 524 U.S. 417, 443-447 (1998) (line between permissible delegation of executive discretion over implementation and impermissible delegation of legislative power depended, *inter alia*, on whether statute set policy to guide discretion and whether executive obtained "the unilateral power to change the text of duly enacted statutes")

[142] *See* American Hospital Ass'n v. Price, 867 F.3d 160, 167 (D.C. Cir. 2017) (in evaluating agency claim that compliance with statute was impossible, accepting agency's argument that suggested workaround of mass settlements did not vitiate impossibility because workaround of mass settlements itself could "violate the statute"); *id.* ("a court may not require an agency to break the law").

[143] 42 U.S.C. § 1395hh.

[144] Azar v. Allina Health Servs., 139 S. Ct. 1804, 1811 (2019) (holding that phrase "substantive legal standard" in Medicare statute is broader than "substantive rule" concept in APA).

[145] 42 U.S.C. § 1395w-23(a)(1)(C)(i)("[T]he Secretary shall adjust the payment amount . . . [for payments to Medicare Advantage insurers] for such risk factors as age, disability status, gender, institutional status, and such other factors . . . so as to ensure actuarial equivalence."); United Healthcare Ins. Co. v. Price, 248 F. Supp. 3d 192, 195 (D.D.C. 2017) (describing insurer's argument that statute requires "CMS to pay Medicare Advantage insurers in a manner that 'ensures actuarial equivalence' between Medicare and Medicare Advantage plans").

The questions how HHS would set policy for administering Medicare during insolvency and whether it would delay payments or reduce them *pro rata* are important, but no question would loom larger than the question of judicial remedies. If Congress failed to legislate a fix and Medicare became insolvent, then hospitals, insurers, and other disappointed claimants could be counted on to seek judicial relief, asking courts to order they be paid the full amount for serving Medicare beneficiaries described in the statute. Would courts grant such a request, ordering payment despite the trust fund's insolvency (and Congress' failure to appropriate funds to cover the shortfall)? Probably, but maybe not.

An understanding of the Judgment Fund appropriation is essential to analyzing the question whether courts might order payment. Courts do not automatically have the power under the Constitution to make funds available—payable—from the federal Treasury. Only Congress can do that, through an appropriation. This means that even when a court issues an order that a federal agency pay someone, the agency cannot comply with that order unless and until Congress itself appropriates the funds.[146] So it is that for much of the country's history, actually getting paid by suing the U.S. for damages had two steps. First, obtain a court order of payment.[147] Then, second, obtain an appropriation from Congress to satisfy the order.[148] Congress always honored such orders but doing so was burdensome; the first Congress was presented with 700 petitions for payment.[149]

For a variety of reasons, Congress in 1956 abandoned the practice of responding to individual court orders with appropriations legislation, enacting the "Judgment Fund" Appropriation.[150] The Judgment Fund is a blanket, catch-all, permanent appropriation of "such sums" as might be necessary to honor federal court judgments, as well as certain compromise settlements negotiated by the Department of Justice in the context of litigation.[151] When Congress failed to appropriate funds to honor statutory obligations in the risk corridors, tribal support cost, and cost sharing reduction programs, courts eventually made some payments available from the Judgment Fund by ordering payment, albeit (in each case) several years after payment was originally due.[152] These precedents raise the possibility that some or all of Medicare's projected $5.3 trillion shortfall would ultimately be paid through the Judgment Fund despite a congressional failure to act.[153]

The most significant determinant of the Judgment Fund's availability would be courts' rulings on the legal question whether the Medicare statute entitles participating

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[146] Lawrence, *Disappropriation*, *supra* nn. 9.

[147] Floyd D. Shimomura, *The History of Claims Against the United States: The Evolution from a Legislative Toward a Judicial Model of Payment*, 45 LA. L. REV. 625, 638 (1985).

[148] *Id.*

[149] *Id.*

[150] *Id.*

[151] 31 U.S.C. § 1304(a).

[152] *See* Me. Cmty. Health Options v. United States, 140 S.Ct. 1308 (2020) (ordering that the government pay the risk corridor deficit as statutorily mandated, five years later than when it was due); Sanford Health Plan v. United States, 969 F.3d 1370 (Fed. Cir. 2020) (mandating payment to providers for those obligations incurred three years prior by the government's refusal to reimburse); Salazar v. Ramah Navajo Chapter, 567 U.S. 182 (2012) (finding that the government was obligated to pay costs as were contracted to Native tribes, which were over ten years overdue).

[153] Bds. Of Trs., *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*, FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS (APR. 22, 2019) https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf (estimating $5.3 trillion shortfall over life of program).

providers and insurers to reimbursement for serving Medicare beneficiaries. As to the first year of insolvency, courts applying current law would likely conclude that it does. As to both Part A (hospital reimbursement) and Part C (insurer reimbursement), the statute specifically commands the agency reimburse and sets forth an intricate formula regarding the amount[154]--features courts have found "money mandating" and sufficient to trigger the Judgment Fund in past cases.[155] This is a powerful and likely insurmountable textual argument in favor of judicial relief.

At the same time, liability would not be certain. The past decade of health policy litigation teaches that it would be a mistake to predict litigation outcomes with a high degree of confidence even when the legal arguments are one sided.[156] And when it comes to the availability of the Judgment Fund to cover Medicare insolvency, the arguments are not quite one sided. There is a plausible argument that the statute conditions payment on the availability of the Hospital Insurance Trust Fund by explicitly pointing to it as the source for payments it requires.[157] Moreover, there is also a difficult but plausible argument that even if the statute does not explicitly condition reimbursement on the availability of appropriations, such a condition is fairly discernible in the context of the statute,[158] specifically, in the trust fund financing structure[159]; the many measures Congress has taken partially, but not completely, to address the program's solvency over the decades; the many provisions in the statute mandating budget neutrality and forbidding courts from reviewing budget neutrality adjustments[160]; and the fact that the statute refers to beneficiaries as "entitled" to benefits more than 100 times but refers to providers as "entitled" to reimbursement in only a few.[161]

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[154] 42 U.S.C. § 1395g (mandating that the Part A "provider of services shall be paid . . . from the Hospital Insurance Trust Fund, the amounts so determined"); § 1395w-23(f) ("The payment to a Medicare+Choice organization under this section . . . shall be paid from the Federal Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under Part A and under Part B represents of the actuarial value of the total benefits under this subchapter"); § 1395ww(d) (setting forth a complicated formula to determine "[i]npatient hospital service payments on basis of prospective rates").

[155] *E.g.*, *Me. Cmty. Health Options*, 140 S.Ct. at 1331 ("In establishing the temporary Risk Corridors program, Congress created a rare money-mandating obligation requiring the Federal Government to make payments . . . [P]etitioners may seek to collect payment through a damages action in the Court of Federal Claims"); *Sanford Health Plan*, 969 F.3d at 1372-73 ("We conclude that *Maine Community* makes clear that the cost-sharing reduction reimbursement provision imposes an unambiguous obligation of the government to pay money and that the obligation is enforceable through a damages action in the Court of Federal Claims . . . .").

[156] *See generally* Abbe Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L. J. 1471 (2020).

[157] *E.g.*, 42 U.S.C. § 1395g(a) ("[T]he provider of services shall be paid . . . from the Federal Hospital Insurance Trust Fund"); § 1395w-23(f) ("The payment to a Medicare+Choice organization . . . shall be paid from the Federal Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund"). This argument is bolstered by language in the Judgment Fund appropriation itself limiting its availability to situations "when payment is not otherwise provided for." 31 U.S.C. § 1304.

[158] King v. Burwell, 576 U.S. 473, 498 (2015) ("A fair reading of legislation demands a fair understanding of the legislative plan").

[159] 42 U.S.C. § 1395(g)

[160] *E.g.*, 42 U.S.C. § 1395w-23.

[161] *Compare* Jost, *supra* note 104, at 32 (the phrase "persons entitled to benefits" appears in the Medicare statute as a reference to beneficiaries more than 100 times) *with id.* (statute refers to providers as "entitled" in "a few instances").

As to years following the onset of insolvency, the Judgment Fund question becomes even less certain. As to such years, providers and insurers would have the option under the statute to leave the Medicare program, and their choice to participate despite that option would be made with an awareness of the fund's insolvency and its corresponding impacts on reimbursement. Judges have been open to arguments that contractors' arguably-voluntary choices to participate in analogous past cases affected their ability to seek damages,[162] and they might be in adjudicating Medicare bankruptcy as well. That said the mitigation question has not been addressed definitively by the Supreme Court[163] and its applicability to Medicare providers and insurers is debatable[164]—hence the difficulty of predicting its resolution.

Importantly, there are things that HHS and the government could do that would substantially increase or decrease the likelihood that courts would order payment of Medicare's shortfall through the Judgment Fund. They could do so through their statements, their settlement decisions, and their regulatory choices.

First, HHS could either increase or decrease the likelihood of recovery through the statements it makes in its regulatory preambles, provider agreements, and insurer agreements. Statements indicating that full statutory amounts would be owed would tend to increase the likelihood of recovery, and *vice versa*. Such statements might receive direct *Chevron* deference because of the agency's role in administering Medicare, though that would depend on the outcome of *American Hospital Association v. Becerra*, which the Supreme Court will be hearing in the upcoming term.[165] (The Article takes up that and a related case and courts' role in Medicare bankruptcy *infra*.[166]) But even absent deference, statements of obligation from the agency may be seen by courts as supporting breach of contract or other damages theories,[167]

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[162] *See Me. Cmty. Health Options*, 140 S.Ct. at 1332 (Alito, J., dissenting) ("These companies chose to participate in an Affordable Care Act program that they thought would be profitable."); *Community Health Choice v. U.S.*, 970 F.3d 1364, 1374 (Fed. Cir. 2020) (applying mitigation theory to reduce damages award for insurers arising from cost sharing reduction disappropriation); *id.* at 1375-76 ("Under common-law principles, the injured party may not recover damages for any 'loss that the injured party could have avoided without undue risk, burden or humiliation."); *cf. Se. Ark. Hospice, Inc. v. Sebelius*, 1 F.Supp.3d 915, 925 (2014) ("The only compulsion to provide hospice services is imposed by virtue of [Plaintiff's] voluntary choice to provide services under the hospice program"), *aff'd*, 815 F.3d 448, 450 (8th Cir. 2018).

[163] The mitigation issue was not presented in the risk corridors case, so not resolved by the Supreme Court in *Maine*.

[164] In *Community Health Choice* the Federal Circuit found the mitigation theory applicable to Affordable Care Act insurers only after concluding that contract law principles should apply to the government's relationship with such insurers, which conclusion was based in part by the fact that the ACA does not set out remedies for insurers disappointed with their payments from the government. 970 F.3d at 1374. This logic would not necessarily apply to Medicare providers or insurers seeking additional payment, as the statute provides elaborate remedies for them to do so. *See supra* nn. 102-103 and accompanying text (describing procedures).

[165] American Hosp. Ass'n v. Becerra, ___ S. Ct. ____, 2021 WL 2742784 (2021) (granting petition for certiorari).

[166] *See infra* Part IV.B.1 (recommending Supreme Court approach entitlement question in upcoming cases with awareness of its future implications for Medicare bankruptcy).

