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## Medicare "Bankruptcy"

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# MEDICARE “BANKRUPTCY”

MATTHEW B. LAWRENCE\*

**Abstract:** Medicare, the social insurance program for the elderly and disabled, 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 some of its obligations. Yet, what happens if and when Medicare becomes insolvent has not previously been explored in legal scholarship and is not addressed in statute or regulation. This Article confronts for the first time the major legal questions that Medicare insolvency would present. It explains what policy-makers could do to 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, this Article argues for the establishment, by law, of rules to govern Medicare bankruptcy.

The Article’s analysis of how an insolvent Medicare program would work reveals several unsettled legal questions, resolution of which would determine insolvency’s harms, who would pay them, and when. Uncertainty surrounding the consequences of insolvency would be problematic from the ex-post perspective 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 because it inhibits compromise and disincentivizes Medicare’s powerful industry constituents from using their influence to promote cost control. In developing this normative insight, this Article for the first time applies the structural, ex-ante theoretical perspective developed in the municipal bankruptcy literature to the law and political economy of a federal spending program. It concludes by addressing the roles of Congress, the Department of Health and Human Services, and courts in clarifying the consequences of Medicare insolvency. Although a partial framework could and should be established by regulation in the short term, this Article calls for a Medicare bankruptcy provision ultimately to be included as a failsafe in future legislation, if and when it comes, to address the current crisis.

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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, even as the water is slowly warmed, oblivious to the creeping threat until the frog is boiled alive.<sup>1</sup> 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 sixty-three million elderly and disabled Americans,<sup>2</sup> and the warming water is the program’s approaching insolvency.<sup>3</sup>

Medicare is predicted to become insolvent within five years.<sup>4</sup> All reserves will eventually deplete as 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.<sup>5</sup> This is the fifth time in five decades that the program has faced insolvency within six years,<sup>6</sup> but the program has never been closer to insolvency than it is now.<sup>7</sup> Moreover, what once seemed unthinkable now seems increasingly plausible: Medicare may actually go “bank-

<sup>1</sup> See, 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> [<https://perma.cc/8SDW-9UDL>] (explaining the use of the boiling frog fable as a metaphor for a failure to react to slow and steady change).

<sup>2</sup> PATRICIA A. DAVIS & PHOENIX VOORHIES, CONG. RSCH. SERV., IF10885, MEDICARE OVERVIEW (2020), <https://crsreports.congress.gov/product/pdf/IF/IF10885> [<https://perma.cc/U4LM-YCNH>].

<sup>3</sup> See, e.g., Sarah O’Brien, *Medicare’s Trust Fund Faces Insolvency in 2026. Here’s How That Squares with Democrats’ Efforts to Expand the Health Insurance Program*, CNBC (Sept. 12, 2021), <https://www.cnbc.com/2021/09/12/democrats-aim-to-expand-medicare-despite-looming-trust-fund-insolvency.html> [<https://perma.cc/WGL7-67UU>] (reporting a projection of Medicare insolvency by 2026).

<sup>4</sup> *Id.* 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(b). The Trustees’ most recent estimate, issued August 31, 2021, predicted insolvency in 2026, which is consistent with a recent Congressional Budget Office (CBO) baseline report. THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, 2021 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 8 (2021), <https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf> [<https://perma.cc/ME92-P7KU>]; CONG. BUDGET OFF., THE BUDGET AND ECONOMIC OUTLOOK: 2021 TO 2031, at 4–9 (2021), <https://www.cbo.gov/system/files/2021-02/56970-Outlook.pdf> [<https://perma.cc/KGQ3-66C8>].

<sup>5</sup> See PATRICIA A. DAVIS, CONG. RSCH. SERV., RS20946, MEDICARE: INSOLVENCY PROJECTIONS 1–3, 8, 12 (2020), <https://fas.org/sgp/crs/misc/RS20946.pdf> [<https://perma.cc/RG6P-N4K6>] (describing insolvency as when the assets credited to the trust fund reach zero).

<sup>6</sup> See *id.* at 4 fig.1 (indicating that insolvency was projected to be within six or fewer years in 1970–72, 1982, 1993, and 1996–97).

<sup>7</sup> Richard G. Frank & Tricia Neuman, Opinion, *Addressing the Risk of Medicare Trust Fund Insolvency*, 325 JAMA 341, 341 (2021) (“Congress has addressed insolvency in the past but never on such a tight deadline.”).

rupt.”<sup>8</sup> Four overlapping trends support this pessimistic conclusion, despite Medicare’s traditional political sanctity. Prior Medicare insolvency “crises” were resolved only by the passage of major bipartisan health reform legislation.<sup>9</sup> This appears unlikely today, especially given analysts’ predictions that this time, extending the program’s life will require unprecedented changes to its financing structure.<sup>10</sup> In health law, Congress has increasingly failed to enact funding needed to honor entitlements, thereby “disappropriating”<sup>11</sup> tribal contract support costs,<sup>12</sup> the Children’s Health Insurance Program,<sup>13</sup> and Affordable Care Act

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<sup>8</sup> See DAVIS, *supra* note 5, at 3, 7 (describing that although the Medicare “[T]rust [F]und has never become insolvent,” current projections indicate insolvency by early 2026). It is common in health policy to object that an insolvent Medicare would not actually be “bankrupt.” See generally Paul N. Van de Water, *Medicare Is Not “Bankrupt,”* CTR. ON BUDGET & POL’Y PRIORITIES 1, <https://www.cbpp.org/sites/default/files/atoms/files/7-12-11health.pdf> [<https://perma.cc/ASU8-EMB3>] (May 1, 2019) (characterizing “claims by some policymakers” that Medicare is going “bankrupt” as misrepresentative); THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 135 (2d ed. 2000) (“[N]o precise analog to private bankruptcy exists in public programs like Medicare.”). This objection is fair in the sense that the program would still have significant revenue and be able to pay most of its liabilities even if insolvent, and thus would not be “bankrupt” in the colloquial sense of the word that means “having no assets or revenue.” See *Bankruptcy*, BLACK’S LAW DICTIONARY (11th ed. 2019) (describing that 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”). 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. See discussion *infra* Section III.A. In this sense, this Article explains, Medicare would indeed be “bankrupt” if it became insolvent, and this Article’s central thesis is that an explicit bankruptcy framework for Medicare should be created before the program actually becomes insolvent. See discussion *infra* Part III.

<sup>9</sup> See, e.g., David Muhlestein, *The Coming Crisis for the Medicare Trust Fund*, HEALTH AFFS. BLOG (Dec. 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20201210.997063/full/> [<https://perma.cc/V5NK-SKD9>] (describing the “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, *supra* note 8, at 136 (describing insolvency as a “thermometer[]”). Nonetheless, that understanding is pervasive and influential, explaining its employment in this Article while developing a richer picture of how insolvency would work in Medicare. This Article further seeks to supplant superficial understandings based only on rhetoric with a more nuanced approach. Cf. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 75 (2003) (“[T]rust fund 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.” (emphasis added)).

<sup>10</sup> See, e.g., Paul N. Van de Water, *Strengthening Medicare Financing: General Revenues Should Be Part of the Solution*, CTR. ON BUDGET & POL’Y PRIORITIES 1 (Dec. 14, 2020), <https://www.cbpp.org/sites/default/files/atoms/files/12-14-20health.pdf> [<https://perma.cc/Z7K9-82VZ>] (“Phasing in spending cuts of [the] magnitude [of Medicare’s projected deficit over a decade] in such a few years would not be feasible—or desirable.”).

<sup>11</sup> Matthew B. Lawrence, *Disappropriation*, 120 COLUM. L. REV. 1, 4, 9, 29 (2020). “Disappropriation” is defined as “the phenomenon of congressional failure to appropriate funds necessary to honor a government commitment.” *Id.* at 24 (citing *Disappropriation*, BLACK’S LAW DICTIONARY, *supra* note 8).

<sup>12</sup> *Id.* at 9, 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-

(ACA) subsidies.<sup>14</sup> In fiscal law, Congress has repeatedly failed to meet the challenge of budgetary pressures and enact “must pass” legislation, often reverting to short-term patches that lead to impasse.<sup>15</sup> The debt ceiling debate, looming once again as of this writing, illustrates this pattern.<sup>16</sup> And politically, an era of “hardball” sees the party opposing the president looking to use their influence in Congress to frustrate governance by any means necessary.<sup>17</sup>

Medicare’s chances of bucking these trends are further diminished by the legal framework governing the program’s insolvency—or lack thereof. As definitive as headlines make it sound, without action, the implications of insolvency in Medicare would be uncertain at the outset and slow to develop. What would actually happen to hospital and insurer reimbursement<sup>18</sup> if Medicare

Determination and Education Act]” (first citing U.S. GEN. ACCT. OFF., GAO/RCED-99-150, INDIAN SELF-DETERMINATION ACT: SHORTFALLS IN INDIAN CONTRACT SUPPORT COSTS NEED TO BE ADDRESSED 3 (1999), <https://www.gao.gov/assets/rced-99-150.pdf> [<https://perma.cc/482E-J8TD>]; and then citing *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 187 (2012)).

<sup>13</sup> *Id.* at 9, 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 (citing Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 301, 129 Stat. 154)).

<sup>14</sup> *See id.* at 9, 30–37 (describing how a rider “limit[ed] the availability of [program management] appropriation for risk corridor payments,” which “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 stoppage of such payments).

<sup>15</sup> *See, e.g.*, Thomas Franck, *Lawmakers Have a Deal on a Short-Term Debt Ceiling Increase, Senate Majority Leader Schumer Says*, CNBC (Oct. 7, 2021), <https://www.cnbc.com/2021/10/07/law-makers-reach-deal-on-short-term-debt-ceiling-increase-schumer-says.html> [<https://perma.cc/CY2X-YJRA>] (reporting on the Senate Majority Leader’s announcement that a short-term deal extending the debt ceiling for an additional two months had been reached).

<sup>16</sup> *See, e.g.*, Katia Dmitrieva, *Treasury to Start Special Measures to Avoid Breaching Debt Limit*, BLOOMBERG (July 30, 2021), <https://www.bloomberg.com/news/articles/2021-07-30/treasury-to-start-special-measures-to-avoid-breaching-debt-limit> [<https://perma.cc/A6VX-TFDD>] (“Congress still lacks a clear plan for averting default later this year.”).

<sup>17</sup> Joseph Fishkin & David E. Pozen, *Asymmetric Constitutional Hardball*, 118 COLUM. L. REV. 915, 921–22, 980 (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, Response, *Constitutional Hardball Yes, Asymmetric Not So Much*, 118 COLUM. L. REV. ONLINE 207, 220–22 (2018), [https://columbialawreview.org/wp-content/uploads/2018/12/Bernstein-CONSTITUTIONAL\\_HARDBALL\\_YES\\_ASYMMETRIC\\_NOT\\_SO\\_MUCH.pdf](https://columbialawreview.org/wp-content/uploads/2018/12/Bernstein-CONSTITUTIONAL_HARDBALL_YES_ASYMMETRIC_NOT_SO_MUCH.pdf) [<https://perma.cc/FFH3-LDHL>] (arguing that constitutional hardball is not more common among Republicans than Democrats).

<sup>18</sup> 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 the event of insolvency. *See* DAVIS, *supra* note 5, at 2 (explaining how the Hospital Insurance Trust Fund only pays for the benefits provided through Part A of Medicare); *infra* notes 50–55 and accompanying text (explain-

reaches insolvency has not previously been explored in any public forum,<sup>19</sup> not even in the robust legal literature focused on the program's finances.<sup>20</sup> But this 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, this Article isolates and analyzes five key open legal questions facing the Department of Health and Human Services (HHS) and courts. The answers to these questions could take years to emerge and would determine the harms of insolvency, who would bear them, when they would materialize, and the "deadline" to avoid them.<sup>21</sup> Hence

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ing the types of services and providers that are reimbursed through the Hospital Insurance Trust Fund).

<sup>19</sup> 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." DAVIS, *supra* note 5, at 8. As Part II of this Article elaborates, that is not quite true; there are no *explicit* provisions of law addressing insolvency in Medicare (this 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. *See* discussion *infra* Part II. Some treatments do address the distinctive question of what might happen if the Social Security Trust Fund—which reimburses beneficiaries directly, not through intermediaries as does Medicare—were to run out. *See, e.g.,* John Harrison, *New Property, Entrenchment, and the Fiscal Constitution*, in FISCAL CHALLENGES: AN INTERDISCIPLINARY APPROACH TO BUDGET POLICY 401, 406–07 (Elizabeth Garrett, Elizabeth A. Graddy & Howell E. Jackson eds., 2008) (discussing the lack of clarity surrounding implications of insolvency in Social Security).

<sup>20</sup> A growing literature discusses the Medicare program and its financial situation, but it has not addressed what would happen should the program become insolvent. *See, e.g.,* Nicholas Bagley, *Bed-side Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519 (2013) (arguing for reform efforts that align the practice patterns of private physicians with federal priorities in administering Medicare); Isaac D. Buck, *Furthering the Fiduciary Metaphor: The Duty of Providers to the Payers of Medicare*, 104 CALIF. L. REV. 1043, 1049 (2016) (arguing that giving providers fiduciary duty to payers would "better protect the fiscal health of the Medicare program"); Jacqueline Fox, *The Hidden Role of Cost: Medicare Decisions, Transparency and Public Trust*, 79 U. CIN. L. REV. 1 (2010) (advocating for a framework that allows Medicare coverage for new technologies to be evaluated explicitly based on costs as opposed to implicitly as is done now); Jill R. Horwitz, *The Virtues of Medicare*, 106 MICH. L. REV. 1001 (2008) (reviewing DAVID A. HYMAN, *MEDICARE MEETS MEPHISTOPHELES* (2006)) (critiquing David A. Hyman's characterization of the Medicare program); David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165 (2003) (comparing the Medicare program to a satanic scheme intent on "undermin[ing] . . . American virtues"); Mark A. Lemley, Lisa Larrimore Ouellette & Rachel E. Sachs, *The Medicare Innovation Subsidy*, 95 N.Y.U. L. REV. 75 (2020) (discussing the interaction between Medicare reimbursement and pharmaceutical innovation). As Section III.C. explains, the question of 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. *See* discussion *infra* Section III.C.

<sup>21</sup> *See* discussion *infra* Part II (exploring the 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 recov-

this Article’s thesis: HHS, or preferably Congress, should establish Medicare bankruptcy rules in advance to make insolvency less unfair, less harmful, less likely, and, a more effective tool for controlling cost and promoting quality in health care.<sup>22</sup>

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.<sup>23</sup> 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.<sup>24</sup> They do so effectively (though not always successfully), in the administrative process, in congress, and in court.<sup>25</sup> 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.<sup>26</sup>

The *threat* of insolvency has a potentially salutary role to play in this dynamic interaction between politics and law. Like the debt ceiling (which has not yet been hit) or annual shutdowns (which repeatedly have occurred), the mere possibility of insolvency in Medicare drives legislative change, and expectations about the consequences of insolvency influence the shape those changes take. This makes it important to consider critically the consequences of insolvency even if those consequences never arrive.

ery from the Judgment Fund; and (5) whether any such recovery would come through prospective injunctions in federal district courts or retrospective damages orders in the court of federal claims).

<sup>22</sup> This 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 discussion *infra* Section III.C. (describing the possibilities); *infra* Part IV (recommending particular clarifications).

<sup>23</sup> See *infra* notes 78–83 and accompanying text (describing the 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) (outlining a new approach for legal scholarship employing the law and political economy approach).

<sup>24</sup> See, e.g., Zack Cooper, Amanda Kowalski, Eleanor Neff Powell & Jennifer Wu, *Politics and Health Care Spending in the United States* 6–7 (Nat’l Bureau of Econ. Rsch., Working Paper No. 23748, 2020), [https://www.nber.org/system/files/working\\_papers/w23748/w23748.pdf](https://www.nber.org/system/files/working_papers/w23748/w23748.pdf) [<https://perma.cc/2HZH-SU82>] (describing the lobbying efforts by the healthcare industry to increase Medicare payments).

<sup>25</sup> See *infra* notes 78–83 and accompanying text (describing how Medicare’s political economy problem allows industry players to wield undue influence over the direction of the program).

<sup>26</sup> See *infra* notes 78–83 and accompanying text (explaining further that the constant temporary Medicare fixes and rising healthcare costs are the result of this political economy problem).



Specifically, the threat of insolvency alone could, if properly calibrated, mitigate the biasing influence of providers, insurers, and pharmaceutical companies by altering their incentives—changing how they wield their influence as opposed to their ability to do so. As municipal bankruptcy literature teaches, 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.<sup>27</sup> Further, it would 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, encouraging powerful interests to direct Medicare away from the boiling pot, rather than into it.

The stakes are so high, and numbers in the Medicare program so large, they can sometimes begin to seem more technical than human. But Medicare’s insolvency would touch the lives of almost every American, potentially transforming the country’s health, welfare, and governance. The program is the linchpin of our health care system, and of many communities. Its roughly sixty million beneficiaries depend on it for medical care.<sup>28</sup> The nation’s 6,023 hospitals, fifteen thousand nursing homes, and nearly five thousand hospice facilities depend on it to remain afloat.<sup>29</sup> Finally, the communities they serve depend on it for the jobs and economic lifeline that Medicare providers bring.<sup>30</sup> Medicare insolvency would eventually impact all those who rely on Medicare. As this 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.