[167] Analogous HHS statements were cited in the risk corridor cases. *Me. Cmty. Health Options*, 140 S.Ct. at 1320-21.

and statements disclaiming obligation may undermine breach of contract and other damages theories in their own right.[168]

Second, the Department of Justice could increase the likelihood and generosity of a Judgment Fund payout by settling Medicare bankruptcy cases on terms more favorable than its career attorneys believed actually warranted under governing law—taking advantage of the Judgment Fund's availability not only for court orders but also for compromise settlements.[169] This might be done either by openly and transparently agreeing to a favorable settlement or by displacing career lawyers from settlement decision-making in favor of political appointees who were willing to bias their legal judgments to support a settlement providing payouts more generous than actually warranted based on the government's objective probability of prevailing in court.[170] There are probably no serious external constraints on the Department of Justice's discretion to settle claims,[171] but institutional and ethical considerations counsel against abuse of that discretion.[172]

Third, HHS could reduce the likelihood of Judgment Fund liability by using notice and comment rulemaking to wield its statutory authority over Medicare payments to prospectively reduce payment rates across the board by an amount sufficient to avoid a shortfall—perhaps promising a subsequent upward adjustment should Congress provide funds. There is a strong argument that the agency already has statutory authority to make such a downward solvency adjustment,[173] through there are strong counter-arguments to this position as well.[174] A solvency adjustment, if indeed legally authorized, would foreclose the Judgment Fund by reducing amounts actually owed under the statute.

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[168] *See* Samuel R. Maizel & Jody A. Bedenbaugh, *The Medicare Provider Agreement: Is It a Contract or Not? And Why Does Anyone Care?*, 71 BUS. LAW. 1207, 1208 (2016) (discussing questions about whether Medicare provider agreements are contracts, with implications for liquidation of health care entities).

[169] 31 U.S.C. 1304(a).

[170] *See* Figley, *supra* note 132, at 148 (expressing concerns about "sue and settle" environmental litigation and other Judgment Fund practices).

[171] Courts have held that the government's decision to settle an individual affirmative case is "committed to agency discretion by law" and so unreviewable, *see* Garcia v. McCarthy, 649 Fed. Appx. 589, 591 (9th Cir. 2016) (collecting sources), and there is no apparent reason that a case challenging the government's decision to settle (or decline to defend) a defensive case would fare any better. *See* T. Patrick Cordova, *The Duty to Defend and Federal Court Standing: Resolving a Collision Course*, 73 N.Y.U. ANN. SURV. Am. L. 109, 153-54 (2017) (assuming that any rule governing government's defense of litigation would "not [be] an externally enforceable requirement"). That said, if the government adopted a transparent and blanket policy of favorably settling Medicare solvency litigation, plaintiffs might argue that policy could be reviewed. *See* Heckler v. Chaney, 470 U.S. 821, 830 n.4 (1985) (suggesting judicial review would be available where agency had "consciously and expressly adopted a general policy that is so extreme as to amount to an abdication of its statutory responsibilities"). Hence the "probably" qualifier above.

[172] Figley, *supra* note 170.

[173] *See* 42 U.S.C. 1395ww(d)(5)(I)(i) ("The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate."); 42 U.S.C. § 1395w-23(a)(1)(C)(i) (Secretary "shall adjust the payment amount" for Medicare Advantage for "such other factors as the Secretary determines to be appropriate . . . so as to ensure actuarial equivalence").

[174] It is hard to argue that solvency is not an "appropriate" consideration for the agency, especially given the many statutory provisions mandating the Secretary consider budget limitations in setting payment amounts. Providers might argue, however, that authority to "adjust" payments is limited by text and context to modest changes in amounts and that a significant downward solvency reduction (approaching 20% according to Trustees' estimates) would cease to be an "adjustment."

The implications of this question are, obviously, huge. If the Judgment Fund is available then the payment disruptions associated with insolvency would be temporary, lasting only for the months or years between the onset of insolvency and ultimate judicial resolution. If not, then these disruptions would be permanent.

There would be significant fiscal-political economy impacts as well. If the Judgment Fund is available for the full amount of Medicare's shortfall, then Medicare bankruptcy would entail a painful, chaotic, and wasteful transition from a capped trust fund financing model for Parts A and C of the program to a hybrid model drawing on both the capped trust fund and uncapped general federal revenues (or new federal debt). That would, in turn, put all the pressure of future budgetary battles on advocates for less-favored federal spending programs whose existence and generosity depend on Congressional action, not inaction, as well as, of course, taxpayer and deficit control advocates.[175] It would give Medicare providers, insurers, and beneficiaries a huge leg up in these budgetary battles. If the Judgment Fund were available then they would need only to beat back change in the law, which either the House, Senate, or President can do unilaterally, to ensure the nation devotes an increasing share of GDP to Medicare as health care costs climb.

On the other hand, if the Judgment Fund were unavailable or available only for one year's shortfall, the political dynamics of Medicare *vis a vis* competing federal resource priorities would be inverted. If Medicare's boosters wanted the program's share of GDP to grow to match rising health care costs in that case, they would need to cobble together major reform legislation capable of support from the House, Senate, and President. For better or worse, this would surely entail significant concessions to supporters of other programs, as well as advocates of deficit reduction and lower taxes.

E. Which Court (and What Kind of Relief)?

The substantive question *whether* courts would order relief from the Judgment Fund is undoubtedly important, but so is an additional, procedural question: what court would hear the case, and what kind of relief might it order? There are two very different procedural avenues though which shorted Medicare claimants might seek relief. First, judicial relief could be sought retrospectively, with resolution months or years after the fact, in damages actions in the Court of Federal Claims. Second, judicial relief could be sought prospectively, in actions seeking injunctive relief in Federal District Court. Intricacies of the jurisdictional provisions that govern access to these courts make them, to some extent, mutually exclusive.

The Court of Federal Claims is an Article I court setup by Congress to resolve a specialized, important group of claims, including damages claims against the government.[176] Its equitable power (including power to order injunctive relief) is severely limited, perhaps nonexistent.[177] Its decisions may be appealed to the Federal Circuit, then the Supreme Court.[178]

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[175] Matthew B. Lawrence, *Subordination and Separation of Powers*, 131 YALE L. J. (forthcoming 2021) (manuscript at 17), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3831227 (describing fragility of annually-funded discretionary programs).

[176] The History of the U.S. Court of Federal Claims, at http://www.uscfc.uscourts.gov/USCFChistory.htm.

[177] Bowen v. Massachusetts, 487 U.S. 879, 905 (1988) ("The Claims Court does not have the general equitable powers of a district court to grant prospective relief.").

[178] 28 U.S.C. § 1491.

Prior disappropriations have all been litigated in the Court of Federal Claims. In the tribal support cost, risk corridor, and cost sharing reductions disappropriations, litigation began there before ultimately reaching the Supreme Court.[179] It might be assumed that Medicare insolvency litigation could and would undoubtedly proceed in that court. This assumption would be too hasty. The Federal Circuit in *Wilson v. United States* held that the Court of Federal Claims lacks jurisdiction over lawsuits that "arise under" the Medicare statute because of the Medicare statute's jurisdictional channeling positions, which tee up district court actions.[180] There is a strong argument that a challenge to HHS's reduction or delay of a Medicare reimbursement claim due to the program's insolvency would also "arise under" the Medicare statute,[181] and so be ineligible for adjudication in the Court of Federal Claims.

As for Federal District Courts, they are tightly constrained in their ability to order the government to pay money. The Administrative Procedure Act's catch-all waiver of sovereign immunity (which by default blocks lawsuits against the government) applies only for relief "other than money damages,"[182] and only as to claims for which there is no other "adequate remedy" in a court (like, perhaps, the Court of Federal Claims).[183]

These limitations might or might not preclude Medicare insolvency litigation in Federal District Court. The Supreme Court held in *Bowen v. Massachusetts* that a claim against the government may seek money but not "money damages" if money is the "very thing" the government has allegedly failed to provide.[184] Moreover, it held that a retrospective damages remedy, even if technically available, is not necessarily "adequate."[185] Indeed, in the case before it, the Supreme Court held in *Bowen* that states could sue for allegedly-denied Medicaid payments to which they were statutorily entitled in Federal District Court because they sought not "damages" but compliance with the statute, and because their need to plan in advance how to administer their Medicaid programs meant that an *ex post* damages remedy would not be "adequate."[186]

The fact that prior disappropriations have been litigated through the Court of Federal Claims makes it impossible to say with assurance that the Federal District Court path would be viable to litigate insolvency in Medicare. Moreover, despite its apparent breadth, courts have tended to read *Bowen* narrowly.[187] That said, although there are superficial legal obstacles to the district court, prospective relief path, *Bowen* demonstrates that these

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[179] Me. Cmty. Health Options v. United States, 140 S.Ct. 1308 (2020) (case began in Court of Federal Claims); Salazar v. Ramah Navajo Chapter, 567 U.S. 182 (2012) (same).

[180] *See* Wilson v. United States, 405 F.3d 1002, 1016 (Fed. Cir. 2005) ("[T]he scheme for comprehensive administrative and judicial review set forth in the Medicare Act preempts Tucker Act jurisdiction over [the] claim for reimbursement."); Allegheny Technologies Inc. v. U.S., 144 Fed. Cl. 126 (Fed. Cl. 2019) (applying *Wilson* in finding no jurisdiction over Medicare claim).

[181] The Supreme Court has held that a claim "arises under" the Medicare statute if the statute "provides both the standing and substantive basis" for the claim. Weinberger v. Salfi, 422 U.S. 749, 761 (1975).

[182] 5 U.S.C. § 702.

[183] 5 U.S.C. § 704.

[184] *Bowen*, 487 U.S. at 895-97.

[185] *Id.* at 905.

[186] *Id.* at 905-06.

[187] *See* Gregory C. Sisk, *The Jurisdiction of the Court of Federal Claims and Forum Shopping in Money Claims Against the Federal Government*, 88 IND. L. J. 83 (2013) (tracing courts' limiting interpretations of *Bowen*); *cf.* Cynthia Grant Bowman, Bowen v. Massachusetts*: The "Money Damages" Exception to the Administrative Procedure Act and Grant-in-Aid Litigation*, 21 URB. L. 557, 577 (1989) (suggesting *Bowen* may be read to allow grant-in-aid litigation to proceed in district court even when seeking money).

arguments are not insurmountable, as does *Wilson*. Plaintiffs hoping to establish Federal District Court jurisdiction in Medicare insolvency litigation could argue the Court of Federal Claims would be inadequate both due to the jurisdictional limitations on that court noted in *Wilson* and their need to know the status of their Medicare claims in order to plan their operations. If this path were open, the Judgment Fund would be available to fund compliance with any resulting court order, as it is for other court judgments.[188]

The procedural path of Medicare bankruptcy litigation would not apparently impact whether courts would ultimately order payment from the Judgment Fund or not.[189] It would nonetheless be important, because prospective relief in Federal District Court would likely proceed much more quickly than damages actions in the Court of Federal Claims. The speed of district court actions would depend to a significant degree on the form of HHS's decisions altering payment,[190] but could potentially begin immediately upon the adoption of insolvency measures and be quickly adjudicated on summary judgment.[191] By contrast, a suit in the Court of Federal Claims could not proceed until damages were actually inflicted, delaying by months or years the course of litigation.[192]

III. REWRITING THE STARS

Thinking about all the confusion and controversy that would surround the administration of insolvency in Medicare naturally motivates thinking about immediate steps to avoid insolvency altogether. It is therefore unsurprising and entirely appropriate that much ink has been spilled during insolvency crises on the questions of how to address the program's immediate needs and render it solvent, either by decreasing spending or increasing revenue.[193]

An unfortunate side effect of this focus on immediate steps to avoid insolvency, however, is that it has left shrouded in mystery what would or should happen if Medicare actually becomes insolvent. Yet, as this Part explains, that mystery itself matters—indeed, it matters even if Medicare actually never becomes insolvent.

This Part problematizes the overarching theme that runs throughout current law's approach to Medicare insolvency and is reflected individually and collectively in each of the questions identified and analyzed in Part II: Is it right for the Medicare statute and regulations to take a head-in-the-sand approach to insolvency, remaining silent on the possibility or its implications and so leaving the administration of insolvency uncertain, to be determined by

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[188] 31 U.S.C. 1304 (incorporating by reference 28 U.S.C. 2414).

[189] Ultimately the core question of statutory interpretation would remain the same, and regardless which court initially heard the $5.3 trillion dollar case, the Supreme Court would presumably take it up in light of its magnitude and import for Medicare, health policy, and the United States budget.

[190] *See supra* Part II.A & B.

[191] *See, e.g.*, *Adirondack Med. Ctr. v. Sebelius*, 29 F. Supp. 3d 25, 35 (D.D.C. 2014) (collecting sources regarding applicability of summary judgment procedure to resolution of legal and administrative law questions in suit challenging agency action). Medicare claimants might seek preliminary relief, but it is highly doubtful that district courts have authority to order payment from the Judgment Fund on a preliminary basis because the Judgment Fund appropriation is itself available only for payment of "final" judgments, 31 U.S.C. § 1304, and because of the strictures of the Appropriations Clause, *See* Disappropriation, *supra* note 9 (describing legal basis for conclusion that Appropriations Clause forbids preliminary relief regarding payment of damages when the availability of an appropriation is in doubt).

[192] *See supra* nn. 179 (collecting cases resolving funding disputes via Court of Federal Claims route).

[193] *Supra* nn. 58 to 63 and accompanying text.

the agency and courts if and when it occurs? This Part answers that question "no" and recommends that (hopefully prophylactic) rules to govern Medicare bankruptcy be established in advance. The next Part will turn to the respective roles of HHS, Congress, and the courts in effectuating this recommendation.

Subpart A explains that clarifying in advance how insolvency in Medicare would be administered would make insolvency less unfair and harmful if it did occur, even if the $5.3 trillion question of liability remained unanswered. Subpart B explains that such clarification would predictably decrease the likelihood that insolvency will occur in the first place, by facilitating preventive compromise in Congress. Subpart C explains that clarification of the liability question itself could make the threat of insolvency more effective at stimulating compromise and cost control in the Medicare program by clearly directing the risk of insolvency to the program's "least cost avoiders"—the powerful economic interests who shape Medicare policymaking.

A. Mitigating the Damage

The first reason Medicare should have explicit rules governing the administration of insolvency is that such rules would reduce the harms of insolvency if it did occur while setting up a fairer distribution of those harms. To see why, it is helpful to begin by mapping the likely harms of insolvency assuming that it follows the "most likely" possibility as to each of the major questions discussed in Part II.

On current law's most likely scenario, the agency would announce its insolvency policy at the last minute after taking extraordinary measures to delay insolvency's offset[194] and would opt to delay payments across the board.[195] After a year or two doctrinal and exhaustion obstacles would have cleared and claimants would seek damages from the Judgment Fund in the Court of Federal Claims. Their suits would progress to the Federal Circuit and then the Supreme Court, and would ultimately be successful. A final "win" in court would largely end the ongoing disruption of insolvency, but it would not undo the damage done. As the health policy world—and, at times, the country—waited with baited breath to see what HHS would do and then for lawsuits to progress through the courts to the Circuit's or the Supreme Court's definitive ruling,[196] providers and insurers would have had to endure months—probably years—of lost revenues and uncertainty. This is almost precisely what happened in the risk corridors and tribal support cost disappropriations.[197]

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[194] *Supra* Part II.A.

[195] *Supra* Part II.A & B.

[196] *Supra* Part II.D & E.

[197] In the risk corridors case, the wait pending judgment put many insurers out of business and effectively collapsed the ACA's promising "co-op" program, which had fueled the creation of dozens of startups that were too financially vulnerable to endure an unexpected loss of revenue. Brief of Amicus Curiae the Nat'l Ass'n of Ins. Comm'rs in Support of Plaintiff Appellee at 12–15, Moda Health Plan, Inc. v. United States, 892 F.3d 1311 (Fed. Cir. 2018) (No. 17-1994), 2017 WL 4077798 ("only six of the 24 Co-Ops operating at peak participation were still in business" because of risk corridors disappropriation); *see* Laurel Clason, *Watchdog Urges Further Oversight of Troubled Health Co-Ops*, CQ Roll Call (Sept. 14, 2017) (describing bankruptcies). The larger insurers were able to weather the disruption, however, and could move in and take over the territory and business given up by the now-defunct small players. *Id.* Then years later the Supreme Court ordered payment in full on all the unpaid claims from the Judgment Fund—too late for the bankrupt insurers, but not

The real-world harms in this most-likely scenario would emerge slowly, and perhaps behind the scenes if some struggling hospitals, nursing homes, and other providers were reluctant to publicize their financial precarity. The harms would nonetheless be severe—and felt most acutely by the least-wealthy providers and communities. Insolvency's direct impact would be on reimbursement for providers, insurers, and others who serve Medicare enrollees, which would on this scenario be delayed by roughly two months in the first year, four months in the second, and so on depending on the extent of the shortfall. (This estimate is based on CBO predictions of a 17% shortfall in the first year rising to a 19% shortfall by 2030.[198])

Experience with past disappropriations of other health programs, along with past rate cuts and revenue shocks in Medicare, offers insight into how providers would respond to an extended delay (or reduction) in their Medicare reimbursements, and so what the disruption's ultimate effects would be. Providers would respond in four ways depending on their customer mix, financial position, and the competitiveness of their markets, creating a broad array of downstream effects on the health care system extending far beyond Medicare.

First, the most financially precarious providers would be rendered insolvent themselves—unable to stay afloat without timely payment of their anticipated Medicare reimbursements.[199] Such providers would either shutter or be forced to merge with larger, better-financed entities, further fueling concentration in health care markets.[200] Provider and insurer insolvencies would, in turn, limit access for all patients in impacted communities, either directly in the case of hospital closures or indirectly due to increased costs, and so

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for the large players. *Me. Cmty. Health Options v. United States*, 140 S.Ct. 1308, 1318, 1331 (2020). Similarly, in the tribal support cost case, tribes were forced to reduce services for members while they waited—twenty-five years—for their billion-dollar case to make their way through the courts, to the Supreme Court, and eventually, to payment of damages. Press Release, Dep't of the Interior, Interior, Justice Departments Announce $940 Million Landmark Settlement with Nationwide Class of Tribes and Tribal Entities (Sept. 17, 2015), https://www.indianaffairs.gov/as-ia/opa/online-press-release/interior-justice-departments-announce-940-million-landmark-settlement; *Ramah*, 567 U.S. at 184.

198 CONG. BUDGET OFFICE, TRUST FUNDS: 2020 TO 2030, *supra* note 3.

199 For example, when the Affordable Care Act's risk corridors subsidy was disappropriated, more than a dozen health insurance companies entered the insolvency process. *See* Sally Pipes, *Obamacare's Co-Op Disaster: Only 7 Remain*, FORBES (July 25, 2016), https://www.forbes.com/sites/sallypipes/2016/07/25/obamacares-co-op-disaster-an-unfunny-comedy-of-errors/?sh=d5244195d5b4 ("Just seven of the original 23 co-ops are still standing.").

200 A concern about hospital bankruptcies associated with lost Medicare revenue due to the coronavirus pandemic prompted Congress and HHS to make hundreds of billions in aid available to offset the pandemic's temporary reduction in net demand for hospital services. This included direct stimulus from Congress-- $100 billion for providers in Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, 134 Stat. 281, and $75 billion from the Paycheck Protection Program and Heath Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620, and an estimated $68 billion of the $520 billion for the paycheck protection program when to providers. It also included billions in "advance" Medicare payments from HHS; the agency increased eligible hospitals' payments in the short term to help them stay afloat, while requiring repayment against future claims in the years to come. *See Fact Sheet: Repayment Terms for Accelerated and Advance Payments Issued to Providers and Suppliers During Covid-19 Emergency*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 8, 2020), https://www.cms.gov/files/document/accelerated-and-advanced-payments-fact-sheet.pdf. Hospitals received advance payments of at least $100 billion through the program. Juliette Cubanski et al., *Medicare Accelerated and Advance Payments for COVID-19 Revenue Loss: More Time to Repay*, KAISER FAM. FOUND. (Oct. 8, 2020), https://www.kff.org/medicare/issue-brief/medicare-accelerated-and-advance-payments-for-covid-19-revenue-loss-more-time-to-repay/.

reduced affordability, associated with the loss of competition among providers and insurers due to merger and closure.[201]

Second, some providers may simply choose to exit the Medicare program, refusing to accept Medicare from their patients, at least for the duration of insolvency. Medicare patients are a critical source of revenue for most providers,[202] making it doubtful that enough would leave for access to be meaningfully impacted across the board—only 1% of providers refuse to accept Medicare. Access impacts would nonetheless be important, however, in two domains. In rural and low-income communities that already struggle with access,[203] even small numbers of providers exiting the program could mean severe shortages.[204] And in fields where providers already decline to participate in Medicare at significant rates—psychiatry (7.2% currently opt out), plastic and reconstructive surgery (3.6%), and neurology (2.8%)[205]—a significant proportion of providers could choose to opt out, or avoid treating patients in inpatient settings. Of course, providers exiting Medicare would increase the concentration of the markets they left behind, at least for Medicare patients.[206]

Third, providers would be forced to find ways to increase revenue or reduce costs, at least until the courts ultimately resolved the damages question—probably in providers' favor.[207] Those in competitive markets could do so in desirable ways, such as by cutting wasteful care, unnecessary investment, or excessive executive or provider salaries.[208] They could also do so in undesirable ways, however, such as by limiting charitable services for the

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[201] *See Health Care Industry Consolidation: What Is Happening, Why It Matters, and What Public Agencies Might Want to Do About It: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy and Com.*, 115th Cong. 1, 6-7 (2018) (testimony of Leemore S. Dafny, Ph.D) (discussing price increases in highly concentrated markets and evidence of lower quality health care in such markets).

[202] As of 2016, Medicare made up 40.8% of hospital costs. *Trendwatch Chartbook 2018: Trends Affecting Hospitals and Health Systems*, AM. HOSP. ASS'N 39 (2018), https://www.aha.org/system/files/2018-07/2018-aha-chartbook.pdf.

[203] Nicole Huberfield, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241, 247-51 (2018) (outlining disparities in rural health care); Emily A. Benfer, et al., *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL'Y, L. & ETHICS 122, 141-42 (2020) ("Health care institutions have closed hospitals in low-income communities and communities of color to relocate in more affluent communities as a result of 'neutral' policies that disproportionately harmed low-income communities and communities of color.").

[204] *See State and Federal Efforts To Enhance Access to Basic Health Care*, COMMONWEALTH FUND, https://www.commonwealthfund.org/publications/newsletter-article/state-and-federal-efforts-enhance-access-basic-health-care ("Hampering access to care is a shortage of primary care physicians, nurses, dentists, and other health personnel, particularly in low-income urban and rural communities.").

[205] Nancy Ochieng et al., *How Many Physicians Have Opted-Out of the Medicare Program*, KAISER FAM. FOUND. (Oct. 22, 2020), https://www.kff.org/report-section/how-many-physicians-have-opted-out-of-the-medicare-program-tables/.

[206] *See United States v. Aetna, Inc.*, 240 F.Supp.3d 1, 41 (D.D.C. 2017) (concluding that for insurance plan merger analysis, relevant market should be seen as "traditional Medicare" and "Medicare Advantage," not all of Medicare).

[207] James Robinson, *Hospitals Respond to Medicare Payment Shortfalls by both Shifting Costs and Cutting Them, Based on Market Concentration*, HEALTH AFFS. (July 2011), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0220.