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.<sup>31</sup> All of these effects would reduce affordability and

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<sup>27</sup> David Schleicher, *Hands On! Part I: The Trilemma Facing the Federal Government During State and Local Budget Crises 5–6* (July 28, 2020) (unpublished manuscript), <https://ssrn.com/abstract=3649278> [<https://perma.cc/JGS9-959J>] (discussing the federal government’s options in avoiding state debt crises).

<sup>28</sup> Lemley et al., *supra* note 20, at 82.

<sup>29</sup> CTRS. FOR MEDICARE & MEDICAID SERVS., MDCR PROVIDERS 1: MEDICARE PROVIDERS: NUMBER OF MEDICARE CERTIFIED INSTITUTIONAL PROVIDERS, CALENDAR YEARS 2014–2019 (2019), <https://www.cms.gov/files/document/2019cpsmdcrproviders1.pdf> [<https://perma.cc/HL2G-98SX>] (providing the national count of such providers as of 2019).

<sup>30</sup> AM. HOSP. ASS’N, RURAL REPORT: CHALLENGES FACING RURAL COMMUNITIES AND THE ROADMAP TO ENSURE LOCAL ACCESS TO HIGH-QUALITY, AFFORDABLE CARE 2 (2019), <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf> [<https://perma.cc/3ER2-QPZ9>].

<sup>31</sup> Medicare subsidizes care for the indigent, undocumented immigrants, and 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

increase inequity in a health care system that is already unaffordable and deeply inequitable.<sup>32</sup> In politics, insolvency would support an argument and perception—justified or not—that government-sponsored health care is financially unsustainable.<sup>33</sup> Medicare’s existing cycle of insolvency is already cited as an argument against “Medicare for All” or other expanded government programs—actually reaching insolvency would supercharge such arguments.<sup>34</sup> In fiscal law, where inter-generational, inter-class, and inter-sector fights about resource allocation play out, the choices made by Congress, courts, and HHS in administering insolvency would determine whether Medicare continues to have a privileged status.<sup>35</sup> If not, it must instead compete directly going forward with those seeking higher wages, profits, or spending on social programs such as public health and education.<sup>36</sup> Finally, the threat of insolvency in Med-

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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 the individual is eligible for Medicare); *id.* § 1395ww(d)(5)(F)(i)(I) (authorizing “additional payment[s]” for providers that “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. See discussion *infra* Section III.A.

<sup>32</sup> See generally Lindsay F. Wiley, Elizabeth Y. McCuskey, Matthew B. Lawrence & Erin C. Fuse Brown, *Health Reform Reconstruction*, 55 U.C. DAVIS L. REV. (forthcoming 2022), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3760086#](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3760086#) [<https://perma.cc/65DM-YHPF>] (describing the deep inequities in the U.S. healthcare system).

<sup>33</sup> THEDA SKOCPOL, SOCIAL POLICY IN THE UNITED STATES: FUTURE POSSIBILITIES IN HISTORICAL PERSPECTIVE 7 (Ira Katznelson, Martin Shefter & Theda Skocpol eds., 1995) (“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.”).

<sup>34</sup> See, e.g., Seth J. Chandler, *Foreword: Medicare for All: The Need for a Long Approach*, 20 HOUS. J. HEALTH L. & POL’Y 1, 10 (2020) (“It might . . . be more persuasive to expand Medicare to a much larger population right away if that particular program were financially stable.”); 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.” (footnote omitted) (citing T.W. Farnam, *Social Security, Medicare Face Insolvency Sooner*, WALL ST. J. (May 13, 2009), <https://www.wsj.com/articles/SB124212734686110365> [<https://perma.cc/KP8E-HK2K>])); see also MARMOR, *supra* note 8, at 137 (stating that 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” (citation omitted)). In the Democratic presidential primary, the aspect of “Medicare for All” that proved pivotal—for the program and for its proponents, especially Senator Elizabeth Warren—was inquiry 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> [<https://perma.cc/5G2L-56NM>].

<sup>35</sup> See generally Matthew B. Lawrence, *Coronavirus Reveals the Fiscal Determinants of Health, in COVID-19 AND THE LAW* (I. Glenn Cohen, Abbe Gluck, Katherine Kraschel & Carmel Schachar eds.) (forthcoming 2022) (on file with author) (surveying the role of fiscal law in health law and policy).

<sup>36</sup> See Matthew B. Lawrence, *Subordination and Separation of Powers*, 131 YALE L.J. 78, 112 (2021) (describing the privileged status of Medicare *vis-a-vis* other health programs in current fiscal arrangements); see also *infra* notes 177–209, 331–344 and accompanying text (describing how the

icare 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.<sup>37</sup>

This 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 that Medicare would actually become insolvent and the resulting harms and unfairness. Its theoretical contribution is to consider whether the threat of insolvency could play a more effective role in health policy—if it must play any role at all. Clarifying these consequences may combat the moral hazard of the powerful economic interests who influence the program's policy between solvency crises. Finally, 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.

This Article proceeds in four parts. Part I provides background about the Medicare program and its ongoing cycle of insolvency.<sup>38</sup> 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.<sup>39</sup> Recent congressional failures to appropriate funds necessary to honor commitments in the ACA and Medicaid programs reveal that the harms of such failures depend very much on the details.<sup>40</sup> Building on these precedents, Part II systematically isolates and analyzes the key choices posed by Medicare bankruptcy, including: (1) the administrative process by which to set insolvency policy; (2) whether to delay payments or reduce them pro rata; (3) whether to insulate some claimants, such as hospitals that serve many indigent patients; (4) whether courts could order shorted providers reimbursed through the "Judgment Fund"; and (5) if so, which courts should do so and when.<sup>41</sup>

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question of Judgment Fund availability would determine whether Medicare would continue to enjoy privileged status post-insolvency).

<sup>37</sup> See Britton-Purdy et al., *supra* note 23, at 1829–32 (describing the stubbornness of economic power and the difficulty of curbing its influence through law).

<sup>38</sup> See *infra* notes 46–109 and accompanying text.

<sup>39</sup> See *infra* notes 110–231 and accompanying text.

<sup>40</sup> See Lawrence, *supra* note 11, at 27 (describing controversies resulting from congressional failure to fund certain Affordable Care Act and Medicaid entitlements).

<sup>41</sup> See *infra* notes 110–231 and accompanying text.

Part III develops this Article’s thesis that the consequences of insolvency in Medicare should be clarified in advance.<sup>42</sup> From the ex-post perspective of an insolvent program, clarity would reduce the unfairness and harms of Medicare bankruptcy. From the ex-ante perspective of a program in the midst of another insolvency crisis, rules established in advance could reduce the likelihood of actual insolvency in the short term (by facilitating compromise in Congress). Additionally, advance rulemaking may 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.<sup>43</sup> 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. Despite courts’ roles being secondary, Part IV explains that by emphasizing predictability in interpreting the Medicare statute, courts can both further the goal of clarifying the consequences of Medicare insolvency and honor congressional intent.<sup>44</sup> The question of *Chevron* deference in Medicare, which the Supreme Court began considering in the October Term 2021, illustrates the relevance of this prescription.<sup>45</sup> Finally, a brief conclusion summarizes the Article’s contribution.

## I. THE FAULT IN MEDICARE’S STARS

Medicare is a federal program that covers health care costs for the elderly and disabled, as well as those with end-stage kidney disease.<sup>46</sup> It covers eligible hospital costs, outpatient care, and pharmaceuticals costs, among other benefits.<sup>47</sup> Scholars rightly describe it as a “cornerstone” of social policy in the United States, and prominent health reform proposals have made Medicare their foundation.<sup>48</sup> It was created in 1965 as part of President Lyndon B. Johnson’s “Great Society.”<sup>49</sup>

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<sup>42</sup> See *infra* notes 232–327 and accompanying text.

<sup>43</sup> See *infra* notes 328–363 and accompanying text.

<sup>44</sup> See *infra* notes 328–363 and accompanying text.

<sup>45</sup> *Am. Hosp. Ass’n v. Azar*, 967 F.3d 818 (D.C. Cir. 2020), *cert. granted sub nom.* *Am. Hosp. Ass’n v. Becerra*, 141 S. Ct. 2883 (2021); see discussion *infra* Section IV.B (analyzing a number of cases evaluating Medicare financing which illustrate the role judicial decision-making plays in ensuring predictability when insolvency occurs).

<sup>46</sup> *What’s Medicare?*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare> [<https://perma.cc/YEF2-9L4W>].

<sup>47</sup> DAVIS, *supra* note 5, at 1.

<sup>48</sup> See Isaac D. Buck, *The Meaning of “Medicare-for-All,”* 20 HOUS. J. HEALTH L. & POL’Y 159, 161 (2020) (“[T]he national narrative has focused on insurance access through ‘Medicare-for-All[.]’ . . . .”); William G. Dauster, *Protecting Social Security and Medicare*, 33 HARV. J. ON LEGIS. 461, 461 (1996) (“Medicare rests as the cornerstone of Lyndon Johnson’s Great Society.” (footnote omitted));

The nation's elderly and disabled are the costliest groups to provide with health care. The heart of Medicare's financing for this care is the "trust fund" system pioneered in Frances Perkins' Social Security program.<sup>50</sup> 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 "Federal Hospital Insurance Trust Fund" (Trust Fund), separate from general revenues; Congress has appropriated this account, in turn, as the source of payment for about half of Medicare costs.<sup>51</sup> These include payments to hospitals, nursing homes, hospice care, Medicare Advantage insurers (or "Part C" insurers), and many others.<sup>52</sup> This structure contributes to the political legitimacy of Medicare and its robust enrollment, as beneficiaries see the program not as government largesse but as an entitlement they "earned" through payroll tax contributions.<sup>53</sup> That said, a plurality of Medicare costs are not financed through the 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 that are paid from a different account not dependent on payroll contributions, the "Supplemental

Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095, 1121 (2003) (describing Medicare's role as a "centerpiece" of the Balance Budget Act of 1997).

<sup>49</sup> See generally Dauster, *supra* note 48; *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](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) [<https://perma.cc/D8KK-2U9M>].

<sup>50</sup> 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 History: Social Security Pioneers: Frances Perkins*, SOC. SEC. ADMIN., <https://www.ssa.gov/history/fperkins.html> [<https://perma.cc/CUS5-HCUD>] (describing the role of Secretary Perkins in the implementation of the Social Security program).

<sup>51</sup> See 42 U.S.C. § 1395i(b).

<sup>52</sup> *Id.* § 1395ww(b), § 1395cc(a) (hospitals); *id.* § 1395yy(h) (skilled nursing facilities); *id.* § 1395w-23(f) (insurers participating in Part C); *id.* § 1395ww(h) (graduate medical centers); *id.* § 1395l(f) (community health clinics); *id.* § 1395g(a)–(e) (hospices); *id.* § 1395b-1(a)(1) ("[P]ublic or private agencies, institutions, and organizations . . . develop[ing] and engag[ing] in experiments and demonstration projects . . ."); *id.* § 1395b-4(a) (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 coverage to individuals who are eligible to receive [Medicare] benefits"); *id.* § 1395b-6 (Medicare Payment Advisory Commission costs); *id.* § 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"); *id.* § 1395m(x) (rural emergency hospitals); *id.* § 1395w-27a(h) (essential hospitals); *id.* § 1395mm(i) (health maintenance organizations); *id.* § 1395ddd (program integrity).

<sup>53</sup> OBERLANDER, *supra* note 9, 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.").

Medical Insurance (SMI) trust fund.”<sup>54</sup> Thus, the SMI trust fund would be insulated from the direct impacts of insolvency.<sup>55</sup>

The trust fund financing structure means that HHS and Congress must ensure that expenditures on hospital and related costs do not exceed revenues through the Medicare payroll tax and other sources. They have repeatedly failed to do so. In its history, Medicare has not controlled the solvency of the program between solvency “crises,” repeatedly depleting the Trust Fund until it was within six years of insolvency.<sup>56</sup> Each time, only major bipartisan legislation restructuring health policy in the United States resolved the resulting Medicare insolvency “crisis.”<sup>57</sup> This included the Social Security Amendments of 1983, eliminating “reasonable cost” reimbursement for hospitals and creating the Inpatient Prospective Payment System (IPPS);<sup>58</sup> the 1997 Balanced Budget Act that included large cuts to Medicaid—a program that covers eligible low income individuals<sup>59</sup>—and set the stage for the rise of Medicare coverage offered through private insurance companies, known as “Medicare Advantage” or “Medicare Part C;”<sup>60</sup> and the ACA, supplemented by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which created “Accountable Care Organizations” and a system of advanced payment models.<sup>61</sup>

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<sup>54</sup> JULIETTE CUBANSKI ET AL., HENRY J. KAISER FAM. FOUND., A PRIMER ON MEDICARE: KEY FACTS ABOUT THE MEDICARE PROGRAM AND THE PEOPLE IT COVERS 32–34 (2015), <https://files.kff.org/attachment/report-a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers> [<https://perma.cc/2DPG-NYJZ>].

<sup>55</sup> See *id.* at 32 (“Part B, the Supplementary Medical Insurance (SMI) trust fund, is financed through a combination of general revenues, premiums paid by beneficiaries, and interest and other sources.”).

<sup>56</sup> OBERLANDER, *supra* note 9, at 75 (describing a “pattern of crisis and reform that has driven Medicare politics since the program’s enactment”); see *supra* note 6 and accompanying text.

<sup>57</sup> Oberlander, *supra* note 48, at 1120–22 (describing “the practice . . . of adopting Medicare reform as a part of large-scale fiscal legislation”); see *supra* note 9 and accompanying text.

<sup>58</sup> Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601–607, 97 Stat. 65, 149–172.

<sup>59</sup> The law came at a time when “the notion that Medicare was a program in crisis [was] a staple of American politics.” OBERLANDER, *supra* note 9, 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, *Overview of Medicaid Provisions in the Balanced Budget Act of 1997*, P.L. 105-33, CTR. ON BUDGET & POL’Y PRIORITIES, <https://www.cbpp.org/sites/default/files/archive/908mcaid.htm> [<https://perma.cc/7ZZR-K7U8>] (Sept. 8, 1997). 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) (“The Balanced Budget Act of 1997 allowed states to simply amend their State Plans to implement managed care rather than requiring them to seek waivers.” (citing 42 U.S.C. § 1396u-2(a) (2005))).

<sup>60</sup> See CUBANSKI ET AL., *supra* note 54, at 32 (describing private Medicare coverage through “Medicare Advantage” plans).

<sup>61</sup> Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Pay-

This cycle of near-insolvency and repair has been harmful to Medicare, to the project of health reform overall, and to the country. Each successive 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.<sup>62</sup> 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.<sup>63</sup> Some such reforms include savings from cuts in benefits, increases in beneficiary obligations, tax increases, and cuts in other programs.<sup>64</sup> This excludes many of the most meaningful, substantive means of reducing health care costs, such as by incentivizing the development of less expensive alternatives to current technologies or encouraging preventive care and care coordination.<sup>65</sup> 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.<sup>66</sup> As the insolvency date draws nearer, however, they are forced to warn that the later solvency is tackled, the fewer such reforms will be possible.<sup>67</sup>

Relatedly, the cycle of insolvency has skewed health policy by ensuring that, when Congress legislates on health reform, it is within a narrative of “solv[ing]” the “cost problem” in health care,<sup>68</sup> or the “spending problem” in

ment Models, 81 Fed. Reg. 28,162 (May 9, 2016) (to be codified at 42 C.F.R. pts. 414, 495) (outlining advanced payment models).

<sup>62</sup> See *supra* note 34 and accompanying text (noting that Medicare’s continuous financial crises undermine support for expanding the program).

<sup>63</sup> Hyman, *supra* note 20, at 1188, 1197 (“The consistent approach when attempting ‘reform’ is to fix the short term and ignore the (far more problematic) long term.” (citing Robert M. Ball, *The Sky Isn’t Falling on Medicare*, L.A. TIMES (July 24, 2001), <https://www.latimes.com/archives/la-xpm-2001-jul-24-me-25899-story.html> [<https://perma.cc/97ES-GDZZ> ])).

<sup>64</sup> See generally Van de Water, *supra* note 10 (outlining potential reforms to Medicare).

<sup>65</sup> See, e.g., 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: AN INTERNATIONAL COMPARISON OF MODELS AND OUTCOMES 17, 34–36 (Wolf Sauter, Jos Boertjens, Johan van Manen & Misja Mikkers eds., 2019) (describing how “accreted health law” contributes to inefficiency and waste in health care systems); Neel U. Sukhatme & M. Gregg Bloche, *Health Care Costs and the Arc of Innovation*, 104 MINN. L. REV. 955, 961 (2019) (problematicizing the lack of incentives to innovate cost-effective treatments and preventive measures).

<sup>66</sup> See, e.g., THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, 2020 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 9 (2020), <https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf> [<https://perma.cc/3FYV-BDR8>].

<sup>67</sup> *Id.*

<sup>68</sup> See, e.g., Press Release, Richard S. Schweiker, Sec’y of Health & Hum. Servs., Statement on Proposed Changes in the Social Security System (May 12, 1981), reprinted in Special, *Schweiker’s Pensions Statement*, N.Y. TIMES, May 13, 1981, at A29 (introducing proposed reforms by explaining they would “keep the system from going broke”).

government.<sup>69</sup> Scholars such as Professor Taleed El-Sabawi have documented how the way Congress defines a regulatory problem shapes the solutions it evaluates and implements.<sup>70</sup> This pattern has proven true when it comes to legislation responding to Medicare solvency crises.<sup>71</sup> Recent legislative debates about Medicare’s solvency frame the problem as inherent in government-run health care, motivating major legislative steps toward the privatization of the program to be run through a for-profit health insurance model.<sup>72</sup>

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, leading legal scholarship rightly (albeit almost exclusively) to focus on specific, substantive policy reforms to reduce spending.<sup>73</sup> These recommendations include giving patients greater “skin in the game” of their health care through cost sharing,<sup>74</sup> incentivizing individual providers to take costs into account at the bedside through fiduciary duties<sup>75</sup> properly incentivizing hospital systems,<sup>76</sup> or allowing the Medicare program to ration treatments and services (but not patient care) based on their cost effectiveness.<sup>77</sup>

<sup>69</sup> See, e.g., Oberlander, *supra* note 48, at 1118 (explaining how political leadership developing the 1997 Balanced Budget Act leveraged the 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”).

<sup>70</sup> 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 (2018) (explaining how the way a problem is defined influences perceptions of possible solutions).

<sup>71</sup> See Oberlander, *supra* note 48, at 1117 (describing how members of Congress who had long sought to reduce entitlement spending seized on “[t]he trust fund shortfall . . . [as] a convenient problem to which [they] could attach the solution that they already had in mind”).

<sup>72</sup> See *infra* notes 317–319 and accompanying text (describing a consistent pressure for Medicare privatization).

<sup>73</sup> See, e.g., Bagley, *supra* note 20 (outlining Medicare cost cutting reforms); Buck, *supra* note 20 (same); Fox, *supra* note 20 (same); Brian Elbel & Mark Schlesinger, *Responsive Consumerism: Empowerment in Markets for Health Plans*, 87 MILBANK Q. 633, 634 (2009) (advocating for Medicare improvement through “consumer empowerment”).

<sup>74</sup> See Elbel & Schlesinger, *supra* note 73, at 634 (“State and federal governments continue to adopt new policies designed to enhance this aspect of consumer empowerment, by creating . . . incentives for consumers to make cost-effective choices.” (citation omitted) (first citing David G. Stevenson, *Is a Public Reporting Approach Appropriate for Nursing Home Care?*, 31 J. HEALTH POL., POL’Y & L. 773 (2006); and then citing Kenneth E. Thorpe, *The Rise in Health Care Spending and What to Do About It*, 24 HEALTH AFFS. 1436 (2005))).

<sup>75</sup> See Buck, *supra* note 20, at 1093–94 (“This Article seeks to expand the fiduciary relationship and recognize a new duty of loyalty that providers would owe to Medicare payers.”).

<sup>76</sup> See Bagley, *supra* note 20, at 577 (“[T]he success of any particular reform will depend fundamentally on . . . align[ing] the practice patterns of Medicare’s physicians . . . with federal priorities.”).

<sup>77</sup> See Fox, *supra* note 20, at 5 (“Medicare needs to be changed, giving CMS the power and obligation to openly consider the cost of new medical treatments before covering them.”).



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.<sup>78</sup> Why do "fixes" never seem to last? Why do the program's policies, as they develop, creep inexorably toward greater spending? Several scholars have pointed to a possible explanation: an alignment of powerful interests who use their influence in the legislative and regulatory processes to steer the program to increase, not decrease, costs.<sup>79</sup> In a phrase, the problem is the program's political economy, in the sense of that term as it is used in the field of law and political economy.<sup>80</sup> 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—are incentivized to make Medicare more "generous," not less.<sup>81</sup> So their

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<sup>78</sup> Cf. SKOCPOL, *supra* note 33, at 5 (noting that "[m]oralists and "technocrats" often develop analyses that "lack . . . historical and political sensibility").

<sup>79</sup> See OBERLANDER, *supra* note 9, at 76 ("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 reform."); Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 7, 10 ("[I]ndustry and other interests . . . manipulate people's thinking . . . both as consumers and as voters."); David A. Hyman, *Getting the Haves to Come Out Behind: Fixing the Distributive Injustices of American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 265, 279 [hereinafter Hyman, *Getting the Haves to Come Out Behind*] ("[P]rovider capture of state and federal legislators . . . is the rule . . ."); Hyman, *supra* note 20, at 1181 (describing the role of lobbying by device manufacturers in preventing cost cutting); Timothy Stoltzfus Jost, *The Independent Medicare Advisory Board*, 11 YALE J. HEALTH POL'Y, L., & ETHICS 21, 21 (2011) [hereinafter Jost, *The Independent Medicare Advisory Board*] (stating that HHS and Congress "are . . . driven by special interest politics . . . . Both Medicare payment formulas and coverage determinations often seem to be driven by political, rather than scientific or economic, considerations." (footnote omitted) (citing Timothy Stoltzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39 (1999) [hereinafter Jost, *Governing Medicare*]); 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).

<sup>80</sup> See Britton-Purdy et al., *supra* note 23, at 1792 (in contrast to "political economy" in "mainstream economics departments," "law and political economy" is used in a 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" (citing Samuel Bowles & Herbert Gintis, *Power and Wealth in a Competitive Capitalist Economy*, 21 PHIL. & PUB. AFFS. 324, 324 (1992)).

<sup>81</sup> See generally, e.g., Hyman, *Getting the Haves to Come Out Behind*, *supra* note 79 (describing comparisons between Medicare providers' reimbursement rates, resulting in continuous advocacy for more generous Medicare reimbursement). 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. See, 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> [<https://perma.cc/R4BL-7PWV>] (describing the "common approach" to "benchmark [private payment rates] against the rates . . . for Medicare beneficiaries").

lobbying dollars and political influence are directed at 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 between solvency crises.<sup>82</sup> It is also true when it comes to HHS’s myriad decisions implementing and adjusting the program.<sup>83</sup>

To be sure, advocates of greater spending do not have complete control, and suffer both wins and losses in their lobbying efforts. Taxpayer groups and those concerned about effects on other federal priorities—not to mention the public interest—have a general interest in combatting efforts to expand wasteful spending through the program.<sup>84</sup> But that counteracting influence is strongest in the midst of solvency crises, not in maintaining the program’s finances when insolvency is many years away.<sup>85</sup>

The nature of judicial review compounds this bias in the political economy of Medicare against controlling costs long term. Courts are not involved when HHS arguably spends “too much” on Medicare or allows 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,<sup>86</sup> the Supreme Court has held that generalized pecuniary interests are insufficient to confer standing.<sup>87</sup> Meanwhile, any effort HHS makes to reduce

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<sup>82</sup> Cooper et al., *supra* note 24, at 10 (citing Christopher Lee, *Medicare Bill Partly a Special Interest Care Package*, WASH. POST (Nov. 23, 2003), <https://www.washingtonpost.com/archive/politics/2003/11/23/medicare-bill-partly-a-special-interest-care-package/d884aebf-005c-4363-a56d-6d7777e0cf28/> [<https://perma.cc/68ZC-M89U>]) (describing provisions added at the behest of home-state senators)).

<sup>83</sup> See LAWRENCE R. JACOBS & THEDA SKOCPOL, *HEALTH CARE REFORM AND AMERICAN POLITICS: WHAT EVERYONE NEEDS TO KNOW* 160 (3d ed. 2016) (describing the role of health care industry lobbyists in the development of regulations implementing the Affordable Care Act, and their focus on costs); Hyman, *supra* note 20, at 1181, 1183 n.60 (describing lobbying efforts by providers and manufacturers); see also Silver & Hyman, *supra* note 79, at 151–52 (noting that, 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 Trust Fund).

<sup>84</sup> Jost, *Governing Medicare*, *supra* note 79, at 78–80 (arguing providers’ influence is “counter-balanced” in Medicare by fiscal constraints and occasional conflict of interest between providers and beneficiaries or among providers).

<sup>85</sup> See OBERLANDER, *supra* note 9, at 147–48 (noting that major Medicare policy choices have been driven by solvency crises, when fiscal concerns dominate, but cumulatively-important minor choices have been driven by interest groups).

<sup>86</sup> 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*, 48 J.L. MED. & ETHICS 434, 441 (2020) (explaining how “[t]he tyranny of the federal budget” can make spending a zero-sum choice about increasing generosity of some programs by reducing generosity of others).

<sup>87</sup> See *Flast v. Cohen*, 392 U.S. 83, 105–06 (1968) (describing limitations on taxpayer standing).

spending is certain to be met with legal challenge by whoever loses out, whether hospital,<sup>88</sup> insurer,<sup>89</sup> dialysis provider,<sup>90</sup> nursing home,<sup>91</sup> or beneficiary.<sup>92</sup> And courts often take a sympathetic view of such plaintiffs—the nature of judicial review means that the slighted party is before the court, telling their story, and expressing their need.<sup>93</sup> 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 billions of dollars,<sup>94</sup> 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 a fiscal crisis in the short term, with insolvency predicted either just before or just after the next presidential election.<sup>95</sup> 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?<sup>96</sup> Or, might Medicare become insolvent and stay that way—crisis, insolvency, insolvency?<sup>97</sup>

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<sup>88</sup> See, e.g., *Am. Hosp. Ass'n v. Hargan*, 289 F. Supp. 3d 45, 47 (D.D.C. 2017) (challenging a 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).

<sup>89</sup> See, e.g., *Fox Ins. Co. v. Ctrs. for Medicare & Medicaid Servs.*, 715 F.3d 1211, 1213–14 (9th Cir. 2013) (challenging the decision to terminate a contract with an insurance company and require repayment of prospective payments to the insurance company).

<sup>90</sup> See, e.g., *Dialysis Clinic, Inc. v. Leavitt*, 518 F. Supp. 2d 197, 198 (D.D.C. 2007) (challenging the denial of reimbursement for certain “bad debts” of a dialysis clinic).

<sup>91</sup> See, e.g., *Blossom S., L.L.C. v. Sebelius*, 987 F. Supp. 2d 289, 292 (W.D.N.Y. 2013) (challenging HHS's termination of a nursing home's provider agreement).

<sup>92</sup> See, e.g., *Kort v. Burwell*, 209 F. Supp. 3d 98, 101 (D.D.C. 2016) (challenging Medicare beneficiaries' denial by HHS of coverage for certain cognitive treatments).

<sup>93</sup> 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).

<sup>94</sup> See, e.g., *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 216 (D.C. Cir. 2011) (ruling for hospitals in a high-stakes reimbursement case); *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 815 (D.C. Cir. 2001) (same); *Am. Hosp. Ass'n v. Azar*, 410 F. Supp. 3d 142, 156 (D.D.C. 2019) (rejecting a 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*, 141 S. Ct. 2853 (2021); *Shands Jacksonville Med. Ctr. v. Burwell*, 139 F. Supp. 3d 240, 265 (D.D.C. 2015) (striking down the Secretary's “0.2 percent reduction” in Medicare reimbursements).

<sup>95</sup> See *supra* notes 3–8 and accompanying text (describing various Medicare insolvency estimates).

<sup>96</sup> This was the path Medicaid's Children's Health Insurance Program (CHIP) followed in 2018. Lawrence, *supra* note 11, 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).

<sup>97</sup> This was the path the ACA's cost sharing reduction subsidies followed after their disappropriation. *Id.* at 32–33.

Although Congress has intervened to address Medicare’s solvency in each past crisis, four overlapping trends indicate that the present situation is different, such that Medicare may well be forced to confront insolvency in the near future. First, insolvency is imminent at this writing. As the Trustees have lamented for years, the closer the program is to insolvency, the more dramatic—and potentially draconian—are the changes necessary to avoid it.<sup>98</sup> 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.<sup>99</sup> This influences political calculations, with any legislative effort to preserve the program’s solvency potentially being cast as either 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).<sup>100</sup>

Second, in health law, “Congress has repeatedly failed to [enact legislation] necessary for the government” to respect and fulfill entitlements, sometimes temporarily and sometimes indefinitely; impacted programs have included the Supplemental Nutrition Assistance Program, the Children’s Health Insurance Program, the Indian Health Service, and the ACA’s individual market cost-sharing reduction subsidies.<sup>101</sup> This has forced administrators to make previously “unthinkable” choices about how to manage a disappropriated program, and has given rise to several billion-dollar lawsuits by disappointed claimants seeking judicial relief.<sup>102</sup>

Third, in fiscal law, Congress has repeatedly failed to rise to the challenge of budgetary pressures and address fiscal issues through regular order.<sup>103</sup> The recurrence of “game-of-chicken” negotiations in the “new fiscal politics” make

<sup>98</sup> See, e.g., THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, *supra* note 66, at 41 (“The sooner solutions are enacted, the more flexible and gradual they can be.”).

<sup>99</sup> See generally Van de Water, *supra* note 10 (discussing options to bolster the Trust Fund).

<sup>100</sup> 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> [<https://perma.cc/B5G4-KKNG>] (“Proponents say ‘free’ health care for all would eliminate premiums, copays, and deductibles for everything from major surgery to dental, vision, hearing, and mental health services. In reality, enormous tax increases for all would simply prepay 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> [<https://perma.cc/N7CU-YAD9>] (outlining AARP’s opposition to passing legislation that would cut Medicare benefits to fix federal debt despite the elderly’s interest in reducing federal debt).

<sup>101</sup> See Lawrence, *supra* note 11, at 4, 27, 30, 34, 37, 41 n.182 (describing disappropriation and the programs impacted by it).

<sup>102</sup> See *id.* at 5 (noting the many “blockbuster” lawsuits resulting from disappropriation).

<sup>103</sup> See David Scott Louk & David Gamage, *Preventing Government Shutdowns: Designing Default Rules for Budgets*, 86 U. COLO. L. REV. 181, 183, 185 (2015) (noting the “failure [of most legislative bodies] to regularly pass” fiscal initiatives and defining “new fiscal politics”).

bargaining failures almost inevitable.<sup>104</sup> And, as illustrated by the return of the debt ceiling impasse at the time of this writing, 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.<sup>105</sup> In Medicare, this could easily take the form of a one-time measure pushing insolvency by a year or two along with a supercommittee or other mechanism whose failure would set up eventual insolvency.

Fourth, in politics, an era of “hardball” sees the party opposing the president constantly looking to exert their influence in Congress to frustrate governance. A vigorous scholarly debate continues about whether one political party is more to blame for this era of “constitutional hardball.”<sup>106</sup> 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. 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 on policy choices of the past.<sup>107</sup>

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 would entail a clear deadline and immediate consequences 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. Further, 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

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<sup>104</sup> *Id.* at 185.

<sup>105</sup> See *Understanding the Sequester*, COMM. FOR A RESPONSIBLE FED. BUDGET (Nov. 22, 2013), <https://www.crfb.org/blogs/understanding-sequester> [<https://perma.cc/6JCA-H98G>] (discussing the effects of sequestration in the years following the Supercommittee’s failure to agree on a budget relief package).

<sup>106</sup> See, e.g., Fishkin & Pozen, *supra* note 17, at 918 (attaching more blame for the current era of “constitutional hardball” on Republicans than Democrats); *supra* note 17 and accompanying text.

<sup>107</sup> 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, Emily Cochrane & Jim Tankersley, *Democrats Roll Out \$3.5 Trillion Budget to Fulfill Biden’s Broad Agenda*, N.Y. TIMES, <https://www.nytimes.com/2021/07/14/us/politics/biden-social-spending-deal.html> [<https://perma.cc/PF2Y-DNEF>] (Aug. 23, 2021) (describing the 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/> [<https://perma.cc/6AUR-AY9P>] (describing the reconciliation process in which “Congress approves budget instructions for bills that affect spending, revenue or debt. . . . [T]hose bills can then advance on an expedited basis and pass in the Senate with a simple majority, with no threat of a filibuster.”).

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.<sup>108</sup> With that rising uncertainty, pressure to act may well wain, not rise.<sup>109</sup>

All of this raises the questions: What would actually happen if Medicare became insolvent? Are there any steps that could be taken now, by HHS, Congress, or courts, to avoid, or at least mitigate, insolvency? The remainder of this 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.<sup>110</sup> It has also touched on the legal framework of statutes, regulations, and guidance that defines and supports that apparatus.<sup>111</sup> For present purposes, it suffices to highlight that Medicare’s administrative apparatus and the underlying statutes, regulations, and guidance assume solvency, yet say nothing specific about what to do if the program becomes insolvent.<sup>112</sup>

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<sup>108</sup> See, e.g., CTR. FOR CHILD. & FAMS., GEO. UNIV. HEALTH POL’Y INST., WHEN WILL CHIP FUNDING RUN OUT? 1–2 (2017), [https://ccf.georgetown.edu/wp-content/uploads/2017/12/20171220\\_PressRelease\\_CHIP.pdf](https://ccf.georgetown.edu/wp-content/uploads/2017/12/20171220_PressRelease_CHIP.pdf) [<https://perma.cc/R9B9-G9JY>] (elaborating on the “CHIP patch” passed by Congress); Timothy Jost, *New Guidance on CSR Payments and Risk Adjustment: Answers . . . and More Questions*, HEALTH AFFS. BLOG (Aug. 11, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170811.061514/full/> [<https://perma.cc/8PGW-QH8J>] (“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 created, 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., <https://www.wsj.com/articles/capitol-hill-lacks-clarity-on-debt-ceiling-date-1497193228> [<https://perma.cc/W3EZ-7HLT>] (June 11, 2017) (bemoaning “[m]ixed messages and a dearth of details” regarding the 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”).