[208] *Id.*

indigent,[209] increasing the aggressiveness of their collection practices to reduce unpaid are costs,[210] laying off employees,[211] and reducing the services they provide to patients. Providers with market power in concentrated markets, meanwhile, could be expected to increase their private-sector rates and thereby pass the cost on to those enrolled in private insurance plans.[212]

Fourth, wealthy, well-resourced providers could bank on the likelihood that disrupted payments would ultimately be ordered by courts in full, with interest,[213] by continuing business as usual, weathering the shortfall and using the opportunity to gain market share over competitors who lacked that financial flexibility. The possibility that richly-resourced hospitals and other providers would use Medicare's insolvency as an opportunity to further increase their market share is yet another reason to believe that insolvency in the program would serve as a driver of increased concentration in the health care marketplace,[214] with lasting follow-on effects on the cost of health care and, so, access.[215]

Stepping back, a general trend is evident in the broad range of harms likely to be brought about by insolvency in Medicare on this most-likely path: Those harms would be distributed unfairly, in the sense that they would be borne disproportionately by certain providers, patients, and communities, based on their wealth and location, not any considered design. The providers most likely to be put out of business by insolvency would be those who rely most heavily on Medicare revenues, which includes safety net hospitals that serve higher proportions of low-income beneficiaries, as well as sole community and rural

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[209] When hospital Medicare reimbursements were cut across the board by 2% to 4% due to Congress's failure to avoid the "sequestration" crisis device in 2013, *Estimated Impact of Automatic Budget Enforcement Procedures Specified in the Budget Control Act*, CONG. BUDGET OFF. 2 (Sep. 12, 2011), https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/09-12-BudgetControlAct_0.pdf, hospital association lobbyists complained that the cuts would ultimately harm patients by reducing such services. *See* Janie Lorber, *Pressure Points: The Sequester and Medicare Reimbursements*, ROLL CALL (Feb. 26, 2013), https://www.rollcall.com/2013/02/26/pressure-points-the-sequester-and-medicare-reimbursements/ (hospital labor groups appealed Congress because "[l]ower payments . . . limit the ability of hospitals and other providers to care for society's more vulnerable populations, including seniors and low-income patients"); Lori Montgomery & Paul Kane, *The Big Sequester Gamble: How Badly Will the Cuts Hurt?*, WASH. POST (Feb. 23, 2013), https://www.washingtonpost.com/politics/the-big-sequester-gamble-how-badly-will-the-cuts-hurt/2013/02/23/be0c44e2-7c4e-11e2-82e8-61a46c2cde3d_story.html (noting that a nonprofit healthcare lobbying coalition fought the cuts on Medicare and the American Health Association lobbied against cuts on medical research).

[210] *See generally* Isaac Buck, *When Hospitals Sue Patients*, 73 HASTINGS L. J. __ (forthcoming 2021-22).

[211] The coronavirus shortfall saw an immediate spike in health care industry layoffs. *Unemployment Weekly Claims*, DEPT. OF LABOR (Mar. 26, 2020), https://oui.doleta.gov/press/2020/032620.pdf.

[212] James Robinson, *Hospitals Respond to Medicare Payment Shortfalls by both Shifting Costs and Cutting Them, Based on Market Concentration*, HEALTH AFFS. (July 2011), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0220 (research into the effect of provider Medicare reimbursement reductions on provider behavior indicates that concentrated markets respond by increasing private-sector reimbursement rates, while those in competitive markets find ways to cut costs).

[213] *See* 42 U.S.C. § 1395h(c)(C) (mandating interest for late payments). From January 2021 through June 2021, the interest rate on late payments was 0.875%. *See* Prompt Payment Interest Rate, 86 Fed. Reg. 7,457-58 (Jan. 28, 2021).

[214] *See* Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, HEALTH AFFS. (Sep. 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556 (discussing the trends of increasing concentration in health care markets, especially among primary care physicians).

[215] Barak D. Richman, *Concentration in Health Care Markets: Chronic Problems and Better Solutions*, AM. ENTER. INST. (2012) (describing increasing trend of concentration in health care markets).

hospitals.[216] Provider cuts to charitable care and efforts to recoup revenues through aggressive debt collection practices would, of course, fall most heavily on financially distressed patients,[217] as would increases in private-sector insurance rates.[218] And increased concentration in health care markets fueled by provider insolvencies, exits, and well-resourced providers' comparative advantage in weathering a temporary disruption, would exacerbate the distributional slant of market concentration's harms described by Professor Havighurst and Professor Richman.[219]

Establishing Medicare bankruptcy rules in advance by regulation or legislation would reduce this harm and unfairness in three ways. First, setting rules in advance would dramatically shorten the interim period of uncertainty between the onset of insolvency and final determination of rights and responsibilities under insolvency, and so the costs associated with the transition. The law could fully resolve all the open questions presented by insolvency, including whether claimants would be entitled to payment from general revenues of statutorily-mandated amounts in the event taht the trust fund became insolvent. In such a case there would be no transition costs at all—if claimants were guaranteed the payments that they likely are entitled to under current law, then the transition would be seamless and harms associated with insolvency avoided entirely. But even if the legal framework for Medicare bankruptcy left the question of Judgment Fund liability (or another uncapped general Treasury backstop) unresolved, having the other aspects of Medicare bankruptcy set in advance and explicit in law would allow claimants to sue as soon as insolvency arrived and streamline litigation, allowing for judicial resolution far more quickly. For example, if HHS simply issued a regulation in advance setting forth its planned approach, that regulation could serve as a vehicle for litigation that would predictably permit litigation to proceed years before it could under an alternative approach whereby HHS waited until after insolvency hit to announce and implement a policy.[220]

Second, a Medicare bankruptcy framework established in advance could prioritize among claimants more freely than policy set on the eve of, or in the midst of, insolvency. Protecting, for example, rural providers and those serving disproportionate numbers of low-income and indigent patients would mitigate the harms and unfairness of insolvency. As described in Part II.C, the agency's legal authority to provide such insulation through

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[216] *See* Matthew Manary, Richard Staelin, William Boulding, & Seth W. Glickman, *Payer Mix & Financial Health Drive Hospital Quality*, 1 BEHAV. SCI. & POL'Y 77, 78-81 https://behavioralpolicy.org/wp-content/uploads/2017/02/BSP_vol1is1_Manary.pdf (noting that hospital financial health is highly correlated with how large a percentage of private-payer patients the hospital serves); Ron Shinkman, *Safety Net Hospitals Hit Particularly Hard by Covid-19*, HEALTHCARE DIVE (Dec. 21, 2020), https://www.healthcaredive.com/news/safety-net-hospitals-hit-particularly-hard-by-covid-19-cut-spending/592520/ (safety net hospitals are particularly dependent on Medicare and Medicaid payments).

[217] Buck, *supra* note 210, at 29-30, 41-42 (outlining patient concerns of bankruptcy as a result of medical expenses and discussing that debt may cause patients to lose housing or fail to continue seeking out medical care).

[218] Samantha Artiga, Petry Ubri & Julia Zur, *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, KAISER FAM. FOUND. (June 1, 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/ ("Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty.").

[219] Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 L. & CONTEMP. PROBS. 7 (2006) (describing adverse distributive impacts of concentration in health care markets).

[220] *See supra* note 126 and accompanying text (contrasting timeline of litigation challenging Medicare payment regulations to timeline of litigation challenging Medicare payment delays).

guidance, last-minute adjudication, or emergency rulemaking is constrained by the Medicare statute as interpreted by the Supreme Court in *Allina*.[221] This sets up a major advantage of advance establishment of Medicare bankruptcy rules, because either HHS (through notice and comment rulemaking) or Congress (through legislation) would have far greater leeway to insulate the most vulnerable or deserving claimants from the effects of insolvency.[222]

Third, establishing Medicare bankruptcy policy in advance would be fairer in the procedural sense that legal policymaking processes are more participatory. Health justice calls for "collective deliberation on . . . the reimbursement policies that will apply to various types of services and practitioners—as an expression and obligation of citizenship."[223] Similarly, administrative law values have long emphasized the importance of policymaking processes that offer opportunities for participation and accountability.[224] Notice and comment rulemaking in advance of insolvency would offer such opportunities for participation, as would, of course, legislation. The last-minute announcement of policy by agency fiat would not.

There is no knowing for sure how long insolvency in Medicare would last if reached. If not established in advance, key questions about the program's operation and priorities decided through closed, non-participatory processes could come to govern Medicare for years, or even indefinitely.

Finally, establishing Medicare bankruptcy policy in advance would reduce the harms and unfairness of insolvency even if we relax the assumption employed so far in this part that under the *status quo* Medicare bankruptcy would follow the most likely path—delayed payments, announced at the last minute, leading after years to court-ordered damages from the Judgment Fund. If instead courts were ultimately to refuse to award damages—as might well happen—Congress might respond to such a refusal by stepping in to provide a source of payment itself,[225] in which case the result (payments being made but only after years of disruption bringing serious and unfair harms) would be the same, albeit reached through a different process.

To be sure, if courts refused to order damages and that result did not trigger a response from Congress, the time it took for providers to learn they would be forced to endure reductions in one of their most important sources of revenue for good would have relatively little impact on the severity or distribution of the resulting harms.[226] But, even in

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[221] *See supra* Part II.C.

[222] *Id.*

[223] Lindsay Wiley, *From Patient Rights to Health Justice*, 37 CARDOZO L. REV. 833, 888 (health justice "seek[s] to foster").

[224] *See, e.g.*, Gillian Metzger, *Administrative Constitutionalism*, 91 TEX. L. REV. 1897, 1928 (2013) (considering value of participation); Paul F. Figley, *The Judgment Fund: America's Deepest Pocket & Its Susceptibility to Executive Branch Misuse*, 18 U. PA. J. CONST. L. 145, 208 (2015) (expressing concerns about Judgment Fund appropriation from perspective of administrative law values).

[225] *Cf.* Pigford v. Glickman, 185 F.R.D. 82, 90 (D.D.C. 1999) (discussing the Congressional waiver of the statute of limitations for particular civil rights claims).

[226] It might be that years of litigation during which ultimate payment was still expected might give hospitals a chance to adapt to increased uncertainty in their revenue streams, mitigating impacts. *Cf.* 2020 Trustees Report, *supra* note 52, at 41 ("The early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations and behavior."). On the other hand, extending the period of uncertainty would also mean increasing the size of the accumulated shortfall hospitals would, on this scenario, unexpectedly become responsible for, exacerbating harms for hospitals who banked on a favorable result in Judgment Fund litigation.

such a case, Medicare bankruptcy pursuant to rules set in advance would be more fair because HHS would still have an opportunity to insulate the most financially vulnerable providers and insurers and those meeting the most critical community needs—and that insulation would be even more important if insolvency means a permanent rather than a temporary disruption in payments. And, even in such a case, Medicare bankruptcy pursuant to rules set in advance would be fairer because HHS or Congress would still be able to consider and address a broad range of views in forming what would, in such a scenario, become the "new" structure of the Medicare program.

B. Startling the Frog

Readers may at this point begin to wonder whether it is not just likely but inevitable that Congress will decline to take major action to address the solvency of Medicare unless and until courts finally address the question of Judgment Fund liability, which would at a minimum entail the executive branch operating an insolvent Medicare program for many months and, more likely, years (if not permanently). In prior work, I drew from the experience of past disappropriations the insight that the likelihood that Congress will take action to avoid a funding shortfall depends in part on how much certainty there is about the consequences of a congressional failure to act.[227] A members' willingness to cast a costly vote to address a program's financial woes—whether by raising taxes, reducing benefits, drawing funds from another program, or borrowing—depends for a variety of reasons on what they might be blamed for if they refuse to cast that vote.[228] The more uncertainty there is about the consequences of a funding shortfall, the easier it is for the member to shift blame to whoever resolves that uncertainty—whether the executive or the courts.[229] Moreover, uncertain impacts make bargaining failure more likely by fueling behavioral biases including optimism and myopia that inhibit compromise.[230]

Although I did not address Medicare directly in *Disappropriation*, the program's impending insolvency offers a straightforward application of this point. With all the uncertainty in current law about the consequences of insolvency, a member of Congress could vote "no" on legislation addressing Medicare's solvency and argue with a straight face that they had done so in order to protect Medicare beneficiaries (from cuts) or taxpayers (from hikes). Further, such a member could argue that her vote did not actually imperil providers or beneficiaries in her district, even though it led to the program's insolvency, because her constituents should have been protected by the agency (by insulating their payments) or by courts (by ordering damages from the Judgment Fund). Members reluctant to pay the political price either for raising revenue for Medicare (by diverting funds from other programs, appropriating general revenues, or creating new taxes) or for reducing Medicare expenditures (which would lead to charges of "cutting" benefits) might see leaving this question to the executive branch and courts in the first instance as a very desirable option. Indeed, that would be the prediction of Professor Ely's famous—and oft-evidenced—insight that a congressional desire to shift blame for hard choices fuels statutory

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[227] Lawrence, *Disappropriation*, *supra* note 9 at 70-72.
[228] *Id.*
[229] *Id.*
[230] *Id.*

delegations and ambiguities.[231] From this perspective, hard-to-trace, slow-developing impacts on competition, affordability, and access to care that could be blamed on the executive branch and courts might be a worthwhile price to pay to a politician worried about avoiding blame for cutting other programs, raising taxes, cutting Medicare, or ballooning the deficit.

At the same time, the lack of any clear deadline by which Congress had to act to avert the effects of insolvency would dilute pressure on congressional leadership to bring such a bill to the floor in the first place.[232] Simultaneously, optimistic providers, confident in their prospects for ultimate success in the courts, might be reluctant to support legislation to address insolvency that adversely impacted their reimbursement rates to any significant extent, limiting the range of possible legislation addressing insolvency to bills drawing revenue from other programs, or increasing taxes, that might be blocked by opponents of either option. Instead of a "game of chicken" negotiation, deliberations about whether and how to address the solvency of the Medicare program could well look more like a game of Russian roulette.

Compared to this current path, establishing a legal framework for Medicare bankruptcy would make insolvency less likely by reducing uncertainty about the consequences of congressional inaction.[233] A legal framework for Medicare bankruptcy would also make extended insolvency less likely by shortening the period of uncertainty between the onset of insolvency and final resolution of open questions about the government's obligations and claimants' rights.[234]

Furthermore, establishing a legal framework for Medicare bankruptcy would also make insolvency less likely if that framework created a concrete deadline by which Congressional action was necessary to avert undesirable impacts. Either a regulation or statute could provide for reductions in Medicare reimbursements to be effective for an entire fiscal year unless preventive action were enacted by a date certain, giving all involved a clear

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[231] JOHN H. ELY, DEMOCRACY AND DISTRUST 132 (1980) (explaining dynamic); *see also* Chafetz, *Congress's Constitution* (describing importance of expectations which branch will be blamed in assessing whether shutdowns further executive or legislative power).

[232] Recent cliffs have seen searching attention into the actual, functional deadlines to avert negative impacts—and a reluctance in Congress to act until the very last minute, or soon after. *E.g.* Elizabeth Chuck, *Millions of Kids May Lose Health Insurance Over Missed Deadline by Congress*, NBC NEWS (Nov. 17, 2017) https://www.nbcnews.com/news/us-news/millions-kids-may-lose-health-insurance-over-missed-deadline-congress-n820261 (CHIP); Nicholas Wu and Christal Hayes, *Congress Faces a Government Shutdown If a Spending Deal Isn't Reached This Week*, USA TODAY, (Dec. 7, 2020) https://www.usatoday.com/story/news/politics/2020/12/07/government-shutdown-happen-if-congress-doesnt-act-friday/3856020001/ (government shutdown); Caitlin Emma, *Democrats Hurtle Toward Debt Deadline Without a Clear Plan*, POLITICO, (June 24, 2021) https://www.politico.com/news/2021/06/24/democrats-debt-ceiling-deadline-495749 (debt ceiling).

[233] The extent of this effect would depend on the degree to which the new framework answered the open questions described in Part II. Specifically, it would depend on whether any discretion left to HHS would need to be exercised in advance through notice and comment rulemaking, whether payments would be delayed or reduced, whether the agency could insulate some claimants, and (either) whether the Judgment Fund would be available in the event of insolvency or (more likely, given the probable difficulty of reaching compromise on that question) the procedural route through which litigation to resolve the Judgment Fund question should proceed.

[234] To maximize this effect, Congress could facilitate prompt judicial resolution of open questions by blessing the district court litigation path, and possibility of prospective relief, as an alternative to Judgment Fund litigation.

deadline for congressional action, each year, to avert the consequences of insolvency for the upcoming year—and minimizing the confusion entailed in administering insolvency.

Despite these significant benefits in terms of reduced likelihood, it is important to note that the effect that clarifying the consequences of insolvency in Medicare would have on its likelihood would not be entirely positive. There could be two categories of cross-cutting effects, one more troubling than the other. The first concern is that whatever benefits a legal framework for Medicare bankruptcy would have *ex post*, openly contemplating how insolvency would affect the program would make insolvency more likely by making that result morally or normatively acceptable. It may be that the possibility of actually allowing the program to become insolvent is today seen as unacceptable or extreme, that this taboo is on track to help ensure the current fiscal challenges are overcome—because no politician could suggest insolvency as an option and remain electorally viable—and that addressing the possibility in law might erode this salutary taboo. In short, perhaps today allowing Medicare to become insolvent is outside the "Overton window"[235] of politically-viable policy options but addressing insolvency explicitly in law would expand that window.

Two considerations diminish the weight of this concern. First, under current law members of Congress can easily—indeed they are on a path to—allow Medicare to become insolvent without ever taking action or adopting a pro-insolvency position. In order for any taboo against supporting Medicare solvency to do its work, a policy cliff must be put in place that crystallizes the need to make a choice, forcing a vote in Congress that can be characterized as "for" or "against" insolvency. As just described, a major benefit of addressing insolvency by law, in advance, is that doing so would set up such a vote by forcing clear deadlines to avoid impacts.

Second, addressing what happens in Medicare in the event the program becomes insolvent would not necessarily make insolvency any less taboo. The expressive function of law depends on its content, not only its subject matter. Many laws address taboo or extreme outcomes—what to do if a person kills another,[236] what to do if a President commits a felony,[237] and, of course, what to do if a municipality or individual becomes insolvent.[238] Thus, bankruptcy scholars have explained that the extent to which bankruptcy laws lessen the "stigma" around personal financial distress, and therefore increase the likelihood of bankruptcy, depends not on the existence of bankruptcy provisions in law but on the content of those provisions.[239] Following the same logic, the concern that addressing Medicare insolvency in law would legitimize it is a reason to focus on the prefatory and expressive content of any law addressing Medicare bankruptcy, not a reason not to adopt such a law.

A second reason to worry that creating a legal framework to govern Medicare bankruptcy might make insolvency more likely is the fact that, as described in subpart A, such a framework would reduce the harms and unfairness of insolvency if it comes. Surely

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[235] *See* Daniel J. Morgan, *The Overton Window and a Less Dogmatic Approach to Antibiotics*, 70 CLINICAL INFECTIOUS DISEASES 2439, 2439 (2020) (describing the Overton Window).

[236] *E.g.* 18 U.S.C. § 1111. *See* Robert Weisberg, *Norms and Criminal Law, and the Norms of Criminal Law Scholarship*, 93 J. CRIM. L. & CRIMINOLOGY 467, 476 (2003) ("When lawmakers make law, they . . . hope to express certain social or cultural values they attach to that behavior.")

[237] *E.g.* Restoring and Enforcing Accountability of Presidents Act, H.R. 1153, 117th Cong. (2021).

[238] *E.g.* Municipal Bankruptcy Act, 11 U.S.C. §§ 901–946.

[239] *See* Rafael Efrat, *Bankruptcy Stigma: Plausible Causes for Shifting Norms*, 22 Emory Bank. Dev. J. 481, 496-97 (2006) (Bankruptcy Reform Act of 1978 may have contributed to reduction in stigma surrounding personal bankruptcy by prohibiting discrimination against those who have declared bankruptcy").

the likelihood that Medicare becomes insolvent depends in part on the severity and distribution of the harms that would result if it does, such that reducing those harms would make insolvency more likely.[240]

The concern that establishing a legal framework for Medicare bankruptcy would tend to make insolvency more likely by lessening the magnitude of its predicted harms is a legitimate (though normatively fraught) one, but assumes that such a framework could not preserve or even increase the deterrent effect of the threat of insolvency. The next subpart turns to why this assumption is incorrect.

C. Medicare's Least Cost Avoiders

In *Disappropriation* I pointed out that reducing the harms associated with a congressional failure to fund an entitlement might make that failure more likely because the harms associated with inaction are a factor in the decisionmaking of leadership and members in Congress.[241] Accordingly, I encouraged caution about reforms that reduce the seriousness or credibility of the threat of disappropriation, while endorsing unequivocally reforms that reduce the *likelihood* but not the *threat* of disappropriation.[242] The benefits of establishing a legal framework to govern Medicare bankruptcy described in the last subpart—reducing the risk of bargaining failure in Congress—satisfy this criterion. But the benefits of establishing a legal framework described in the first subpart—that doing so would reduce the severity and unfairness of the harms—do not. Reducing the harms of insolvency would indeed reduce the severity of the threat of insolvency. It is therefore necessary to ask: Would a Medicare bankruptcy law's impacts on the threat of insolvency ultimately be desirable, or not?

This is an important question, because the threat of insolvency in Medicare has played an influential role in health and welfare policy over the past five decades, even though the program has not yet actually become insolvent.[243] The threat of insolvency has acted as what Professor Kamin (who is now Deputy Director of President Biden's National Economic Council) calls a "crisis device," a legislatively-created trigger that forces preemptive action, pushing Congress to regulate on a subject it might otherwise leave alone at a time when it might otherwise do nothing.[244]

If Congress or HHS created a legal framework to govern insolvency that made it effectively costless for everyone directly involved in the program—such as guaranteeing payment from general treasury revenues in the event that the trust fund runs dry—they would thereby make insolvency (much) more likely, not less. They would truly make insolvency an accounting tool that operated merely as a "thermometer" on some Medicare

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[240] Whether Medicare actually becomes insolvent depends on many factors, the interaction of which might be modeled in different ways. But it is hard to imagine a plausible model predicting whether the program will become insolvent in which the harms predicted to come from insolvency are not a paramount consideration.

[241] *Disappropriation*, *supra* note 9, at 66-67 (noting distinction between durability and entrenchment).

[242] *Id.* at 69.

[243] *See supra* nn. 45-49 (describing legislation enacted to resolve solvency crises); *e.g.*, Jennifer Conley, *Medicare and Medical Tourism: Saving Medicare with a Global Approach to Coverage*, 21 ELDER L. J. 183, 185 (2013) (proposing reform to "help save the Medicare HI Trust Fund from going bankrupt"); Jost, *supra* note 18 (describing prominence of fiscal concerns in Medicare legislation).

[244] David Kamin, *Legislating Crisis*, *in* THE TIMING OF LAWMAKING 34 (Frank Fagan & Saul Levmore, eds 2017).

costs.[245] This might well be a good thing,[246] in which case reducing the threat of insolvency is an end to be desired, an argument for, not against, legislation reducing insolvency's costs. This Article assumes, however, that insolvency will continue to entail harms, and so that the threat of insolvency will continue to play an important role in the program.

The creation of a legal framework to govern Medicare bankruptcy offers an opportunity to calibrate those harms, not just reduce them. It thereby offers an opportunity to make the threat of insolvency more effective at prompting preventive action both in the short term (by better motivating compromises in Congress necessary to resolve insolvency crises) and the long term (by more powerfully steering Medicare policy to maintain solvency and thereby prevent insolvency crises).