<sup>109</sup> See discussion *infra* Section III.B.

<sup>110</sup> See, e.g., Bagley, *supra* note 20, at 522 (citing the lack of uniformity of interests between private physicians and the government in administering Medicare); Jost, *Governing Medicare*, *supra* note 79, at 79–80 (describing how the government, interest groups, and beneficiaries all “shape [Medicare] policy”); Eleanor D. Kinney, *The Accidental Administrative Law of the Medicare Program*, 15 YALE J. HEALTH POL’Y, L., & ETHICS 111, 111 (2015) (noting the complexity of not only the “web of legislative [and agency] rules,” but also the appeals process, which governs a “variety of issues” for beneficiaries and providers alike).

<sup>111</sup> See, e.g., Jost, *Governing Medicare*, *supra* note 79, at 79–80. See generally Bagley, *supra* note 20; Kinney, *supra* note 110.

<sup>112</sup> See Juliette 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/> [<https://perma.cc/V6JY-VSA3>] (“[T]here is no automatic process in place or precedent to determine how to apportion the available funds or how to fill the shortfall.”).

If this occurs, the Appropriations Clause of the U.S. Constitution would forbid spending beyond the Trust Fund (and the Anti-Deficiency Act would render it a felony with a five-year statute of limitations).<sup>113</sup> Thus, if and when the statute's assumption of Trust Fund solvency becomes false, administering an insolvent Medicare program will force determination—by HHS, courts, and perhaps Congress—of five open legal questions: (1) How will choices about administering 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 in federal district court?

This Part discusses each choice, its determinants, and its implications for the likelihood and course of insolvency in Medicare. Section A addresses the administrative law question of the process for deciding how to administer insolvency in Medicare.<sup>114</sup> Section B then addresses the substantive question whether to delay or reduce payments.<sup>115</sup> Section C discusses the substantive question of insulating high-priority claimants.<sup>116</sup> Section D addresses the five trillion dollar remedies question of whether shorted providers could collect from the Judgment Fund through litigation.<sup>117</sup> Section E addresses the procedural question of the path of such blockbuster litigation—whether through the Court of Federal Claims or federal district court.<sup>118</sup>

### A. Process

An insolvent Medicare program will be unable to operate as required by the Medicare statute.<sup>119</sup> Insolvency would force the agency to make substantive decisions discussed in the following sections, 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?

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<sup>113</sup> See Lawrence, *supra* note 11, 83–84 (first citing 31 U.S.C. §§ 1341(a)(1), 1350; and then citing 18 U.S.C. § 3282(a)) (describing how the Anti-Deficiency Act “prohibit[s] both executive expenditures and commitments in advance of appropriations” while proscribing criminal sanction for its violation).

<sup>114</sup> See *infra* notes 119–137 and accompanying text.

<sup>115</sup> See *infra* notes 138–158 and accompanying text.

<sup>116</sup> See *infra* notes 159–176 and accompanying text.

<sup>117</sup> See *infra* notes 177–209 and accompanying text.

<sup>118</sup> See *infra* notes 211–231 and accompanying text.

<sup>119</sup> It is worth repeating 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. See *supra* notes 54–55 and accompanying text.

In prior disappropriations, HHS decided for itself what to do, without public consultation, announcing its approach in guidance documents.<sup>120</sup> One could certainly imagine HHS taking this path now—avoiding explicit advance consideration or public involvement in its decisions about how to manage insolvency until it was actually reached (itself a difficult date to pin down). It then might simply announce its approach by fiat—or even just implement its insolvency plan and allow 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.<sup>121</sup> HHS is required by the Medicare statute annually to propose, seek comment on, and finalize formal payment notices governing Medicare reimbursement for hospitals and insurers.<sup>122</sup> These notices routinely include a range of administrative changes and adjustments, big and small. Initial proposals ordinarily must be published in spring during the year ahead of the year to which they apply in order to be finalized by applicable deadlines.<sup>123</sup> 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 resolve litigation by providers either challenging the agency’s approach to administering insolvency or asking for an order for full payment.<sup>124</sup> The reason has to do with Medicare’s jurisdictional “channeling”—or “exhaustion”—provisions that mean that, “in most instances, judicial review is available only after the ex-

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<sup>120</sup> See *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, the agency’s approach for handling shortfall in fiscal year 1994 appropriations); *CTRS. FOR MEDICARE & MEDICAID SERVS. & CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, DEP’T OF HEALTH & HUM. SERVS., RISK CORRIDORS AND BUDGET NEUTRALITY 1* (Apr. 11, 2014), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf> [<https://perma.cc/HT7D-C6NK>] (providing guidance in the case of a risk corridor fund shortfall); *CTR. FOR CHILD. & FAMS., GEO. UNIV. HEALTH POL’Y INST.*, *supra* note 108 (describing confusion about how CHIP shortfalls would be administered in states).

<sup>121</sup> See 42 U.S.C. § 1395hh(a)–(b) (granting the agency authority to act by rulemaking, requiring both notice and the opportunity for public comment regarding proposed rules).

<sup>122</sup> *Id.* § 1395ww(d)(6) (describing Part A payment notice); *id.* § 1395w-23(b) (describing Part C payment notice).

<sup>123</sup> *Id.* § 1395ww(j)(5); *id.* § 1395w-23(b)(1)–(2) (requiring advance notice and comment on changes in Medicare Advantage payment methodology “[a]t least 45 days” before a final rule to be issued by “the first Monday in April before the calendar year concerned”).

<sup>124</sup> The specifics of such litigation are discussed in Section II.D. See *infra* notes 177–209 and accompanying text.



haustion of lengthy administrative processes.”<sup>125</sup> The Medicare statute allows expedited consideration of challenges to regulations through these processes, so a regulation dictating the agency’s approach could be challenged directly in federal court just weeks or months after its issuance.<sup>126</sup> 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.<sup>127</sup> Additionally, the Medicare statute’s exhaustion provision would preclude judicial review until that process ran its course.<sup>128</sup>

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 *Ac-cardi* doctrine) binds the agency to follow its own regulations.<sup>129</sup> By contrast, if the agency does not regulate in advance, then its approach would remain an open question during congressional deliberations. This would increase the uncertainty in those deliberations about what would 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 United States Supreme Court emphasized, in 2019, in *Azar v. Allina Health Ser-*

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<sup>125</sup> TIMOTHY STOLTZFUS JOST, *DISSENTMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 34 (2003) (first citing 42 U.S.C. §§ 405(h), 1395ii; and then citing *Heckler v. Ringer*, 466 U.S. 602 (1984)); see *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000) (“‘[E]xhaustion’ . . . demands the ‘channeling’ of virtually all legal attacks through the agency . . .”).

<sup>126</sup> See § 1395oo(f)(1) (providing for expedited judicial review when “the [Provider Reimbursement Review] Board determines . . . that it is without authority to decide the question”); 42 C.F.R. § 405.1842(f)(1)(ii) (2021) (noting that expedited review is available if “the legal question is a challenge . . . to the substantive or procedural validity of a *regulation or CMS Ruling*” (emphasis added)); see, e.g., *Am. Hosp. Ass’n v. Azar*, 967 F.3d 818, 823, 834 (D.C. Cir. 2020) (describing procedural history where a challenge to a regulation issued November 13, 2017 was dismissed for failure to exhaust, but exhaustion was completed and a new suit over which the court had jurisdiction was brought, which the district court resolved in the hospitals’ favor on December 27, 2018; the United States Court of Appeals for the D.C. Circuit subsequently reversed), *cert. granted sub nom.* *Am. Hosp. Ass’n v. Becerra*, 141 S. Ct. 2883 (2021).

<sup>127</sup> *Cf.* *Flast v. Cohen*, 392 U.S. 83, 105–06 (1968) (requiring the claimant to show a sufficient nexus between taxpayer status and the nature of the unconstitutional action to secure judicial review).

<sup>128</sup> JOST, *supra* note 125, at 34–35 (“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 toehold.”).

<sup>129</sup> *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 267 (1954) (“In short, as long as the regulations remain operative, the Attorney General denies himself the right to sidestep the Board or dictate its decision in any manner.”).

vices,<sup>130</sup> that the Medicare statute endorses these values through its mandated rulemaking for changes in payment standards, whether made in “substantive . . . [or] interpretive rules.”<sup>131</sup> A process such as advance rulemaking, with notice and comment, would promote these values and align with the Medicare statute’s endorsement.<sup>132</sup> Meanwhile, even if lawful by virtue of an emergency, last-minute decision-making by agency fiat would risk increasing controversy and confusion.<sup>133</sup>

Even though administrative law favors advance rulemaking, the process decision would largely be within the discretion of HHS under current law. The Medicare statute’s preference for rulemaking notwithstanding,<sup>134</sup> an agency failure to address insolvency in advance through regulation would leave no option but to do so later, without such formality, to comply with the Appropriations Clause.<sup>135</sup> 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.<sup>136</sup> Additionally, the lack of an explicit statutory command that the agency make policy, let alone a deadline for one, would prove fatal under those doctrines.<sup>137</sup>

### 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

<sup>130</sup> 139 S. Ct. 1804, 1808–09 (2019) (interpreting 42 U.S.C. § 1395hh).

<sup>131</sup> *Id.* at 1809, 1811 (“Congress didn’t just adopt the APA’s notice-and-comment regime for the Medicare program. . . . Instead, Congress chose to write a new, Medicare-specific statute.”). See generally Graham Haviland, *Not So Different After All: The Status of Interpretive Rules in the Medicare Act*, 85 U. CHI. L. REV. 1511 (2018) (discussing judicial interpretations of the Medicare statute’s “notice and comment [requirement] for proposed regulations”).

<sup>132</sup> *Allina Health Servs.*, 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 . . .”).

<sup>133</sup> 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, whether legislative or administrative).

<sup>134</sup> § 1395hh (requiring notice and comment rulemaking for “substantive” rules).

<sup>135</sup> See Hyman, *supra* note 20, at 1182 (“The sooner this problem is addressed, the less severe the resulting dislocations will be.”).

<sup>136</sup> See Sidney A. Shapiro, *Rulemaking Inaction and the Failure of Administrative Law*, 68 DUKE L.J. 1805, 1818 (2019) (“[A]s a general proposition, this court will compel an agency to institute rulemaking proceedings only in extremely rare circumstances.” (quoting *Ark. Power & Light Co. v. ICC*, 725 F.2d 716, 723 (D.C. Cir. 1984))).

<sup>137</sup> See *id.* at 1820–21 (noting that “an agency has an obligation . . . to respond to a rulemaking petition” but that “courts are split” on how much weight to give Congress’s promulgation of a response deadline (citing 5 U.S.C. § 555(b))).

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 hospitals, and so on. This is because access to care from providers is structured as an entitlement for beneficiaries, so there does not appear to be any legal path by which beneficiaries’ eligibility for care could be circumscribed directly.<sup>138</sup> 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 ACA’s risk corridors disappropriation.<sup>139</sup> It committed to paying all claims in full eventually but, with insufficient funds, noted that it would need to delay payment until funds came in, resulting in an increasingly long backlog.<sup>140</sup> In the case of Medicare, that would mean payment delays on all claims payable from the Hospital Insurance Trust Fund. This includes hospital inpatient claims, skilled nursing facility claims, and the inpatient component of Medicare Part C plan payments, among others.<sup>141</sup>

The duration of delays in payment would begin small and gradually grow longer and longer unless and until Congress acted. Specific delays would depend on real-time solvency projections and the logistics of different payment pathways.<sup>142</sup> Generally, based on CBO projections, the required delays before payment would be roughly two months in the first year of insolvency, four

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<sup>138</sup> See JOST, *supra* note 125, at 31 (“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 . . . .”); Timothy Stoltzfus Jost, *Medicare: What Are the Real Problems? What Contribution Can Law Make to Real Solutions?*, 1 ST. LOUIS U. J. HEALTH L. & POL’Y 45, 49–50 (2007) (“Medicare is an entitlement under federal law . . . .” (footnote omitted) (citing 42 U.S.C. §§ 426, 426-1(a), 1395c)); see also § 426(a) (“Every individual who [is eligible] shall be entitled to hospital insurance benefits under part A . . . .”).

<sup>139</sup> See Lawrence, *supra* note 11, at 32 (“HHS did not pay insurers the \$12.3 billion called for by the statutory formula over the three-year run of the program, even while recording the unpaid amounts in ‘obligations’ in its financial reports.” (first citing *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1332 (Fed. Cir. 2018) (Newman, J., dissenting), *rev’d sub nom.* *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308 (2020); then citing *Molina Healthcare of Cal., Inc. v. United States*, 133 Fed. Cl. 14, 25 (2017); and then citing Leslie Small, *Government’s Unpaid Risk Corridor Tab Swells to \$12.3B*, FIERCEHEALTHCARE (Nov. 16, 2017), <https://www.fiercehealthcare.com/aca/government-s-unpaid-risk-corridor-tab-swells-to-12-3b> [<https://perma.cc/2XWE-UB28>])).

<sup>140</sup> CTRS. FOR MEDICARE & MEDICAID SERVS. & CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, DEP’T OF HEALTH & HUM. SERVS., *supra* note 120.

<sup>141</sup> See *supra* notes 51–52 and accompanying text (listing statutory provisions providing for the types of payments that are withdrawn from the Hospital Insurance Trust Fund).

<sup>142</sup> See *supra* note 123 and accompanying text (explaining the variables that make pinning down an exact insolvency date difficult).

months in the second, and would eventually approach a year.<sup>143</sup> Finally, the delay would stretch into multiple years as backlogs stacked up and the Trust Fund’s shortfall increased.<sup>144</sup>

Alternatively, in the tribal support cost disappropriation, the agency employed the pro rata reduction approach, paying all claims as usual but reducing them by a rate necessary to maintain overall solvency.<sup>145</sup> It is not hard to imagine how this would operate in Medicare, because payment rate adjustments for various purposes are common.<sup>146</sup> The agency would simply estimate, conservatively, the necessary adjustment for a given year and reduce payment rates by a corresponding percentage.<sup>147</sup> 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. The result is an approximately 17% reduction 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.<sup>148</sup>

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 contrast, a pro rata reduction would be implemented a year at a time in that year’s payment rates.<sup>149</sup> This would create a clear annual deadline by which Congress would be required to act to avoid direct impacts on hospitals’ and insurers’ balance sheets. The presence

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<sup>143</sup> The CBO has not estimated delay length, but it has predicted a 17% shortfall in the first year rising to a 19% shortfall by 2030. *The Outlook for Major Federal Trust Funds: 2020 to 2030*, CONG. BUDGET OFF. (Sept. 2020), [<sup>144</sup> See \*infra\* note 242 and accompanying text \(estimating the likely length of reimbursement delays based on CBO shortfall projections\).](https://www.cbo.gov/publication/56541#:~:text=According%20to%20the%20Congressional%20Budget,billion%20in%20fiscal%20year%202020.&text=Spending%20from%20the%20trust%20funds,2030%20(see%20Table%202) [https://perma.cc/453J-2MN5]. The estimate above reflects the author’s simple arithmetic calculation converting this percentage of payments due in a year into weeks of delay in a year.</p></div><div data-bbox=)

<sup>145</sup> See *Distribution of Fiscal Year 1994 Contract Support Funds*, 58 Fed. Reg. 68,694, 68,694 (Dec. 28, 1993) (noting that “all tribes will be treated the same [in the event of] a shortfall”); see also Lawrence, *supra* note 11, at 28.

<sup>146</sup> See, e.g., *Adirondack Med. Ctr. v. Sebelius*, 740 F.3d 692, 700 (D.C. Cir. 2014) (describing agency adjustment authority).

<sup>147</sup> If there were a surplus at year’s end, the agency could roll it into the next year’s adjustment.

<sup>148</sup> This estimate is based on CBO projections. See generally *The Outlook for Major Federal Trust Funds: 2020 to 2030*, *supra* note 143.

<sup>149</sup> See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS. & CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, DEP’T OF HEALTH & HUM. SERVS., *supra* note 120 (explaining how Trust Fund shortfalls, and therefore pro rata reductions, are evaluated on an annual basis).

or absence of such a clear deadline may prove determinative of whether Congress takes action to avert insolvency or not, as discussed in Section III.B.<sup>150</sup>

Just as significant, however, may be the implication of both the choice between delayed payment and a pro rata reduction for the timing of litigation, as well as courts' involvement in Medicare bankruptcy. Like the choice of process, this choice would have a significant impact on when and how litigation could proceed. The delayed payment option would mean a long wait before litigation. This is not only due to applicable exhaustion requirements,<sup>151</sup> but also to limitations on judicial relief forcing unlawfully withheld agency action,<sup>152</sup> as well as the ripeness doctrine.<sup>153</sup> By contrast, a pro rata reduction would avoid these threshold barriers.<sup>154</sup> This would shorten by months, and more likely years, the time it would take for claimants to access federal court, and so obtain any relief available there.<sup>155</sup>

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<sup>150</sup> See discussion *infra* Section III.B (explaining how clarification of Medicare insolvency procedures would predictably decrease the likelihood that insolvency will occur in the first place, by facilitating preventive compromise in Congress).

<sup>151</sup> 42 U.S.C. § 405(h) (precluding ordinary federal question jurisdiction over claims "arising under" statute); *id.* § 1395ii (applying § 405(h) to Medicare claims); *Shalala v. Ill. Council on Long Term Care*, 529 U.S. 1, 13 (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, 201–02 (D.D.C. 2017) (addressing the explicability of the exhaustion requirement to Medicare Advantage).

<sup>152</sup> See *Shapiro*, *supra* note 136, at 1818 (describing limited doctrines in which plaintiffs could hope to force unlawfully withheld agency action).

<sup>153</sup> *Abbott Lab's v. Gardner*, 387 U.S. 136, 148–49 (1967) (describing the ripeness doctrine, where courts exercise discretion to decline injunctive and declaratory remedies depending on "fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration" (footnote omitted)), *abrogated by Califano v. Sanders*, 430 U.S. 99 (1977).

<sup>154</sup> *Shands Jacksonville Med. Ctr. v. Azar*, 959 F.3d 1113, 1116 (D.C. Cir. 2020) (noting that provisions allow hospitals to "seek review of [reimbursement] rates before the Provider Reimbursement Review Board" (citing § 1395oo(a)(1)(A)(ii))). As an agency action, a pro rata reduction would not require litigation to compel. As for ripeness objections, a pro rata reduction would avoid these both by: (1) providing a concrete policy for courts to review; and (2) by guaranteeing a one-year change in rates, thereby avoiding ripeness arguments that 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 (1967) (stating the hardship prong considers whether withholding judicial review will have an "immediate and substantial impact" on the plaintiff); *Sys. Application & Techs., Inc. v. United States*, 691 F.3d 1374, 1383 (Fed. Cir. 2012) (commenting that "[a] claim is not ripe for judicial review [if] it is contingent upon future events that may or may not occur" (citing *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580–81 (1985))).

<sup>155</sup> See discussion *infra* Sections II.D, II.E (explaining how a pro rata approach would likely shorten the timeframe for providers to access judicial relief). The comparison of two recent Medicare litigations—one over a delay, the other over a payment reduction—is informative. *Compare Am. Hosp. Ass'n v. Azar*, No. 14-851, 2018 WL 5723141, at \*1 (D.D.C. Nov. 1, 2018) (seeking "mandamus to compel [HHS] to comply with . . . statutory" appeals deadlines), *with Adirondack Med. Ctr. v. Sebelius*, 891 F. Supp. 2d 36, 39 (D.D.C. 2012) (challenging a reduction in Medicare payments to rural community hospitals by HHS), *aff'd*, 740 F.3d 692 (D.C. Cir. 2014). It took several years for the courts to conclude they could even hear the delay case; the payment reduction case was heard almost

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.<sup>156</sup> As for logistics, Medicare’s payment processes are certainly capable of accommo-

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immediately and resolved shortly thereafter. *Compare Am. Hosp. Ass’n*, 2018 WL5723141, at \*1 (“This case is now before the Court for a third time, following a second remand from the D.C. Circuit. . . . [Plaintiffs] filed this suit in May 2014.”), with *Adirondack Med. Ctr.*, 740 F.3d at 696 (noting that plaintiff sought review by “the Provider Reimbursement Review Board, which disclaimed jurisdiction,” filed the original suit in federal district court in 2012, and exhausted their appeals by January 2014). Specifically, in *American Hospital Ass’n v. Azar*, which was before the U.S. District Court for the District of Columbia in 2018, the American Hospital Association (AHA) sued HHS over delays in the processing of Medicare payment appeals. 2018 WL5723141, at \*1–2. A rising flood of appeals in 2011 saw Medicare begin to miss the statutory deadline to render a decision within ninety days of appeal. See § 1395ff(d) (outlining the ninety day deadline and allowance for District Court review in the event the deadline lapses); *Average Processing Time by Fiscal Year*, HHS.GOV, <https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html> [<https://perma.cc/WE6R-FK7S>] (Feb. 8, 2021) (reporting a 121-day appeal processing time in 2011 that has risen exponentially to 1,430 days in 2020). 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> [<https://perma.cc/7G8Z-3LSJ>] (providing court documents related to AHA litigation seeking to require HHS to observe appeals decision deadlines). 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 over three years. *Average Processing Time by Fiscal Year*, *supra* (noting that average appeals processing time in 2020 was almost four years). By contrast, in *Adirondack Med. Ctr.*, which the U.S. District Court for the District of Columbia decided in 2012, the agency promulgated a prospective reduction in payment rates for fiscal year 2012 (beginning October 1, 2011) in August of 2011. 891 F. Supp. 2d at 41–42; see Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services, 75 Fed. Reg. 50,042, 50,067–71 (Aug. 16, 2010) (to be codified at 42 C.F.R. pts. 412, 413, 415, 424, 440, 441, 482, 485, 489) (outlining the coming reduction in payments); Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY2012 Rates; Hospitals’ FTE Resident Caps for Graduate Medical Education Payment, 76 Fed. Reg. 51,476, 51,498–99 (Aug. 18, 2011) (to be codified at 42 C.F.R. pts. 412, 413, 476) (same). Plaintiffs immediately sought and obtained an “expedited judicial review” determination from the Provider Reimbursement Review Board and filed suit on October 15, 2012. *Adirondack Med. Ctr.*, 891 F. Supp. 2d at 42. The Court ruled on the statutory interpretation question on which the case depended on September 17, 2012. *Id.* at 36, 48.

<sup>156</sup> The statute both mandates payments to claimants and requires compliance within a specific timeframe. *Compare* § 1395g(a) (“[T]he provider of services shall be paid . . . the amounts due such provider under this part . . . .”), with *id.* § 1395h(c)(2)(A)–(c)(2)(B)(ii)(V) (“[Ninety-five] percent of all claims submitted . . . [must be paid within thirty] 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 Anti-Deficiency Act by spending despite the shortfall in appropriations). See *supra* note 113 and accompanying text (describing the Appropriations Clause and Anti-Deficiency Act complications regarding Medicare insolvency).

dating a pro rata reduction, and more than likely could accommodate payment delays.<sup>157</sup> This 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.<sup>158</sup>

### C. Triage?

It is easy enough for an academic to refer to a seventeen percent reduction in Medicare payment rates, or to long delays in payments. Yet, for struggling healthcare providers in a harsh environment—especially an asset-poor provider or one particularly reliant on Medicare dollars—the reality of disrupted Medicare payments would be challenging, to say the least. Section 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.<sup>159</sup>

The fact that even uniform reductions or delays in Medicare payment would impact various providers differently, posing a much greater challenge for some, raises an additional, substantive question that HHS would have to address, regardless of which approach it pursued. In the Social Security context, Professor John Harrison suggests that the costs of insolvency should be targeted toward wealthier beneficiaries.<sup>160</sup> 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, 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-size-fits-all approach?<sup>161</sup> For example, could Medicare prioritize payments for hospitals that

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<sup>157</sup> 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.*, 959 F.3d at 1120 (discussing the "significant administrative burden" avoided with a prospective, across-the-board remedy to an improper reduction of reimbursement rates).

<sup>158</sup> 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* note 176 and accompanying text (explaining the issues posed by the actuarial equivalence requirement and providing statutory support).

<sup>159</sup> See discussion *infra* Section III.A (examining the potential harms of Medicare insolvency and how advanced rulemaking could mitigate them).

<sup>160</sup> Harrison, *supra* note 19, at 407 ("Congress today could provide that, in the case of a cash shortage, the reduction in payments would be means tested, with high-income recipients of benefits absorbing most or all of the reductions.").

<sup>161</sup> See *Triage*, MERRIAM-WEBSTER DICTIONARY, <https://www.merriam-webster.com/dictionary/triage> [<https://perma.cc/Y5WN-DQLH>] (in medicine, "triage" means "the sorting of and allocation of

serve a disproportionate share of low-income beneficiaries, or rural hospitals that 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 entails “tremendous complexity.”<sup>162</sup> 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 allocate the financial resources needed for Medicare to hold hearings within the timeframe required by statute.<sup>163</sup> This has led to a multi-year backlog in Medicare’s appeals process,<sup>164</sup> in which the agency has triaged among claimants, allowing beneficiary claimants to cut the line.<sup>165</sup> Although the backlog itself has been subject to extensive litigation, the agency’s choice to triage in this way has not been challenged in that litigation.<sup>166</sup>

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 it—would depend significantly on the process by which the agency made decisions about administering insolvency (the question confronted in Section A of this Part).<sup>167</sup> The best case for agency discretion to insulate some claimants from insolvency is if the agency promulgates its policy in advance, through notice and comment rulemaking, and invokes its

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treatment to patients . . . according to a system of priorities designed to maximize the number of survivors”).

<sup>162</sup> See *Cnty. Care Found. v. Thompson*, 318 F.3d 219, 225 (D.C. Cir. 2003) (recognizing “enhance[d] . . . deference [to] the Secretary’s decision” in light of the “‘tremendous complexity’ of the Medicare program” (quoting *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1229 (D.C. Cir. 1994))).

<sup>163</sup> See Matthew J.B. Lawrence, *Procedural Triage*, 84 *FORDHAM L. REV.* 79, 102 & n.114 (2015) (reporting Congress’s knowledge of the backlog in appeals but lack of motivation to resolve the problem).

<sup>164</sup> See *id.* at 91 (recognizing that “at the beginning of 2014, half a million appeals and counting were waiting for hearing,” with “that number [growing] throughout the year” (citing NANCY GRISWOLD, OFF. OF MEDICARE HEARINGS AND APPEALS (OMHA), U.S. DEP’T OF HEALTH & HUM. SERVS., *MEDICARE APPELLANT FORUM* (2014), [https://www.hhs.gov/sites/default/files/omha/files/apellant\\_forum\\_presentations.pdf](https://www.hhs.gov/sites/default/files/omha/files/apellant_forum_presentations.pdf) [<https://perma.cc/BX62-C5ZD>])).

<sup>165</sup> See *id.* (describing actions taken by the Office of Medicare Hearings and Appeals in an attempt to address the backlog).

<sup>166</sup> The AHA and many hospitals have challenged the agency’s delay in holding hearings, but not the agency’s decision to prioritize patient claims for more timely hearings. See *generally, e.g.*, *Am. Hosp. Ass’n v. Burwell*, 812 F.3d 183 (D.C. Cir. 2016) (“seeking mandamus compelling [HHS] to [facilitate Medicare appeals] in accordance with statutory timeline”).

<sup>167</sup> See discussion *supra* Section II.A (outlining the procedural options available to plan for Medicare insolvency).



catchall authority to adjust Medicare payments.<sup>168</sup> That adjustment authority is broad and flexible,<sup>169</sup> so the agency would only need to justify any prioritization by reference to underlying goals of the Medicare statute.<sup>170</sup> 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. This is true 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 it is forced to do so by insolvency. This authority is a byproduct of the Appropriations Clause and Congress' ability to command payment without appropriating funds necessary to meet that command.<sup>171</sup> Unlike the agency's discretion under its statutory adjustment authorities, the extent to which it would have discretion in wielding this inherent authority to break the law is altogether unclear.<sup>172</sup>

Courts might be sympathetic to arguments that a one-size-fits-all approach is compelled in such a case because a one-size-fits-all approach would plausibly minimize the extent of the breach from legal requirements. Regardless, it is almost certain that courts would hold that the agency, in administering insolvency, must honor all pre-existing laws that it is *possible* to honor.<sup>173</sup> This would in-

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<sup>168</sup> See 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"); *id.* § 1395hh(a)–(b) (requiring notice and comment rulemaking for "substantive" rules); see also *id.* § 1395i(t)(2)(E) (providing authority to make "other adjustments as determined to be necessary to ensure equitable payments").

<sup>169</sup> *Adirondack Med. Ctr. v. Sebelius*, 891 F. Supp. 2d 36, 44–45, 48 (D.D.C. 2012) (noting § 1395ww(d)(5)(I)(i) "grants broad authority" and upholding adjustment of a hospital's reimbursement rate), *aff'd*, 740 F.3d 692 (D.C. Cir. 2014).

<sup>170</sup> For example, the agency might exempt Disproportionate Share Hospital (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.

<sup>171</sup> See Lawrence, *supra* note 11, at 16–17 ("While the Constitution reserves to Congress the power to permit Treasury expenditures via the Appropriations Clause, Congress has in many cases delegated this power to the executive [(including executive agencies)]." (footnote omitted) (first citing *Off. of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 424 (1990); then citing *United States v. MacCollom*, 426 U.S. 317, 321 (1976); then citing *Reese v. Walker*, 52 U.S. (11 How.) 272, 291 (1850); and then citing *Ass'n of Civilian Technicians v. Fed. Lab. Rels. Auth.*, 269 F.3d 1112, 1116 (D.C. Cir. 2001))).

<sup>172</sup> See Neil H. Buchanan & Michael C. Dorf, *How to Choose the Least Unconstitutional Option: Lessons for the President (and Others) from the Debt Ceiling Standoff*, 112 COLUM. L. REV. 1175, 1221–22 (2012) (discussing the question of executive discretion forced by competing statutory commands).

<sup>173</sup> See *Am. Hosp. Ass'n v. Price*, 867 F.3d 160, 167 (D.C. Cir. 2017) (accepting the HHS impossibility of compliance argument based on the mass settlement workaround itself being violative of the statute). "[A] court may not require an agency to break the law . . ." *Id.* (first citing *Ala. Power Co. v.*

clude the statutory requirement that the agency make substantive changes in Medicare policy only through notice and comment rulemaking.<sup>174</sup> In turn, this would foreclose non-regulatory prioritization efforts that could be characterized as “substantive” within the meaning of the statute, a broad category.<sup>175</sup>

Hospitals (paid through Part A) and insurers (paid through Part C), the two biggest Trust Fund claimants, are reimbursed through very different formulae and processes, providing a final lesson for the agency’s discretion to prioritize. This could lead the agency to administer insolvency using an approach that privileges one set of claimants or the other. Its authority to do so could be circumscribed, however, by a provision of the Medicare statute arguably requiring the agency to ensure that Part A and Part C reimbursements be “actuarial[ly] equivalen[t].”<sup>176</sup> This provision may be 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*

How HHS would administer Medicare during insolvency and whether it would delay payments or reduce them pro rata are important considerations, but no question looms larger than that 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. Further, these parties would petition the courts to order that they be paid the full amount for serving Medicare beneficiaries described in the statute.<sup>177</sup> 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.

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Costle, 636 F.2d 323, 359 (D.C. Cir. 1979); and then citing *NRDC v. Train*, 510 F.2d 692, 713 (D.C. Cir. 1974)).

<sup>174</sup> 42 U.S.C. § 1395hh(b)(1) (“[T]he Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.”).

<sup>175</sup> *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1811 (2019) (holding that the phrase “substantive legal standard” in Medicare statute is broader than the “substantive rule[.]” concept in APA (emphasis omitted)).

<sup>176</sup> § 1395w-23(a)(1)(C)(i) (“[T]he Secretary shall adjust the payment amount . . . [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.”); *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 870, 886 (D.C. Cir. 2021) (“The role of the actuarial-equivalence provision is to require CMS to model a demographically and medically analogous beneficiary population in traditional Medicare to determine the prospective lump-sum payments to Medicare Advantage insurers.”).

<sup>177</sup> § 1395g(a) (requiring that providers be compensated for “services furnished by [them]”).

An understanding of the Judgment Fund appropriation is essential to analyzing the question of whether courts might order payment. Courts do not automatically have the power under the Constitution to make funds available from the federal Treasury.<sup>178</sup> Only Congress can do that, through an appropriation. This means that even when a court orders a federal agency to pay someone, the agency cannot comply with that order unless and until Congress appropriates the funds.<sup>179</sup> Thus, for much of the country's history, actually getting paid by suing the United States for damages required two steps. First, obtain a court order of payment.<sup>180</sup> Second, obtain an appropriation from Congress to satisfy the order.<sup>181</sup> Congress always honored such orders, but doing so was burdensome; the first Congress was provided with over seven hundred petitions for remuneration.<sup>182</sup>

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.<sup>183</sup> The Judgment Fund is a blanket, permanent appropriation of "[n]ecessary amounts" necessary to honor federal court judgments, as well as certain settlements negotiated by the Department of Justice in the context of litigation.<sup>184</sup> When Congress failed to fund 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.<sup>185</sup> Unfortunately, in each case, these payments

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<sup>178</sup> Compare U.S. CONST. art. I, § 9, cl. 7 (granting Congress the power to appropriate Treasury funds as an operation of law), with *id.* art. III (providing for no enumerated powers of the Judiciary over the Treasury).