This point requires some unpacking. In theorizing how the risk of insolvency in the Medicare program might be assigned, it is helpful to conceptualize the insolvency of the Medicare program as analogous to the insolvency of a state or municipality. Like a state or municipality, the Medicare program is a legal creation with constituents (providers and beneficiaries), assets (trust fund revenues), and a complex web of expenditures. Most crucially, a central focus of the municipal bankruptcy literature is that of the often-problematic concept of "moral hazard,"[247] namely, the possibility that if those who are responsible for the policy direction of a municipality expect to receive the benefits of spending but not pay the costs, they will steer the municipality to spend more than it brings in, which will ultimately lead to insolvency.[248] This concern is the most important source of reluctance among scholars and policymakers for "bailing out" insolvent municipalities—the fear that by helping municipalities facing insolvency, the federal government might inadvertently encourage other municipalities to put themselves in the same position.[249] Thus, a focus of this literature is to find ways to "internalize" the costs of municipal profligacy by directing them toward the voters and the politicians responsible for municipal spending and revenue decisions.[250]

Of course, Medicare is different from a municipality in important ways. Relevant to the relationship between responsibility for the costs of insolvency, on the one hand, and the likelihood of insolvency, on the other—the question of moral hazard—Medicare policy is not determined directly by voters and its expenditures benefit patients and health care industry participants, not residents. So who should bear the risk of insolvency in the program, if we hope to put that risk to good use by targeting it in a way that combats moral hazard in the program and ultimately makes insolvency less likely?

Here, the concept of the "least cost avoider" developed initially in tort law is helpful. A leading normative insight associated with the economic analysis of tort law is that liability

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[245] Marmor, *supra* note 6.

[246] This Article has discussed several implications of the threat of insolvency for the functioning of Medicare and the federal government, including effects on political support for Medicare and the bargaining position of Medicare in budgetary debates in which Medicare is often pitted not only against taxes but also against other spending programs, and the potential to combat "moral hazard" described here.

[247] Tom Baker, *On the Geneology of Moral Hazard*, 75 TEX. L. REV. 237 (1996).

[248] David Schleicher, *Hands On! Part I: The Trilemma Facing the Federal Government During State and Local Budget Crises*, YALE L. SCH. PUB. L. & LEGAL THEORY RSCH. PAPER SERIES at 7-10 (forthcoming 2020), https://ssrn.com/abstract=3649278 (discussing the federal government's options in avoiding state debt crises).

[249] *Id.* at 6.

[250] Clayton P. Gillette, *Fiscal Federalism, Political Will, and Strategic Use of Municipal Bankruptcy*, 79 U. CHI L. REV 281, 287 (2012).

for a risk *ex post* should be assigned to whoever is best positioned to manage that risk *ex ante*.[251] Combining the moral hazard concern of the municipal bankruptcy literature with the "least cost avoider" concept from tort law presents a concrete prescription for the design of Medicare bankruptcy: if insolvency in Medicare is to carry harms, those harms should be directed toward the "least cost avoider" for insolvency in the program. Who, then, is that?

It is highly doubtful that the asset-poor hospitals and financially distressed patients who would be impacted most acutely by a temporary disruption in Medicare payments under current law are the program's "least cost avoiders," *i.e.*, that they are particularly well positioned to protect the program's solvency either by influencing Medicare policy between insolvency crises or by prompting necessary compromise to resolve those insolvency crises that do arise. As described above, the most economically powerful hospitals would be least impacted by a disruption of months or even a few years, especially considering the fact that Judgment Fund liability, if granted, would ultimately come with a generous payment of interest.[252] Instead the most acute impacts would be on the least economically powerful hospitals and providers and, in turn, the low-income patients they serve.[253] This group's lack of economic strength alone makes it poorly positioned to protect Medicare's solvency, either by forcing necessary compromises in Congress or by steering the program to adopt cost-cutting policies long term.

The threat of insolvency in Medicare would predictably be more effective at prompting congressional compromise and motivating reforms to protect the program's solvency long-term if it were directed instead at all hospitals and insurers, regardless of financial status, and if it were expanded to target pharmaceutical and device manufacturers, as well (which would mean tying the threat of insolvency into Medicare Parts B and D, not just A and C). If Medicare is to feature a threat of harm to someone in the event of insolvency, that someone should be the economically powerful health care industry players whose lobbying before the agency and Congress influences the short- and long-term course of the program: the hospital and nursing home industry, the health insurance industry, and the pharmaceutical and device manufacturing industry.

These three industries represent three of the leading lobbying industries in the country—in 2020 pharmaceutical companies were number one, hospitals were number seven, and health insurers were number thirteen.[254] The significant influence they play in the development of health policy has been noted and studied in depth by historians,[255] by political scientists,[256] and by law professors.[257]

The risk of insolvency shared with the health care industry need not be one-sided, limited to the downside risk of an insolvent trust fund. Hospitals, insurers, and/or

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[251] *See, e.g.*, Guido Calabresi & Jon T. Hirschoff, *Toward a Test for Strict Liability in Torts*, 81 YALE L.J. 1055, 1060-67 (1972).

[252] *See supra* note 213 (discussing interest on late Medicare payments).

[253] *Supra* Part III.A.

[254] Erin Duffin, *Leading Lobbying Industries in the United States in 2020, by Total Lobbying Spending*, STATISTICA (Mar. 4, 2021), https://www.statista.com/statistics/257364/top-lobbying-industries-in-the-us/.

[255] *E.g.* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 401-402 (1982).

[256] *E.g.*, Oberlander, *supra* note 20; LAWRENCE R. JACOBS & THEDA SKOCPOL, HEALTH CARE REFORM AND AMERICAN POLITICS 144 (3d ed., 2016) (describing role of health care industry lobbyists in drafting Affordable Care Act and then in develop of regulations implementing its provisions, and their focus on costs).

[257] *E.g.*, David A. Hyman, *Follow the Money: Money Matters in Health Care, Just Like In Everything Else*, 36 AM. J.L. & MED. 270 (2010).

pharmaceutical companies might also be given "skin in the game" of Medicare's solvency with the promise of a positive, upward adjustment in their payment rates to be triggered if, and only if, the program's solvency were projected to extend past ten years.[258]

A positive adjustment would have significant benefits from a policy perspective, as well. Numerous scholars have noted in different ways that reining in health care costs will be impossible unless and until pharmaceutical companies, hospitals, and other health care industry players can be incentivized to invest in and support technologies and reforms that make health care cheaper in the long term.[259] Giving these industries clear "skin in the game" of Medicare's solvency whether the program is nearing insolvency or not would offer a concrete fiscal means to that end.[260] Under such an arrangement they would have an immediate, present-day interest in policy, technological, or practice changes that predictably lower the program's long-term costs.

That said, a Medicare bankruptcy framework need not be so ambitious to make the threat of insolvency more effective. Explicitly addressing how Medicare payments would be impacted by insolvency in advance would naturally re-direct its harms by lessening the extent to which temporary disruption served as insolvency's most likely hazard. Policymakers concerned that doing so would take the "teeth" out of the threat of insolvency could replace the current, uncertain threat of probably-temporary disruption with any cross-cutting, certain threat, such as a modest reduction in reimbursement rates across all parts of the program for the duration of insolvency (akin to sequester), an automatic formula reducing rates by an amount necessary to protect the program's solvency (or perhaps automatically raising payroll taxes at the same time), [261] or the combination of negative and positive solvency adjustments just described.

This argument is not without its challenges. There are two significant reasons to doubt that an explicit Medicare bankruptcy framework would make the threat of insolvency

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[258] Politically speaking, offering such a "benefit" might be necessary to overcome health care industry players' reluctance to support any Medicare bankruptcy framework that explicitly assigned downside risk to the industry.

[259] *See* William M. Sage, *Be a Transformational President, Mr. Biden: Launch a Commission to Create an Ethical Health Care System*, BILL OF HEALTH (May 4, 2021), https://blog.petrieflom.law.harvard.edu/2021/05/04/biden-commission-ethical-health-care/ ("The U.S. health care system will not change without permission from health professionals, especially America's physicians."); Neel U. Sukhatame & M. Gregg Bloche, *Health Care Costs and the Arc of Innovation*, 104 MINN. L. REV. 955, 961-62 (2019) (health care cost growth driven in part by lack of innovation incentives for cost-reducing drugs and technologies); Nicholas Bagley & Rachel E. Sachs, *Limiting State Flexibility in Drug Pricing*, 379 N. ENGL. J. MED. 1002, 1002 (2018); Bagley, *supra* note 17, at 533 ("[T]he urgent and interesting question is . . . how to yoke the immense network of Medicare's private physicians to a broader notion of public values, one that's more attentive to questions of cost and quality.").

[260] This approach builds on proposals by Professor Bagley and Professor Buck to use law to give providers an interest in Medicare costs. Professor Bagley proposes that providers be given such an interest through participation in contract organizations that themselves are financially motivated, Bagley, *supra* note 16, at 522, and Professor Buck proposes that providers be understood to have a fiduciary duty to Medicare as a payer. Buck, *supra* note 17, at 1064. Neither proposal would check the industry's incentive to steer the development of Medicare policy and health care institutions toward greater cost, but a solvency adjustment would.

[261] The Affordable Care Act includes an analogous provision capping the net cost of premium tax credits based on a fraction of gross domestic product. *See* 31 U.S.C. § 36B(b)(3)(A)(ii)(III) (indexing provision triggered "only if" ACA subsidy costs "exceed[] an amount equal to 0.504 percent of [GDP] for the preceding calendar year").

more effective than the current uncertain threat as a tool to promote compromise and cost control, but upon inspection neither actually undermines the case for such a framework.

To start, skeptics might point out that the extent to which clearly tying Medicare payments to the hospital, insurance, and pharmaceutical industries to the program's solvency would alter their lobbying behavior, let alone the effect of that behavior, is difficult to predict. This argument applies to the current, uncertain threat too, however. It is a reason to doubt that the threat of insolvency plays a useful role at all, not an objection to the possibility of better targeting the threat if there must be one.

More fundamentally, experience supports the view that there would be at least some incentive effect. There are numerous examples of changes in Medicare law altering the program's political economy—changing who lobbies in the program, and for what. The trust fund financing structure itself was intended by its creators to generate political buy-in for the program from constituents and voters,[262] and it is believed to have had this intended effect.[263] The "doc fix"—a statutorily-scheduled cut to provider reimbursements that triggered annual legislation to postpone its effective date until it was permanently repealed in 2015—saw the health care industry lobbying Congress every year for an extension through legislation that served to force compromise from the industry.[264] The Medicare Modernization Act expanded Medicare's privatized component, which has resulted in a powerful lobby of insurers working to further privatize Medicare or increase the generosity of insurer payments.[265] And the creation of the "Recovery Audit Contractor" program very clearly illustrated the endogeneity of law to economics and economics to politics: the pilot program created "RACs," private entities promised a share of any hospital overpayments

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[262] As President Roosevelt put it regarding the Social Security trust fund financing structure on which Medicare's is based, "[w]e put those payroll contributions there so as to give the contributors a legal, moral, and political right to collect the pensions." Oberlander, *supra* note 20, at 80; *see also* Jost, *supra* note 18 at 51 ("Protecting the Medicare program from future political attack was one factor motivating the trust fund financing of the program.").

[263] Jost, *supra* note 18 at 52 ("trust fund financing of the program has both contributed to the sense of ownership that beneficiaries have in the program and to the reliance that Americans place in its continued existence").

[264] *See* Michael J. McWilliams, *MACRA: Big Fix or Big Problem* 122-24 (2017) (noting that significant permanent change in Medicare reimbursement, MACRA, was enacted in exchange for change in law permanently eliminating the "doc fix"); Stuart Guterman, *The "Doc Fix"—Another Missed Opportunity*, 24 New England J. Med. 370, 2263 (2014) (describing how numerous small cuts were imposed to offset "cost" of one-year delay in "doc fix" in 2014).