<sup>179</sup> Lawrence, *supra* note 11, at 74 n.326 (citing *Reeside v. Walker*, 52 U.S. (11 How.) 272, 291 (1850)) (explaining that "courts cannot order a payment of funds that are not appropriated" by Congress).

<sup>180</sup> 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, 694 (1985).

<sup>181</sup> *Id.* ("Congress had historically refused to enact a continuing appropriation for the payment of all judgments, and the federal courts had refused to enforce payment without a specific appropriation." (footnote omitted) (citing *Reeside*, 52 U.S. at 290–91)).

<sup>182</sup> *Id.* at 638.

<sup>183</sup> *Id.* at 686 (explaining the congressional adoption of "a continuing appropriation for all judgments certified by the Comptroller General not in excess of \$100,000" (citing the Automatic Payment of Judgments Act, ch. 748, 70 Stat. 694 (1956) (codified as amended at 31 U.S.C. § 1304))).

<sup>184</sup> 31 U.S.C. § 1304(a).

<sup>185</sup> See *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1331 (2020) (ordering the payment of the statutorily-mandated risk corridor payment); *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 193 (2012) (holding that the government was obligated to pay the tribes the full amount of their contractual promise and could not escape this burden by failing to appropriate the funds); *Sanford Health Plan v. United States*, 969 F.3d 1370, 1382 (Fed. Cir. 2020) (requiring the government to fulfill its obligation to reimburse providers).

came several years after their original due date.<sup>186</sup> 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.<sup>187</sup>

The most significant determinant of the Judgment Fund’s availability would be courts’ rulings on whether the Medicare statute entitles participating 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 for hospital reimbursement and Part C for insurer reimbursement, the statute specifically commands the agency to reimburse and sets forth an intricate formula regarding the amount.<sup>188</sup> Courts have found these features “money mandating” and sufficient to trigger the Judgment Fund in past cases.<sup>189</sup> 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 confidence, even when the legal arguments are one sided.<sup>190</sup> 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

<sup>186</sup> See *Me. Cmty. Health Options*, 140 S. Ct. at 1316 (ordering risk corridors program payments five years after they original came due between 2014 and 2016); *Salazar*, 567 U.S. at 202 (ordering payment ten years after the original due date between 1994 and 2001); *Sanford Health Plan*, 969 F.3d at 1372 (ordering payment three years after reimbursement was due in 2017).

<sup>187</sup> THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS., 2019 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 67 (2019), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf> [<https://perma.cc/S2DR-3AEX>] (estimating \$5.3 trillion shortfall over the life of the program).

<sup>188</sup> 42 U.S.C. § 1395g(a) (mandating that the Part A “provider of services shall be paid . . . from the Federal Hospital Insurance Trust Fund, the amounts so determined”); *id.* § 1395w-23(f) (“The payment to a Medicare+Choice organization under this section . . . shall be made . . .”); *id.* § 1395ww(d) (setting forth a complicated formula to determine “[i]npatient hospital service payments on [the] basis of prospective rates”).

<sup>189</sup> See, e.g., *Me. Cmty. Health Options*, 140 S. Ct. at 1329 n.13, 1331 (citing *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1320 n.2 (Fed. Cir. 2018), *rev’d sub nom.* *Me. Cmty. Health Options*, 140 S. Ct. at 1308) (“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 on the government to pay money and that the obligation is enforceable through a damages action in the Court of Federal Claims . . .”).

<sup>190</sup> See generally Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act’s Litigation Decade*, 108 GEO. L.J. 1471 (2020) (recounting a decade of legal challenges to the Affordable Care Act).

Trust Fund by explicitly pointing to it as the source of required payments.<sup>191</sup> Moreover, there is 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 statute.<sup>192</sup> Arguably, this is implied in: (1) the trust fund financing structure;<sup>193</sup> (2) the many partial but incomplete measures Congress has taken to address the program's solvency over the decades; (3) the statute's provisions mandating budget neutrality while also forbidding courts from reviewing budget neutrality adjustments;<sup>194</sup> and (4) the fact that the statute refers to beneficiaries as "entitled" to benefits over one hundred times, but refers to providers as "entitled" to reimbursement only a few times.<sup>195</sup>

As to what would happen in the years following the onset of insolvency, the Judgment Fund question becomes even less certain. Providers and insurers would have the statutory option to leave the Medicare program. Further, their choice to participate would be made with an awareness of the fund's insolvency and its corresponding impacts on reimbursement; indeed Part C insurers might even explore the possibility of increasing premium bids to offset expected shortfalls. Judges have been open to arguments that contractors' arguably voluntary choices to participate in analogous past cases affected their ability to seek damages.<sup>196</sup> They might be receptive to these arguments in adjudi-

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<sup>191</sup> See, e.g., § 1395g(a) ("[T]he provider of services shall be paid . . . from the Federal Hospital Insurance Trust Fund . . ."); *id.* § 1395w-23(f) ("The payment to a Medicare+Choice organization . . . shall be made from the Federal Hospital 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(a)(1).

<sup>192</sup> See *King v. Burwell*, 576 U.S. 473, 498 (2015) ("A fair reading of legislation demands a fair understanding of the legislative plan.").

<sup>193</sup> 42 U.S.C. § 1395(g).

<sup>194</sup> See, e.g., *id.* § 1395w-23 (requiring budget neutrality while limiting the opportunity for judicial review).

<sup>195</sup> Compare *JOST*, *supra* note 125, at 31 ("[P]ersons entitled to benefits' . . . [is] a phrase that appears [in the Medicare statute as a reference to beneficiaries] over 100 times . . ."), with § 1395w-23 (referring to providers as "entitled" in a few instances).

<sup>196</sup> See *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1332 (2020) (Alito, J., dissenting) ("These companies chose to participate in an Affordable Care Act program that they thought would be profitable."); *Cmty. Health Choice, Inc. v. United States*, 970 F.3d 1364, 1377 (Fed. Cir. 2020) (applying the mitigation theory to reduce a damages award for insurers arising from "cost-sharing reduction" disappropriation, *cert. denied sub nom.* *United States v. Me. Cmty. Health Options*, 141 S. Ct. 2796 (2021); *cf.* *Se. Ark. Hospice, Inc. v. Sebelius*, 1 F. Supp. 3d 915, 925 (E.D. Ark. 2014) ("The only compulsion to provide hospice services is imposed by virtue of [plaintiff's] voluntary choice to provide services under the hospice program."). The Court of Appeals for the Federal Circuit summed up the concept of mitigation as follows: "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.'" *Cmty. Health Choice, Inc.*, 970 F.3d at 1375–76 (quoting *RESTATE-*

cating Medicare bankruptcy as well. That said, the mitigation question has not been addressed definitively by the Supreme Court<sup>197</sup> and its applicability to Medicare providers and insurers is debatable—hence the difficulty of predicting its resolution.<sup>198</sup>

Importantly, HHS and the government could substantially alter 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. This may depend on the outcome of *American Hospital Ass’n v. Becerra*, which the United States Supreme Court is expected to decide soon after this writing.<sup>199</sup> But even absent deference, statements of obligation from the agency may be seen by courts as supporting breach of contract or other damages theories.<sup>200</sup> Similarly, statements disclaiming obligation may undermine breach of contract and other damages theories in their own right.<sup>201</sup>

Second, the Department of Justice could increase the likelihood and generosity of a Judgment Fund payout by settling Medicare bankruptcy cases on favorable terms—taking advantage of the Judgment Fund’s alternative availa-

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MENT (SECOND) OF CONTRACTS § 350(1) (AM. L. INST. 1981)) (first citing 3 DAN B. DOBBS, LAW OF REMEDIES § 12.6(1), at 127 (2d ed. 1993); and then citing *Roehm v. Horst*, 178 U.S. 1, 11 (1900)).

<sup>197</sup> The mitigation issue was not presented in the risk corridors case, so it was not resolved by the Supreme Court in *Maine Community Health Options*. 140 S. Ct. at 1308. This Article takes up that and a related case and courts’ role in Medicare bankruptcy *infra* Section IV.B.1. See discussion *infra* Section IV.B (recommending the Supreme Court approach the entitlement question in upcoming cases with awareness of its future implications for Medicare bankruptcy).

<sup>198</sup> In *Community Health Choice, Inc.*, the United States Court of Appeals for the Federal Circuit found the mitigation theory applicable to ACA insurers only after concluding that contract law principles should apply to the government’s relationship with such insurers. 970 F.3d at 1374. This conclusion was based in part on the fact that the ACA does not set out remedies for insurers disappointed with their payments from the government. *Id.* 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* notes 125–128 and accompanying text (describing Medicare’s elaborate procedural remedies and the requirement that they be exhausted before pursuing judicial action).

<sup>199</sup> 141 S. Ct. 2883 (2021) (granting petition for certiorari).

<sup>200</sup> Analogous HHS statements were cited in the risk corridor cases. See *Me. Cmty. Health Options*, 140 S. Ct. at 1324–25.

<sup>201</sup> 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, 1207–08 (2016) (discussing questions about whether “the Medicare Provider Agreement is a contract,” with implications for liquidation of health care entities).

bility for compromise settlements.<sup>202</sup> This might be done either by openly agreeing to a favorable settlement or by displacing career lawyers in favor of political appointees who are willing to support a settlement providing payouts more generous than warranted.<sup>203</sup> There are probably no serious external constraints on the Department of Justice's discretion to settle claims,<sup>204</sup> but institutional and ethical considerations counsel against abuse of that discretion.<sup>205</sup>

Third, HHS could reduce the likelihood of Judgment Fund liability by using its rulemaking authority over Medicare payments to prospectively reduce payment rates uniformly 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,<sup>206</sup> though there are strong counter-arguments as well.<sup>207</sup> A solvency adjustment, if indeed legally authorized,

<sup>202</sup> 31 U.S.C. § 1304(a)(3).

<sup>203</sup> See Paul F. Figley, *The Judgment Fund: America's Deepest Pocket & Its Susceptibility to Executive Branch Misuse*, 18 U. PA. J. CONST. L. 145, 148 (2015) (expressing concerns about “sue and settle” environmental litigation and other Judgment Fund practices).

<sup>204</sup> Courts have held that the government's decision to settle an individual affirmative case is only reviewable under specified circumstances. See *Garcia v. McCarthy*, 649 F. App'x 589, 591–92 (9th Cir. 2016) (“A decision that is committed to agency discretion by law may nonetheless be reviewable where the agency has ‘consciously and expressly adopted a general policy’ that is so extreme as to amount to an abdication of its statutory responsibilities.” (quoting *Heckler v. Chaney*, 470 U.S. 821, 833 n.4 (1985))). Further, 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, 152–54 (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 this would allow the policy to be reviewed. See *Heckler*, 470 U.S. at 833 n.4 (suggesting judicial review would be available where an agency had “‘consciously and expressly adopted a general policy’ that is so extreme as to amount to an abdication of its statutory responsibilities” (citing *Adams v. Richardson*, 480 F.2d 1159 (D.C. Cir. 1973) (en banc))). Hence the “probably” qualifier above.

<sup>205</sup> See Figley, *supra* note 203, at 179–200 (sounding the alarm regarding “[r]aids on the Judgment Fund”).

<sup>206</sup> 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.”); *id.* § 1395w-23(a)(1)(C)(i) (providing that “the Secretary shall adjust the payment amount” for Medicare Advantage for enumerated factors and “such other factors as the Secretary determines to be appropriate . . . so as to ensure actuarial equivalence”).

<sup>207</sup> 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.” See *The Outlook for Major Federal Trust Funds: 2020 to 2030*, *supra* note 143 (predicting a nineteen percent Trust Fund shortfall by the year 2030).

would foreclose the Judgment Fund by reducing the amounts actually owed under the statute.

The implications of this question are 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 the ultimate judicial resolution. If not, these disruptions would be permanent, lasting as long as Congress’s failure to act.

There would be significant fiscal-political economy impacts as well. If the Judgment Fund is available for the full amount of the shortfall, then Medicare bankruptcy would entail a painful, chaotic, and wasteful transition from a capped Trust Fund financing model 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.<sup>208</sup> Additional pressure would, of course, come from taxpayer and deficit control advocates.<sup>209</sup> 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 restrain change in the law, which neither Congress nor the President can do unilaterally, to ensure devotion of 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-à-vis competing federal resource priorities would be inverted. If Medicare’s boosters wanted the program’s share of GDP to grow with rising health care costs in that case, they would need to cobble together major reform legislation capable of becoming law. 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 too is an additional, proce-

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<sup>208</sup> Matthew B. Lawrence, *Subordination and Separation of Powers*, 131 YALE L.J. 78, 104 (2021) (describing the fragility of annually funded discretionary programs).

<sup>209</sup> Cf. Jessica Banthin, Deputy Assistant Dir., Cong. Budget Off., Presentation to a Conference Organized by the Center for Sustainable Health Spending, Washington, DC: Health Care Spending Today and in the Future: Impacts on Federal Deficits and Debt 25 (July 18, 2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/52913-presentation.pdf> [<https://perma.cc/5HHK-DJYY>] (presenting the correlation between the growth in Medicare spending and the Federal Debt).



dural question: What court would hear the case, and what kind of relief might it order? There are two very different procedural avenues through which typical shorted Medicare claimants might seek relief.<sup>210</sup> First, judicial relief could be sought retrospectively, with a 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 set up by Congress to resolve a specialized group of claims, including damages claims against the government.<sup>211</sup> Its equitable power (including the power to order injunctive relief) is severely limited, perhaps nonexistent.<sup>212</sup> Its decisions may be appealed to the federal circuit courts, then to the Supreme Court.<sup>213</sup>

Prior disappropriations have been litigated in the Court of Federal Claims. In the tribal support cost, risk corridor, and cost sharing reduction disappropriations, litigation began there before ultimately reaching the Supreme Court.<sup>214</sup> Although it might be assumed that Medicare insolvency litigation could and would undoubtedly proceed in that court, this assumption would be too hasty. The United States Court of Appeals for the Federal Circuit, in 2005,

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<sup>210</sup> A third route, in addition to those discussed above, might be available for some plaintiffs. Specifically, hospitals that became insolvent themselves could potentially press their entitlement to reimbursement in bankruptcy court. The circuits are split over whether section 405(h) precludes bankruptcy court jurisdiction over unexhausted reimbursement claims. *Compare* Benjamin v. U.S. Soc. Sec. Admin., 932 F.3d 293, 296–97 (5th Cir. 2019) (acknowledging a split with the Third, Seventh, Eighth, and Eleventh Circuits created by finding that section 405(h) does not preclude bankruptcy court jurisdiction), *with In re* Bayou Shores SNF, LLC, 828 F.3d 1297, 1314 (11th Cir. 2016) (holding that section 405(h) does preclude bankruptcy court jurisdiction of unexhausted claims). *See generally* Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*, 32 EMORY BANKR. DEVS. J. 19 (2015) (arguing for jurisdiction); John Aloysius Cogan, Jr. & Rodney A. Johnson, *Administrative Channeling Under the Medicare Act Clarified: Illinois Council, Section 405(h), and the Application of Congressional Intent*, 9 ANNALS HEALTH L. 125 (2000) (developing an argument against jurisdiction). In a circuit court on the side of this split finding jurisdiction, it could be possible to adjudicate a hospital's entitlement to full reimbursement at relatively early stages of the reimbursement process.

<sup>211</sup> *United States Court of Federal Claims: The People's Court*, U.S. CT. OF FED. CLAIMS, [http://www.uscfc.uscourts.gov/sites/default/files/uscfc\\_court\\_history\\_brochure\\_20210325.pdf](http://www.uscfc.uscourts.gov/sites/default/files/uscfc_court_history_brochure_20210325.pdf) [<https://perma.cc/2QQK-9QLJ>].

<sup>212</sup> *See* 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.”).

<sup>213</sup> 42 U.S.C. § 300aa-12(f) (allowing for a Court of Federal Claims decision to be appealed to the United States Court of Appeals for the Federal Circuit within sixty days of adjudication).

<sup>214</sup> *See, e.g.,* Me. Cmty. Health Options v. United States, 140 S. Ct. 1308, 1318 (2020) (noting the original filing was in the Court of Federal Claims); Cmty. Health Choice v. United States, 970 F.3d 1364, 1370 (Fed. Cir. 2020) (same), *cert. denied sub nom.* United States v. Me. Cmty. Health Options, 141 S. Ct. 2796 (2021); Sanford Health Plan v. United States, 969 F.3d 1370, 1372 (Fed. Cir. 2020) (same).

held in *Wilson ex rel. Estate of Wilson v. United States* that the Court of Federal Claims does not have jurisdiction over lawsuits that “arise[] under the Medicare [statute].”<sup>215</sup> This is because of the Medicare statute’s jurisdictional channeling positions that tee up district court actions.<sup>216</sup> There is a strong argument that a challenge to HHS’s reduction or delay of payment of a Medicare claim due to insolvency would also “arise under” the Medicare statute, and so be ineligible for adjudication in the Court of Federal Claims.<sup>217</sup>

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: (1) “relief other than money damages”;<sup>218</sup> and (2) only as to claims that have “no other adequate remedy in a court” (such as, perhaps, the Court of Federal Claims).<sup>219</sup>

These limitations might or might not preclude Medicare insolvency litigation in federal district court. In 1988, The United States 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.<sup>220</sup> Moreover, it held that a retrospective damages remedy, even if technically available, is not necessarily “adequate.”<sup>221</sup> Indeed, 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.<sup>222</sup> The Court reasoned the states sought not “damages” but compliance with the

<sup>215</sup> 405 F.3d 1002, 1010, 1016 (Fed. Cir. 2005).

<sup>216</sup> *See id.* at 1010–12, 1016 (“[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 Techs. Inc. v. United States*, 144 Fed. Cl. 126, 134 (2019) (applying *Wilson* in finding no jurisdiction over Medicare claims).

<sup>217</sup> *See Weinberger v. Salfi*, 422 U.S. 749, 760–61 (1975) (holding that a claim “arises under” the Medicare statute if the statute “provides both the standing and substantive basis for the [claim]”).

<sup>218</sup> 5 U.S.C. § 702.

<sup>219</sup> *Id.* § 704.

<sup>220</sup> 487 U.S. 879, 895 (1988) (quoting *Md. Dep’t of Hum. Res. v. Dep’t of Health & Hum. Servs.*, 763 F.2d 1441, 1446 (D.C. Cir. 1985) (first citing § 702; and then citing *D. DOBBS, HANDBOOK ON THE LAW OF REMEDIES 135 (1973)*)) (“The fact that in the present case it is money rather than in-kind benefits that pass from the federal government to the states . . . cannot transform the nature of the relief sought—specific relief, not relief in the form of damages.” (quoting *Md. Dep’t of Hum. Res.*, 763 F.2d at 1446 (citing *Clark v. Libr. of Cong.*, 750 F.2d 89, 104 n.33 (D.C. Cir. 1984))).

<sup>221</sup> *Id.* at 905 (citing *Massachusetts v. Departmental Grant Appeals Bd. of the U.S. Dep’t of Health & Hum. Servs.*, 815 F.2d 778, 789 (1st Cir. 1987) (Coffin, J., concurring)).

<sup>222</sup> *Id.* at 907. “[T]he nature of the controversies that give rise to disallowance decisions typically involve state governmental activities that a district court would be in a better position to understand and evaluate . . .” *Id.* at 907–08.

statute, and that their need to plan in advance how to administer their Medicaid programs meant that an ex-post damages remedy would not be “adequate.”<sup>223</sup>

With prior disappropriations having been litigated through the Court of Federal Claims, it is 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.<sup>224</sup> That said, although there are superficial legal obstacles to relief via the district court, *Bowen* demonstrates that these arguments are not insurmountable, as does *Wilson*.<sup>225</sup> Plaintiffs hoping to establish federal district court jurisdiction in Medicare insolvency litigation could argue that the Court of Federal Claims would be inadequate both due to its jurisdictional limitations noted in *Wilson* and the plaintiffs’ need to know the status of their Medicare claims to plan their operations.<sup>226</sup> 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.<sup>227</sup>

The procedural path of Medicare bankruptcy litigation would not apparently impact whether courts would ultimately order payment from the Judgment Fund or not.<sup>228</sup> 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 significantly on the form of HHS’s decisions altering

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<sup>223</sup> *Id.* at 905–07 (“It is no answer to suggest that a State will not be harmed as long as it retains the money, because its interest in planning future programs . . . may be more pressing than the monetary amount in dispute.”).

<sup>224</sup> 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, 93 (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. LAW. 557, 574–75 (1989) (suggesting *Bowen* may be read to allow grant-in-aid litigation to proceed in district court even when seeking money).

<sup>225</sup> See *Wilson ex rel. Est. of Wilson v. United States*, 405 F.3d 1002, 1016 (Fed. Cir. 2005) (holding that the Court of Federal Claims “lacks jurisdiction . . . [to evaluate a] claim aris[ing] under the Medicare Act”); *Bowen*, 487 U.S. at 907 (suggesting the district court may be a better forum for disallowance claims).

<sup>226</sup> See *Wilson*, 405 F.3d at 1016 (finding jurisdictional boundaries to bringing Medicare claims in the Court of Federal Claims); *Bowen*, 487 U.S. at 907 (suggesting the district court may be more accommodating to the state’s interest in planning future programs).

<sup>227</sup> 31 U.S.C. § 1304(a)(3)(A) (incorporating by reference 28 U.S.C. § 2414). The Attorney General is authorized by statute to pay settlements for imminent claims against the United States out of the Judgment Fund. 28 U.S.C. § 2414.

<sup>228</sup> Ultimately the core question of statutory interpretation would remain the same, and regardless of 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.

payment,<sup>229</sup> but may potentially begin immediately upon adoption of insolvency measures and be quickly adjudicated on summary judgment.<sup>230</sup> 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.<sup>231</sup>

### III. REWRITING THE STARS

Thinking about 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 attention is paid during insolvency crises to the question of how to address the program’s immediate needs and render it solvent, either by decreasing spending or increasing revenue.<sup>232</sup>

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

This Part problematizes the overarching theme that runs throughout current law’s approach to Medicare insolvency, as reflected in each of the questions identified and analyzed in Part II. It is motivated by the question whether it is right for the Medicare statute and regulations to remain silent on the possibility of insolvency or its implications, leaving its administration uncertain, to be determined by the agency and courts if and when it occurs. This Part responds to that question with a resounding “no,” and recommends that (hopefully prophylactic) rules to govern Medicare bankruptcy be established in ad-

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<sup>229</sup> See discussion *infra* Sections II.A, II.B (weighing the consequences of delaying Medicare reimbursement payments or continuing them on schedule pro rata).

<sup>230</sup> See, e.g., *Adirondack Med. Ctr. v. Sebelius*, 29 F. Supp. 3d 25, 35 (D.D.C. 2014) (applying a more deferential summary judgment standard to agency action, determining whether such “action is supported by the administrative record and otherwise consistent with the APA standard of review” (quoting *Sierra Club v. Mainella*, 459 F. Supp. 2d 76, 90 (D.D.C. 2006) (citing *Richards v. INS*, 554 F.2d 1173, 1177 & n.28 (D.C. Cir. 1977))), *appeal dismissed*, Nos. 06-5419, 07-5004, 2007 WL 1125716, at \*1 (D.C. Cir. Mar. 30, 2007)), *aff’d sub nom. Adirondack Med. Ctr. v. Burwell*, 782 F.3d 707 (D.C. Cir. 2015). 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 and because of the strictures of the Appropriations Clause. 31 U.S.C. § 1304; see Lawrence, *supra* note 11, at 37 (describing the legal basis for a conclusion that the Appropriations Clause forbids preliminary relief regarding payment of damages when the court has “doubt about the availability of appropriations” (citing *California v. Trump*, 267 F. Supp. 3d 1119, 1121 (N.D. Cal. 2017))).

<sup>231</sup> See *supra* notes 211–214 and accompanying text (reciting funding dispute cases originally filed in the Court of Federal Claims).

<sup>232</sup> See *supra* notes 63–77 and accompanying text (describing the often short-term reforms to Medicare imposed during insolvency crises seeking to increase revenue or, more likely, cut costs).

vance. Part IV will turn to the respective roles of HHS, Congress, and the courts in effectuating this recommendation.<sup>233</sup>

Section A of this Part discusses how advanced clarification on the administration of Medicare insolvency would make it less unfair and harmful if it did occur, even if the \$5.3 trillion question of liability remained unanswered.<sup>234</sup> Section B highlights that such clarification would predictably decrease the likelihood that insolvency will occur in the first place, by facilitating preventive compromise in Congress.<sup>235</sup> Finally, Section 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.<sup>236</sup> This would be accomplished by 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 insolvency is that if insolvency did occur such rules would reduce its harms and make their distribution more fair. 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.<sup>237</sup>

Based 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<sup>238</sup> and would opt to delay payments across the board.<sup>239</sup> After a year or two, doctrinal and exhaustion obstacles would be resolved, and claimants would seek damages from the Judgment Fund in the Court of Federal Claims. Their suits would progress to the federal circuit courts and then to

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<sup>233</sup> See discussion *infra* Part IV.

<sup>234</sup> See *infra* notes 237–274 and accompanying text.

<sup>235</sup> See *infra* notes 275–289 and accompanying text.

<sup>236</sup> See *infra* notes 290–328 and accompanying text.

<sup>237</sup> See discussion *supra* Part II (discussing the most consequential questions for administering insolvency: (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 recovery would come through prospective injunctions in federal district courts or retrospective damages orders in the Court of Federal Claims).

<sup>238</sup> See Hyman, *supra* note 20, at 1182 (“[L]egislative sloth, confirmed by past history, ensures that any solution will be deferred until a true crisis emerges . . .”); *supra* notes 120–137 and accompanying text (acknowledging that HHS has historically addressed financial crises in a slow and ad-hoc manner, leading to confusion among providers).

<sup>239</sup> See discussion *supra* Section II.B (suggesting pro rata payments may pose a problem in light of the actuarial equivalence requirement).

the Supreme Court, ultimately gaining success. 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 for HHS action and for the definitive resolution of lawsuits, providers and insurers would have had to endure months or years of lost revenues and uncertainty.<sup>240</sup> This is almost precisely what happened in the risk corridors and tribal support cost disappropriations.<sup>241</sup>

The real-world harms in this most-likely scenario would emerge slowly, and perhaps behind the scenes if some struggling hospitals, nursing homes, other providers, and impacted insurers 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 hamper reimbursement for providers, insurers, and other service providers,

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<sup>240</sup> See discussion *supra* Sections II.D, II.E (illustrating the circumstances that providers would face in light of HHS’s failure to prepare for insolvency); see also Laura N. Coordes, *Reorganizing Healthcare Bankruptcy*, 61 B.C. L. REV. 419, 421 (2020) (“The healthcare industry regularly grapples with numerous problems, including increased competition, legislative uncertainty, changing payment models, higher pharmaceutical costs, and rising wages.” (citing Mark G. Douglas, *Focus on Health Care Provider Bankruptcies*, JONES DAY (Sept.–Oct. 2017), <http://www.jonesday.com/Focus-on-Health-Care-Provider-Bankruptcies-10-01-2017/> [<https://perma.cc/H5RW-ELGF>])).

<sup>241</sup> 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 National Ass’n of Insurance Commissioners in Support of Plaintiff-Appellee at 12–13, *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018) (No. 17-1994), 2017 WL 4077798, at \*12–13 (noting that “only six of the 24 CO-OPs operating at peak participation were still in business” because of risk corridors disappropriation), *rev’d sub nom. Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308 (2020); see *Watchdog Urges Continued Oversight of Troubled Co-Ops*, CQ HEALTHBEAT (Sept. 12, 2017), reprinted in *Watchdog Urges Continued Oversight of Troubled Co-ops*, NEWSBANK (Sept. 12, 2017), <https://infoweb-newsbank-com.eu1.proxy.openathens.net/apps/news/document-view?p=WORLDNEWS&docref=news/166FDD840C698938&f=basic> [<https://perma.cc/J456-FAQG>] (describing co-op bankruptcies). The larger insurers were able to weather the disruption, however, and could move in and assume the territory and business of the now-defunct small players. See Brief of Amicus Curiae, *supra*, at 9–10 (“[T]he market is populated by these disadvantaged insurers, while other financially stronger insurers are disincentivized from participating.”). 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 for the large players. *Me. Cmty. Health Options*, 140 S. Ct. at 1331. 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 its way through the courts, to the Supreme Court, and eventually, to payment of damages. Press Release, Indian Affairs., U.S. 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> [<https://perma.cc/8XAX-HP2F>]; *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 201 (2012).

which in this scenario, would be delayed by roughly two months in the first year, four in the second, and so on depending on the extent of the shortfall.<sup>242</sup>

Past disappropriations of other health programs, along with rate cuts and revenue shocks in Medicare, illustrate how providers would respond to an extended delay (or reduction) in reimbursements, and thus what the disruption's ultimate effects would be. The most pronounced impacts would be on hospitals and other providers reimbursed mostly through Part A, and so dependent on the Hospital Insurance Trust Fund, with somewhat diluted impacts on Medicare Advantage insurers (who would see impacts only for that share of Medicare Advantage payments associated with inpatient hospital stays).<sup>243</sup> These providers would respond in four ways depending on their customer mix, financial position, and the competitiveness of their markets. This would ultimately create 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.<sup>244</sup> Such providers would either shutter or be forced to merge with larger, better-financed entities, further fueling concentration in health care markets.<sup>245</sup> Provider insolvencies would, in turn, limit ac-

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<sup>242</sup> See *The Outlook for Major Federal Trust Funds: 2020 to 2030*, *supra* note 143. This estimate is based on CBO predictions of a 17% shortfall in the first year rising to a 19% shortfall by 2030. See *id.*; see also *supra* note 143 and accompanying text.

<sup>243</sup> See 42 U.S.C. 1395w-23(f) (providing that payment for Medicare Advantage insurers shall be made from the HI 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”); see also *supra* notes 50–55 and accompanying text (describing interaction of trust funds).

<sup>244</sup> Cf. Brief of Amicus Curiae, *supra* note 241, at 12 (“It’s not that they couldn’t be made into viable businesses: it’s that they couldn’t last long enough to reach that point.” (quoting Tim Worstall, *The Problem with Health Care Coops: No Capitalists to Absorb the Losses*, FORBES (Sept. 26, 2015), <https://www.forbes.com/sites/timworstall/2015/09/26/the-problem-with-health-care-coops-no-capitalists-to-absorb-the-losses/?sh=5e57a97b7155> [<https://perma.cc/LW9K-UQE7>])). For example, when the ACA’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> [<https://perma.cc/YU95-66EZ>] (“Just seven of the original 23 co-ops are still standing.”).

<sup>245</sup> 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. One hundred billion dollars was allotted for providers in the Coronavirus Aid, Relief, and Economic Security (CARES) Act. CARES Act, Pub. L. No. 116-136, 134 Stat. 281, 368–75 (2020). Seventy-five billion dollars was allotted from the Paycheck Protection Program and Health Care Enhancement Act. Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620, 620–30 (2020). Finally, an estimated \$68 billion of the \$520 billion for the paycheck protection program was allotted for providers. Keeping American Workers Paid and Em-

cess for all patients in impacted communities, either directly in the case of hospital closures or indirectly due to increased costs.<sup>246</sup> Affordability, associated with the loss of competition among providers and insurers due to merger and closure, would therefore be reduced.<sup>247</sup>

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 revenue source for most providers,<sup>248</sup> making it doubtful that enough would leave for access to be meaningfully impacted across the board—only one percent of providers refuse to accept Medicare.<sup>249</sup> Access impacts would nonetheless be important, however, in two domains. In rural and low-income communities already struggling with access,<sup>250</sup>

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ployed Act, Pub. L. No. 116-136, 134 Stat. 286, 286–313 (2020). 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> [<https://perma.cc/Q646-27UJ>] (outlining “[e]ligibility and [r]epayment” criteria for COVID-19 advances to providers). Hospitals received advance payments of at least \$100 billion through the program. Juliette Cubanski, Karyn Schwartz, Jeannie Fuglesten Biniek & Tricia Neuman, *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/> [<https://perma.cc/D7H8-DH3A>].

<sup>246</sup> *See* Brief of Amicus Curiae, *supra* note 241, at 9–10, 12 (citing *Rising Health Insurance Premiums Under the Patient Protection and Affordable Care Act: Hearing Before the U.S. H. Oversight & Gov’t Reform Subcomm. on Health Care, Benefits, & Admin. Rules*, 114th Cong. 6 (2016) (testimony of Al Redmer, Jr., Comm’r, Nat’l Ass’n of Ins. Comm’rs) (emphasizing how the failure of risk corridors payments to materialize ultimately impacts consumers by increasing costs and driving providers and insurers from the market).

<sup>247</sup> *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, Professor, Harvard Bus. Sch & Harvard John F. Kennedy Sch. of Gov’t) (discussing price increases and evidence of lower quality health care in highly concentrated markets).

<sup>248</sup> *See* AM. HOSP. ASS’N, TRENDWATCH CHARTBOOK 2018: TRENDS AFFECTING HOSPITALS AND HEALTH SYSTEMS 39 chart 4.5 (2018), <https://www.aha.org/system/files/2018-07/2018-aha-chartbook.pdf> [<https://perma.cc/B682-GP7Q>] (noting that Medicare made up 40.8% of hospital costs as of 2016).

<sup>249</sup> Nancy Ochieng, Karyn Schwartz & Tricia Neuman, *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/> [<https://perma.cc/HBQ9-JQFY>] (providing data on physicians who do not participate in the Medicare program).

<sup>250</sup> Emily A. Benfer, Seema Mohapatra, Lindsay F. Wiley & Ruqaiyah Yearby, *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) (“[H]ealth 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.” (citing ALAN SAGER & DEBORAH SOCOLAR, CLOSING HOS-



even small numbers of providers exiting the program could mean severe shortages.<sup>251</sup> And in fields where providers already decline participation in Medicare at significant rates—such as psychiatry (7.2% currently opt out), reconstructive surgery (3.6%), and neurology (2.8%)—a significant proportion of providers could opt out, or avoid treating patients in inpatient settings.<sup>252</sup> Of course, providers exiting Medicare would increase the concentration of the markets they left behind, at least for Medicare patients.<sup>253</sup>

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.<sup>254</sup> Those in competitive markets could do so in desirable ways, such as by cutting wasteful care, unnecessary investment, or excessive executive or provider salaries.<sup>255</sup> They could also do so in undesirable ways, however, such as by limiting charitable services for the indigent,<sup>256</sup>

PITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESS TO HEALTH CARE (2006), <https://www.bu.edu/sph/files/2015/05/Sager-Hospital-Closings-Short-Report-20Nov06.pdf> [<https://perma.cc/AB5J-FJKQ>]); Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241, 247–51 (2018) (outlining disparities in rural health care).