[265] *See, e.g.*, Fred Schulte, *Medicare Advantage Lobbying Machine Steamrolls Congress*, CTR. FOR PUB. INTEGRITY (June 10, 2014) https://publicintegrity.org/health/medicare-advantage-lobbying-machine-steamrolls-congress/. That said, a group's incentive to lobby for changes that benefit its members depends on a variety of factors, *see generally* MANCUR OLSON, THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS (1965) (discussing collective action challenge to interest group mobilization and approaches by which that challenge may be overcome); *id.* (pointing to AMA as organization that overcome collective action challenges through provision of selective benefits) and there are indications that the cohesiveness of the insurance lobby has begun to deteriorate. *See* Bob Herman, *Big Insurer Defections Signal AHIP's Fading Clout*, MODERN HEALTHCARE (June 9, 2016), https://www.modernhealthcare.com/article/20160109/MAGAZINE/301099969/big-insurer-defections-signal-ahip-s-fading-clout (noting departures of Aetna and United Healthcare from trade group).

they identified. When the time came to consider extending the program, the RAC lobby had a seat at the table, arguing for an extension.[266]

Taking a different tack, a reader persuaded that Medicare bankruptcy rules could more effectively target the threat of insolvency may doubt that the creation of any rules that would target economically powerful industry players would be possible given the power of their targets—would hospitals, insurers, or pharmaceutical companies not ensure that they were better off, not worse, under any Medicare bankruptcy framework? In other words, does not the possibility run afoul of what Professor Posner and Professor Vermeule call the "inside/outside fallacy,"[267] *i.e.*, recommending public-interested changes be made through a system that is itself governed by self-interested actors?

As a preliminary matter, this objection, insofar as it holds, is a reason to worry that a Medicare bankruptcy framework tailored to make the threat of insolvency more effective may not come to fruition—or a reason to oppose a framework advanced in Congress or by the agency that undermined the goals discussed here—not a reason not to try. More to the point, this objection assumes that Medicare bankruptcy rules would make health care industry players worse off, but that is not necessarily true. As the possibility of a positive solvency adjustment illustrates, such rules need not necessarily *reduce* hospitals', pharmaceutical manufacturers', or insurers' expected future profits—they need only change where and how they expect to make them.

Furthermore, this objection also assumes that industry players' ability to influence the formation of Medicare policy would translate to the formation of rules governing the administration of insolvency, but again this is not necessarily true. Professor Jost notes that industry players' ability to win policy fights over counteracting fiscal and beneficiary interests has historically been at its lowest ebb in the midst of insolvency crises.[268] Every insolvency "crisis" offers momentum for administrative change, as well as an opportunity for significant

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[266] RACs are private entities that enter contracts with Medicare to review provider claims and identify overpayments. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF THE INSPECTOR GEN., MEDICARE RECOVERY AUDIT CONTRACTORS AND CMS'S ACTIONS TO ADDRESS IMPROPER PAYMENTS, REFERRALS OF POTENTIAL FRAUD, AND PERFORMANCE 1 (2013). For every overpayment a RAC identifies, it receives a fee. *Id.* at 2-3. RACs were created by Congress as an experimental way to identify and address waste in the Medicare program. They were "successful," in the sense that they identified many, many instances of overpayment, but problematic because they also falsely flagged many other provider claims, ultimately flooding the Medicare hearing system with provider appeals. STAFF OF S. COMM ON AGING, 113TH CONG., IMPROVING AUDITS: HOW WE CAN STRENGTHEN THE MEDICARE PROGRAM FOR FUTURE GENERATIONS 2-3 (Comm. Print 2014). That led Congress to pause the program for the purpose of re-evaluating it, before ultimately, in a pitched political battle, re-authorizing it in part. *See FY2015 RAC Report to Congress: Recoveries Decline Due to Program Pause*, COUNCIL FOR MEDICARE INTEGRITY (Dec. 12, 2016), http://medicareintegrity.org/fy2015-rac-report-to-congress-recoveries-decline-due-to-program-pause/. The RAC program's history is a perfect example of the endogeneity of politics to law. Before the program was first created, there were no RACS, the cottage industry did not even exist. But once created by law, the program took on a life of its own. The RACS formed into an association, the American Coalition for Healthcare Claims Integrity, that itself is now an active lobbyist, participating before Congress and HHS in discussions of the future of the program that created them. *See* Michelle M. Stein, *Spending Bill Bashes RACs, Hits CMS and OMHA Over Appeals Backlog*, 17 INSIDE CMS 1, 12 (2014) ("The American Coalition for Healthcare Claims Integrity, which represents RACs, slammed appropriators for being sympathetic to providers.").

[267] Eric Posner & Adrian Vermeule, *Inside or Outside the System?*, 80 U. CHI. L. REV. 1744, 1789 (2013) (in proposing changes to a system to alter the behavior of actors within that system, an analyst must "confront the [] question whether any relevant actors have both the capacity and motivation to change the rules of the system").

[268] Jost, *supra* note 21, at 78. 8

legislative change in the Medicare program that (absent reforms to the filibuster, an electoral landslide, or a fix capable of passage through reconciliation) would require bipartisan buy-in.[269] Special interests with the power to block structural "change" may well lack the power to dictate its terms if it is forced upon them,[270] as many key levers of power in the federal system, from the filibuster to rulemaking, operate as vetogates, that is, they give those who control them the ability to block changes from the status quo, not to steer changes when they must be made.[271] Medicare's current insolvency crisis therefore may offer an opportunity for reforms that might be impossible in a non-crisis environment.

Finally, stepping back and looking beyond Medicare, the possibility elaborated in this Part represents a novel means of overcoming a thorny problem at the heart of much legal scholarship coalescing in the field of law and political economy, namely, that of the distorting influence of economic interests in the policymaking and political processes.[272] Scholars are pessimistic about the prospects of preventing economically powerful interests from influencing regulatory and legislative processes.[273] Connecting the revenues of health care industry players to Medicare (and so health care) costs would accept the influence of hospitals, insurers, and pharmaceutical manufacturers in the political and regulatory processes as inevitable but harness this "problem" by redirecting that influence toward salutary ends.

IV. WHO DECIDES?

This Part assumes the goal of establishing rules for Medicare bankruptcy and addresses a final, "legal process" question: Who decides?[274] What role should HHS, Congress, and the courts play in establishing rules for Medicare bankruptcy? Subpart A explains that although any added clarity would be a step forward, it would be better, from the standpoint of the likelihood, harm, and effectiveness of insolvency, for Medicare bankruptcy rules to be set by Congress by statute rather than HHS by regulation. Subpart B turns to the secondary role of courts, describing the implications for Medicare bankruptcy of two cases that the Supreme Court is expected to consider in spring of 2022.

A. Legislation Is Preferable to Regulation

As described above, establishing Medicare bankruptcy rules could be beneficial whether done through regulation or legislation, and whether those rules addressed only some

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[269] MOLLY REYNOLDS, EXCEPTIONS TO THE RULE: THE POLITICS OF FILIBUSTER LIMITATIONS IN THE U.S. SENATE (2017).

[270] *See* Jost, *Governing Medicare*, *supra* note 22, at 80 ("though interest groups generally have limited success in effectuating Medicare policy initiatives, they are much more successful in blocking or delaying change")

[271] *See* William N. Eskridge, *Vetogates, Chevron, Preemption*, 83 NOTRE DAME L. REV. 1441, 1444-48 (2008) (identifying nine "vetogates" throughout the legislative process).

[272] *See generally* Britton-Purdy et al., *supra* nn. 20 (describing field).

[273] *E.g.* Michael S. Kang, *The Hydraulics and Politics of Party Regulation*, 91 IOWA L. REV. 131, 148 (2005) (describing a "hydraulics" effect whereby "[l]egal constriction" of one means of translating economic power into political power simply pushes powerful to utilize alternative such means).

[274] Gil Seinfeld, *Article I, Article III, and the Limits of Enumeration*, 108 MICH. L. REV. 1389, 1450 (2010) (explaining that "defining feature of the Hart & Wechsler paradigm and the Legal Process school is that they . . . focus . . . on second-order questions of 'who decides'").

of the open questions described in Part II or all of them. Either process would reduce uncertainty about the effects of Medicare bankruptcy, thereby both encouraging whoever stands to lose if the program becomes insolvent to work to prevent that result and reducing the risk of failure in bargaining over a solution.[275] Either process would mitigate the confusion and chaos that would result from insolvency, and the attendant harm to Americans' confidence in their institutions in general and Medicare in particular.[276] And either process would hasten the ultimate resolution of legal challenges prompted by insolvency, reducing the unfairness of its impacts for resource-poor hospitals and insurers.[277]

At this writing insolvency is imminent, so the regulatory course is most likely. The agency should proceed with setting forth a Medicare bankruptcy plan by notice and comment rulemaking as soon as possible, but in any event no later than the annual spring and summer payment notices it will issue in the fiscal year preceding insolvency.[278] At the very least, doing so would make the deadline for congressional action and the conseequences of congressional inaction clear to Congress and the public.

If Congress enacts legislation to address the current crisis, however—whether a short-term patch of one or two years or a longer-term fix—it should include in that legislation a provision establishing a failsafe framework for administering insolvency should it arise in the future. It should do so regardless whether the agency promulgates a rule governing insolvency or not. This is because legislation governing Medicare bankruptcy would carry several advantages over regulation.

As a vehicle for lawmaking, legislation avoids two irreducible sources of uncertainty in regulation. First, the possibility of change. Regulations can be changed more easily than legislation, and often are when presidential administrations change.[279] The possibility of change would dilute the *ex ante* incentive effects of a Medicare bankruptcy regulation because an actor's incentive to take action today to avoid a legal outcome tomorrow is only as strong as the actor's expectation that the law in effect today will still be in effect tomorrow.[280] Second, the likelihood of legal challenge. Regulations carry a risk of invalidation in court on statutory authority or administrative law grounds that is impossible to eliminate until insolvency actually occurs due to federal court justiciability doctrines.[281] Legislation can be challenged only on constitutional grounds, and so carries much less litigation risk.

Further, legislation brings legitimacy that regulation lacks. Legislation is produced through the constitutionally-appointed mechanism for providing democratic accountability of bicameral approval by elected representatives, followed by presentment to an elected

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[275] *See supra* Parts III.B & C.

[276] *See supra* Part III.A.

[277] *Id.*

[278] *See supra* nn. 100 and accompanying text (describing rulemaking processes).

[279] *E.g.* Executive Order on Strengthening Medicaid and the Affordable Care Act, 86 Fed. Reg. 7793 § 3 (Feb. 2, 2021) (ordering agencies to "review all existing regulations" for possible changes). Statutes can be changed, of course, but unlike a regulation statutory changes requires action not only by the executive branch but also the House and the Senate.

[280] David S. Law, *The Paradox of Omnipotence: Courts, Constitutions, and Commitments*, 40 Ga. L. Rev. 407, 415–16 (2006) (describing need "ensure the government's ability to make persuasive commitments").

[281] *See supra* nn. 124-125 (describing ripeness doctrine).

President.[282] Although the transparency and regularity of this process can vary greatly,[283] legislation carries inherent legitimacy by virtue of these democratic and constitutional *bona fides*.[284]

The legitimacy benefits of legislation would be especially important for Medicare bankruptcy insofar as it addressed the Judgment Fund question and targeted the risk of insolvency. Congress is better suited than HHS to make the high-stakes tradeoffs between the interests of younger generations, taxpayers, and other programs, on the one hand, and the interests of Medicare claimants and beneficiaries, on the other, that this question demands. HHS's expertise does not include the resolution of such inter-generational, inter-class, and inter-industry tradeoffs.[285] Thus, although the details of Medicare bankruptcy of course raise technical questions of health care administration well suited for HHS—questions that congress could well leave to the agency—the broad contours do not.

Finally, legislation would be preferable to regulation because Congress could do things that HHS cannot do under current law. Most importantly, Congress could freely dictate the target of the risk of insolvency, placing that risk on the actors best positioned to prompt compromise in Congress and cost control in health care and insulating the most vulnerable hospitals and communities, whereas HHS would be limited in doing so.[286]

B. Predictability and Judicial Review

In a statutory program like Medicare courts do not make rules, they interpret them. Part II presented the judicial role as something of a wildcard. Under current law, insolvency would leave courts with a lot of work to do. Important questions courts could come to face described in Part II included HHS's authority to adjust payment rates for insolvency, its authority to triage among claimants, the availability of judicial relief, which court would hear insolvency claims, and the applicability of various justiciability doctrines to different potential agency choices. And although that Part predicted how courts would resolve these open questions using the tools courts use—interpretation and precedent, the lack of explicit law made those predictions unavoidably tentative, like "maybe," "probably not," and "likely."[287]

As the Article has explained, this uncertainty is itself a problem, and reducing it would make insolvency in Medicare less unfair, less harmful, less likely, and more effective. Although the most important work in reducing the uncertainty surrounding Medicare bankruptcy is up to HHS and Congress, courts nonetheless can help by respecting predictaqbility as a particularly important value in the Medicare program. Specifically, in interpreting the Medicare statute and resolving Medicare controversies courts should

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[282] U.S. Const. Art. I, sec. 7.

[283] *See* Abbe R. Gluck, Anne Joseph O'Connell, & Rosa Po, *Unorthodox Lawmaking, Unorthodox Rulemaking*, 115 COLUM. L. REV. 1789, 1865 (2015) (noting "great variation" in pathways legislation takes to enactment).

[284] Lawrence B. Solum, *Procedural Justice*, 78 S. CAL. L. REV. 181, 276 (2004) ("[t]he connection between participation and legislative legitimacy is a strong one").

[285] *Cf.* Industrial Union Dep't, AFL-CIO v. American Petroleum Inst., 448 U.S. 607, 678 (1980) (discussing reasons "fundamental" policy judgments should be made by Congress rather than agency).

[286] For example, HHS's adjustment authority would permit it to tailor any insolvency adjustment for hospitals, but would not permit the agency to direct any of the risk of insolvency to pharmaceutical companies, as doing that requires connecting insolvency to Parts D and B for the first time. *See supra* nn. 173 to 174 and accompanying text (describing extent of and limitations on adjustment authority).

[287] *Supra* Part II.

consider whether the precedents they set will make Medicare's administration more predictable in the future or not, and favor doctrines and presumptions that promote predictability.

There are firm bases in law for courts to emphasize predictability in resolving Medicare cases. In some places, predictability is directly relevant to a factor that existing doctrinal tests include in their balancing.[288] The value of predictability can also be inferred from the structure of the Medicare statute; as I have written elsewhere, Congress relinquishes its "power of the purse" when it creates a mandatory entitlement like Medicare, so the structural choice to do so manifests a congressional intent to prioritize reliance.[289] Uncertainty about the existence or scope of rights and obligations under the statute undermines reliance, and clarity promotes it. Finally, as a general matter, predictability is not a value foreign to judicial consideration; quite the opposite, "courts routinely fashion rules and doctrines that encourage predictability."[290]

This predictability criterion may seem abstract compared to the prior discussion in this Article. That is a necessary reflection of the level on which courts bound by the rule of law engage on such questions (the modalities of doctrinal and interpretive argument). It would despite its abstraction have concrete, determinative implications for the adjudication of individual Medicare controversies and for the program's potential insolvency. Contrasting two looming Supreme Court cases illustrates this point. In July 2021, the Court surprised the health policy world by taking up two significant Medicare cases that it is likely to hear in spring 2022.[291] These cases are *Becerra v. Empire Health Foundation*,[292] a challenge to HHS's calculation of disproportionate share hospital (DSH) payments, and *American Hospital Association v. Becerra*,[293] a challenge to HHS's adjustment of 340B payments to hospitals. Neither *Empire Health* nor *AHA* is specifically about Medicare bankruptcy, but the Supreme Court's resolution of a key interpretation question they each present—that of *Chevron* deference in Medicare—could profoundly influence the likelihood and course of insolvency, and demonstrate the importance of the predictability criterion.

The applicability of *Chevron* deference to HHS's interpretations of the Medicare statute is at issue in both *Empire Health* and *AHA*. Commentators have looked to these cases as a potential *Chevron* killer, speculating about whether the Court may use the case to

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[288] Predictability is directly relevant to the ripeness doctrine's "hardship of withholding judicial review" consideration. *Abbott Labs v. Gardner*, 387 U.S. 136, 148 (1967); *see supra* Part III.A (describing harms of delay in resolution). And the Supreme Court in *Bowen* cited the uncertainty of waiting on resolution of the state's Medicaid challenges in the Court of Federal Claims as a reason that forum was "inadequate" for purposes of the APA's waiver of sovereign immunity. *Bowen*, 487 U.S. at 905 (prospective relief was necessary in light of "complex ongoing relationship" between states and federal government.

[289] Matthew B. Lawrence, *Congress's Domain: Appropriations, Time, and* Chevron, 70 DUKE L. J. 1057, 1076 (2021).

[290] "[C]ourts routinely fashion rules and doctrines that encourage predictability." Knopf v. Esposito, No. 17CV5833(DLC), 2021 WL 867584, at *3 (S.D.N.Y. Mar. 5, 2021) (collecting sources); *see also* Amanda L. Tyler, *Continuity, Coherence, and the Canons*, 99 Nw. U. L. Rev. 1389, 1406 (2005) (endorsing "consistent application of interpretive guides that advance continuity and coherence"); Evan Caminker, *Precedent and Prediction: The Forward-Looking Aspects of Inferior Court Decisionmaking*, 73 Tex. L. Rev. 1 (1994) (recommending courts focus on predictability in developing jurisprudence).

[291] Thomas Barker, *Supreme Court Will Hear Several Health Care Cases in 2022 Term*, JDSupra.com (July 21, 2021).

[292] Becerra v. Empire Health Found., 958 F.3d 873 (9th Cir., 2020) (cert. granted July 2, 2021).

[293] Am. Hosp. Ass'n v. Becerra, 967 F.3d 818 (D.C. Cir. 2020) (cert. granted July 2, 2021).

invalidate or hobble the doctrine.[294] This line of thinking assumes that *Chevron* applies across-the-board to the Medicare statute. That assumption is supported by circuit court statements and decisions applying *Chevron* to interpretations of the Medicare statute or even indicating that heightened deference is owed to such interpretations.[295] As I explain in *Congress' Domain*, however, *Chevron* deference to permanent spending provisions, such as the Medicare statute, raises a unique set of separation of powers questions that may warrant distinctive treatment within the *Chevron* framework.[296]

The Court's resolution of the deference question in each case could have significant implications for Medicare bankruptcy. *Empire Health* grows out of a dispute about who is "entitled to" Medicare benefits within the meaning of the statute, and its resolution could have implications for the $5.3 trillion dollar Judgment Fund question.[297] The Court's resolution of that question would have obvious relevance to the potential future question of the availability of the Judgment Fund to make claimants whole in the event of insolvency. Moreover, as to that question, deference would undermine predictability. Judicial deference on the nature of the Medicare "entitlement," applied in the case of insolvency, would mean that the fundamental question of the Judgment Funds's availability—and so the future of the Medicare program—could change from Administration to Administration, perhaps even becoming a partisan question in future elections. Deference to the agency's effort to resolve that question would thereby increase and prolong the uncertainty surrounding the effects of insolvency, as it would not eliminate the possibility of courts rejecting the agency's resolution but would ensure that, if the courts accepted the agency's interpretation, that interpretation would remain subject to change by the executive branch, whether in the current administration or the next one.[298]

Meanwhile, *AHA* hinges on a question about the meaning of a statutory condition on the agency's authority to set reimbursement rates for hospitals participating in the 340B drug discount program, with potential future implciations for the agency's authority to triage among claimants.[299] If deference is *not* available to the agency when it exercise authorities explicitly given it under the statute to set and adjust payment rates, it would be substantially limited in its ability to insulate claimants from the effects of insolvency, and to reduce the harms of insolvency by addressing it through ex ante rulemaking.[300] Moreover, in this case deference would promote predictability; the agency already has discretion to set payment rates; refusing deference would not change that. But providing deference would mean that

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[294] Lydia Wheeler, *Chevron Deference Scope Tested in Supreme Court Medicare Case*, Bloomberg (May 21, 2021).

[295] *E.g. Robert Wood Johnson Univ. Hosp. v. Thompson*, 297 F. 3d 273, 282 (3d Cir. 2002) ("The Broad deference of *Chevron* is even more appropriate in cases that involve a 'complex and highly technical regulatory program,' such as Medicare").

[296] Lawrence, *Congress's Domain*, supra at 1106.

[297] *See Empire Health*, 958 F.3d at 885 (interpreting "entitled to" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)).

[298] *See* King v. Burwell, 576 U.S. 473, 485-86 (2015) (refusing deference to agency interpretation of ACA on question of "deep economic and political significance" that was "central to the statutory scheme").

[299] The specific statutory question is whether the agency may adjust average acquisition cost-based reimbursement rates based on participation in the 340B program notwithstanding the statute's explicit provision for hospital-specific adjustments when the agency has collected "hospital acquisition cost data." 42 U.S.C. § 1395*l*(t)(14)(A)(iii)(I). *See Am. Hosp. Ass'n*, 967 F.3d at 829 ("the sole question before us is whether HHS had statutory authority to . . . 'adjust[]' the amounts 'as necessary for purposes of this paragraph'") (quoting 42 U.S.C. § 1395*l*(t)(14)(A)(iii)(II)).

[300] *See supra* Part II.A, II.C. (describing agency statutory authorities).

the odds of judicial invalidation would be greatly reduced when the agency exercises that authority.

The predictability criterion, then, supports a nuanced approach to *Chevron*'s applicability to the Medicare statute, rather than a one-size-fits all approach. As to a binary question like eligibility or entitlement to Medicare benefits over which the agency does not already have discretion, deference would undermine predictability. When it comes to the inherently continuous and variable question of the extent of the agency's authority to adjust Medicare payment rates, on the other hand, deference would promote predictability.

This resolution of the deference questions in *AHA* and *Empire Health*, grounded in inferences from congressional intent drawn from the structure of the Medicare statute—would honor the Court's instruction in *Mead* to "to tailor deference to variety."[301] It would also offer a way for the Court to resolve both cases on Medicare-specific grounds consistent with *Mead* that would not require it to affirm, reject, or otherwise weigh in on the future of the *Chevron* doctrine more generally. And it would begin to shift the role of courts in the development of Medicare from wildcard (and one-way ratchet) to peacemaker.

CONCLUSION

The Article began with the fable of the boiled amphibian, comparing the metaphorical frog to Medicare. That oversimplified somewhat. As the Article has explained, the health and welfare of the entire country is at risk in Medicare's looming insolvency, and the speed and nature of the boil—whether insolvency has a clear deadline or not, whether it comes about, who it harms, and how long the uncertainty surrounding it would last—is not some unalterable, exogenous force. The determinants and consequences of insolvency in Medicare are a function of law, which means we can change them. The adoption of explicit rules addressing Medicare bankruptcy would make insolvency less unfair, less harmful, less likely, and more effective as a tool for forcing compromise and controlling health care costs. HHS, Congress, and courts should all work toward that goal. If successful, they would change the health care system for the better while demonstrating that the endogeneity of politics to law can be an asset, not only a liability, in institutional design.

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[301] *Mead*, 533 U.S. at 236. In the nomenclature of *Mead*, the leading case in which Justice Breyer articulated a broad, intent-focused test for the applicability of *Chevron*, the fact that the legal question in *Empire Health* pertains to who is entitled to Medicare benefits is an indication that Congress did not "intend for the agency to speak with the force of law," *id.*, on that question. It is such a question because the core purpose of creating an entitlement—despite the inherent downsides of legally entrenching a benefit due to reduced flexibility and congressional power—is "to engender reliance," but *Chevron* deference destroys reliance as to questions to which it applies by removing the solidifying force of *stare decisis* in favor of executive discretion and the whims of the political process. Thus, deference should be unavailable for that question. Lawrence, *Congress's Domain*, *supra* at 1093. At the same time, the fact that the legal question in *AHA* is one on which Congress explicitly granted the agency policy discretion—the setting of reimbursement rates for 340B hospitals—is an indication that Congress did indeed "intend for the agency to speak with the force of law" on that question. Thus, deference should be available in the one case, but not the other.