<sup>251</sup> See *State and Federal Efforts to Enhance Access to Basic Health Care*, THE COMMONWEALTH FUND, <https://www.commonwealthfund.org/publications/newsletter-article/state-and-federal-efforts-enhance-access-basic-health-care> [<https://perma.cc/HL79-4PUW>] (“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.”).

<sup>252</sup> Ochieng et al., *supra* note 249 (providing data on provider participation in the Medicare program by field).

<sup>253</sup> See *United States v. Aetna, Inc.*, 240 F. Supp. 3d 1, 32, 41–42 (D.D.C. 2017) (concluding that for insurance plan merger analysis, the relevant market should be seen as “traditional Medicare” and “Medicare Advantage,” not all of Medicare).

<sup>254</sup> James Robinson, *Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration*, 30 HEALTH AFFS. 1265, 1266 (2011) (“The choice between revenue enhancement and cost reduction will become more acute as the federal government seeks to reduce its budget deficit in part by reducing Medicare payments to hospitals.”).

<sup>255</sup> See *id.* at 1270 (questioning “whether . . . costs [will be reduced] through better management of capacity, technology, and staffing” for hospitals in competitive markets, or by less desirable means).

<sup>256</sup> 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, hospital association lobbyists complained that the cuts would ultimately harm patients by reducing such charitable services. See CONG. BUDGET OFF., ESTIMATED IMPACT OF AUTOMATIC BUDGET ENFORCEMENT PROCEDURES SPECIFIED IN THE BUDGET CONTROL ACT 2 (2011), [https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/09-12-BudgetControlAct\\_0.pdf](https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/09-12-BudgetControlAct_0.pdf) [<https://perma.cc/3R36-NL95>] (reporting on the Medicare reductions between 2013 and 2021); 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/> [<https://perma.cc/56CL-ANZU>] (reporting the hospital labor groups appeal to 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](https://www.washingtonpost.com/politics/the-big-sequester-gamble-how-badly-will-the-cuts-hurt/2013/02/23/be0c44e2-7c4e-11e2-82e8-61a46c2cde3d_story).

increasing the aggressiveness of their collection practices,<sup>257</sup> laying off employees,<sup>258</sup> and reducing the services they provide to patients.<sup>259</sup> Providers with market power in concentrated markets, meanwhile, could be expected to increase their private-sector rates and thereby pass the cost onto those enrolled in private insurance plans.<sup>260</sup>

Fourth, wealthy, well-resourced providers could bank on the likelihood that disrupted payments would ultimately be ordered by courts in full, with interest.<sup>261</sup> This would provide them the opportunity to continue business as usual, weather the shortfall, and use the opportunity to gain market share over competitors who lacked that financial flexibility. This poses a danger that well-resourced hospitals and other providers would use Medicare’s insolvency as an opportunity to increase their market share further. Additionally, it provides yet another reason to believe that insolvency in the program would serve as a driver of increased concentration in the health care marketplace,<sup>262</sup> with lasting effects on the cost of and access to health care.<sup>263</sup>

As for Medicare Advantage insurers, the most dramatic result would be decisions to increase bids or opt out of the program altogether beginning the year after any extended insolvency. Less competition and pricier plans could lead fewer beneficiaries to opt into Medicare Advantage in the first place, and reduce affordability or benefits for those who do. Meanwhile, some insurers

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html [<https://perma.cc/CTT8-FJN9>] (noting that a nonprofit healthcare lobbying group opposed the cuts to Medicare and the AHA lobbied against reductions on medical research due to the sequester).

<sup>257</sup> See generally Isaac D. Buck, *When Hospitals Sue Patients*, 73 HASTINGS L.J. 191 (2022) (describing the trend of hospitals turning to increasingly aggressive debt collection in the face of cuts, to maintain their bottom lines).

<sup>258</sup> The coronavirus shortfall saw an immediate spike in health care industry layoffs. See U.S. DEP’T OF LAB., NEWS RELEASE: UNEMPLOYMENT INSURANCE WEEKLY CLAIMS 1 (2020), <https://oui.doleta.gov/press/2020/032620.pdf> [<https://perma.cc/PVQ3-5WPC>] (“Additional industries heavily cited for the increases [in unemployment insurance claims] included the health care and social assistance . . . industries.”).

<sup>259</sup> See Lorber, *supra* note 256 (warning that cuts will likely lead to a decrease in services).

<sup>260</sup> See, e.g., Robinson, *supra* note 254, at 1267 (outlining research about the effect of provider Medicare reimbursement reductions on provider behavior that indicated that concentrated markets respond by increasing private-sector reimbursement rates, while those in competitive markets find ways to cut costs).

<sup>261</sup> See 42 U.S.C. § 1395h(c)(2)(C) (mandating interest for late payments). From January 2021 through June 2021, the interest rate on late payments was 0.875%. Prompt Payment Interest Rate; Contract Disputes Act, 86 Fed. Reg. 7,457, 7,458 (Jan. 28, 2021).

<sup>262</sup> See Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, 36 HEALTH AFFS. 1530, 1531 (2017) (discussing the trends of increasing concentration in health care markets, especially among primary care physicians).

<sup>263</sup> BARAK D. RICHMAN, AM. ENTER. INST., BEYOND REPEAL AND REPLACE: CONCENTRATION IN HEALTH CARE MARKETS: CHRONIC PROBLEMS AND BETTER SOLUTIONS 3–4 (2012), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2163749](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2163749) [<https://perma.cc/9HB5-EFXU>] (describing market concentration and its effect on health care prices).

might also face solvency challenges themselves as a result of disrupted reimbursement—though as discussed above, this impact would be reduced by the fact that the HI Trust Fund is the source of only part of Medicare Advantage plans' Medicare payments.

Stepping back, the general trend that emerges from the broad range of harms likely to stem from Medicare insolvency is that those harms would be unfairly distributed. They would be borne disproportionately by certain providers, patients, and communities, based on their wealth and location, rather than any considered design. Hospitals serving higher proportions of low-income beneficiaries, as well as sole community and rural hospitals, would likely be put out of business, as they rely heavily on Medicare revenues.<sup>264</sup> Provider cuts to charitable care and efforts to recoup revenues through aggressive debt collection practices would fall most heavily on financially distressed patients,<sup>265</sup> as would increases in private-sector insurance rates.<sup>266</sup> Further, increased concentration in health care markets fueled by provider insolvencies, exits, and well-resourced providers' advantage in weathering a disruption would exacerbate the distributional slant of the market concentration's harms described by Professor Clark Havighurst and Professor Barak Richman.<sup>267</sup>

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 judicial determination of rights and responsibilities, as well as the costs associated with the transition. The law could fully resolve all open questions presented by insolvency, including whether claimants would be entitled to payment from general revenues of stat-

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<sup>264</sup> See Matthew Manary, Richard Staelin, William Boulding & Seth W. Glickman, *Payer Mix & Financial Health Drive Hospital Quality: Implications for Value-Based Reimbursement Policies*, 1 BEHAV. SCI. & POL'Y, no. 1, 2015, at 87, 91–92, [https://behavioralpolicy.org/wp-content/uploads/2017/05/bsp\\_vol1issue1\\_web.pdf](https://behavioralpolicy.org/wp-content/uploads/2017/05/bsp_vol1issue1_web.pdf) [<https://perma.cc/M9WQ-UR69>] (finding that hospital financial outcomes are 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, Will Have to Cut Future Spending*, HEALTHCARE DIVE (Dec. 21, 2020), <https://www.healthcarediver.com/news/safety-net-hospitals-hit-particularly-hard-by-covid-19-cut-spending/592520/> [<https://perma.cc/SAJ4-4DZ7>] (noting that “safety net hospitals” are especially dependent on Medicare and Medicaid payments).

<sup>265</sup> Buck, *supra* note 257, at 211, 219 (outlining patient concerns of bankruptcy as a result of medical expenses and discussing that hospital debt may cause patients to lose housing or fail to continue seeking out medical care).

<sup>266</sup> 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/> [<https://perma.cc/F8ZF-KHAN>] (“Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty.”).

<sup>267</sup> See generally Havighurst & Richman, *supra* note 79 (describing the adverse distributive impacts of concentration in health care markets).

utorily-mandated amounts if the trust fund became insolvent. This would result in no transition costs at all—if claimants were guaranteed the payments they are likely entitled to under current law, then the transition would be seamless and insolvency harms avoided entirely. Even if the question of Judgment Fund liability was unresolved, setting the other aspects of Medicare bankruptcy in advance would allow claimants to sue as soon as insolvency arrived, streamlining litigation and allowing for a much quicker judicial resolution. For example, if HHS simply issued a regulation in advance setting forth its planned approach, that regulation could serve as a vehicle for litigation. This would predictably permit litigation to proceed years before it could if HHS waited until after insolvency to announce and implement a policy.<sup>268</sup>

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 Section II.C, the agency’s legal authority to provide such insulation through guidance, last-minute adjudication, or emergency rulemaking is constrained by the Medicare statute as interpreted in 2019 by the United States Supreme Court in *Azar v. Allina Health Services*.<sup>269</sup> This sets up a major advantage of advance establishment of Medicare bankruptcy rules. It allows HHS (through notice and comment rulemaking) or Congress (through legislation) far greater leeway in insulating the most vulnerable or deserving claimants from the effects of insolvency.<sup>270</sup>

Third, establishing Medicare bankruptcy policy in advance would be fairer procedurally because legal policymaking processes are more participatory than policy by agency fiat. Health justice “seek[s] to foster collective deliberation on . . . the reimbursement policies that will apply to various types of services and practitioners—as an expression and obligation of citizenship.”<sup>271</sup> Similarly, administrative law values have long emphasized the importance of policymaking processes that offer opportunities for participation and accounta-

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<sup>268</sup> See *supra* notes 151–155 and accompanying text (contrasting the timeline of litigation challenging Medicare payment regulations to the timeline of litigation challenging Medicare payment delays).

<sup>269</sup> See 139 S. Ct. 1804, 1815–16 (2019) (requiring notice and comment rulemaking in a broader array of circumstances); see also discussion *supra* Section II.C (discussing potential impediments to HHS emergency action while administering Medicare insolvency).

<sup>270</sup> See discussion *supra* Section II.C (discussing the advantages of advanced rulemaking regarding Medicare bankruptcy).

<sup>271</sup> Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public’s Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 888 (2016).

bility.<sup>272</sup> 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. This holds true even if we relax the assumption that status quo Medicare bankruptcy would follow the most likely path—delayed payments, announced at the last minute, leading after years of legal battles 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.<sup>273</sup> If this were the 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.

If neither the courts nor Congress offered relief, the period when providers learned they would be forced to endure permanent reductions in necessary sources of revenue would not directly impact the severity or distribution of resulting harms.<sup>274</sup> Even in such a case, however, Medicare bankruptcy pursuant to rules set in advance would be fairer because HHS would still be able to insulate financially vulnerable providers and insurers, as well as those meeting critical community needs. 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 could still consider a broad range of views in forming this “new structure” of the Medicare program.

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<sup>272</sup> See, e.g., Gillian E. Metzger, *Administrative Constitutionalism*, 91 TEX. L. REV. 1897, 1928–29 (2013) (considering the value of participation); Figley, *supra* note 203, at 208 (expressing concerns about Judgment Fund appropriation from the perspective of administrative law values).

<sup>273</sup> 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), *aff'd*, 206 F.3d 1212 (D.C. Cir. 2000), *enforcement denied sub nom.* *Pigford v. Schafer*, 536 F. Supp. 2d 1 (D.D.C. 2008).

<sup>274</sup> 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. THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, *supra* note 66, at 41 (“[T]he 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, in this scenario, unexpectedly become responsible for, exacerbating harms for hospitals who banked on a favorable result in Judgment Fund litigation.

### B. Startling the Frog

Readers may at this point begin to wonder whether it is not just possible but likely that Congress will decline to take major action to address the solvency of Medicare unless and until courts finally address Judgment Fund liability. This 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 following insight: the likelihood that Congress will take action to avoid a funding shortfall depends in part on how much certainty there is about the repercussions of a congressional failure to act.<sup>275</sup> A member’s willingness to address a program’s financial woes—whether by raising taxes, reducing benefits, drawing funds from another program, or borrowing—depends on what they might be blamed for if they refuse to cast that vote.<sup>276</sup> The greater the uncertainty about the consequences of a funding shortfall, the easier it is for the member to transfer blame to whoever resolves that uncertainty—whether the executive branch or the courts.<sup>277</sup> Moreover, uncertain impacts make bargaining failure more likely by fueling behavioral biases, including optimism and myopia, that inhibit compromise.<sup>278</sup>

Although I did not address Medicare directly in my earlier article, *Disappropriation*, the program’s impending insolvency offers a straightforward application of this point. With all the current uncertainty about the consequences of insolvency, a member of Congress could vote down Medicare solvency legislation and argue with a straight face they had done so to protect Medicare beneficiaries from cuts or taxpayers from hikes. Further, such a member could argue that their vote did not actually imperil providers or beneficiaries in their district, even though it led to the program’s insolvency. They might assert, for example, that their 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 expend political capital, either for raising revenue for Medicare or reducing expenditures, might see leaving this question to the executive branch and courts in the first instance as a desirable option. Indeed, that would be the prediction of Professor John Hart Ely’s famous—and oft-evidenced—insight that a congressional desire to shift blame for difficult

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<sup>275</sup> Lawrence, *supra* note 11, at 70 (“[U]ncertainty . . . about consequences increases the likelihood of disappropriation . . .”).

<sup>276</sup> *Id.* at 60–61 (citing David Kamin, *Legislating Crisis*, in *THE TIMING OF LAWMAKING* 34, 34 (Frank Fagan & Saul Levmore eds., 2017)).

<sup>277</sup> *Id.* at 49–50.

<sup>278</sup> *Id.* at 70.

choices fuels statutory delegations and ambiguities.<sup>279</sup> 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 for a politician worried about avoiding accountability for cutting Medicare or other programs, raising taxes, or ballooning the deficit.

At the same time, the lack of any clear deadline for Congress to avert the effects of insolvency would dilute pressure on leadership to bring such a bill to the floor at all.<sup>280</sup> Simultaneously, optimistic providers, expecting success in the courts, might be reluctant to support legislation addressing insolvency that would also adversely impact their reimbursement rates. The result would limit the range of possible insolvency legislation to bills that draw revenue from other programs or that increase taxes, either of which might be blocked by opponents. Instead of a game of chicken, deliberations about whether and how to address the solvency of the Medicare program may 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.<sup>281</sup> 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

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<sup>279</sup> JOHN HART ELY, *DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW* 132 (1980) (first quoting 122 CONG. REC. 31,628 (1976) (statement of Rep. Elliott Levitas); and then quoting *id.* at 31,622 (statement of Rep. Walter Flowers)) (explaining this dynamic). See generally JOSH CHAFETZ, *CONGRESS'S CONSTITUTION: LEGISLATIVE AUTHORITY AND THE SEPARATION OF POWERS* (2017) (describing the importance of expectations about which branch will be blamed in assessing whether shutdowns further executive or legislative power).

<sup>280</sup> 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. See, 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> [<https://perma.cc/D2WM-ZDXV>] (reporting on the lapse of CHIP authorization); Nicholas Wu & 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/> [<https://perma.cc/GQ4F-KVJQ>] (reporting on the failure to reach an agreement on looming 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> [<https://perma.cc/D3WD-E47Q>] (reporting on Democrats' need to address the debt ceiling within the quickly-approaching deadline).

<sup>281</sup> The extent of this effect would depend on the degree to which the new framework answered the open questions described in Part II. See discussion *supra* 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.

resolution of open questions about the government’s obligations and claimants’ rights.<sup>282</sup>

Furthermore, if this Medicare bankruptcy legal framework created a concrete deadline by which congressional action was necessary to avert undesirable impacts, actual insolvency would be less likely. 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 certain date. This would give all involved a clear deadline for congressional action to avert the consequences of the upcoming year’s insolvency—minimizing the confusion entailed in administering insolvency.

Despite these significant benefits of reduced likelihood of insolvency, it is important to note that the effect of clarifying the consequences would not be entirely positive. There could be two categories of cross-cutting effects, one more troubling than the other. The first is that whatever benefits a legal framework for Medicare bankruptcy would have ex-post, openly contemplating the effects of insolvency would increase its likelihood by making that result morally or normatively acceptable. It may be that the possibility of actually allowing the program to become insolvent is seen as unacceptable or extreme, that this taboo is on track to help overcome the current fiscal challenges, 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” of politically-viable policy options, but addressing insolvency explicitly in law would expand that window.<sup>283</sup>

Two considerations diminish the weight of this concern. First, under current law, members of Congress can easily allow Medicare to become insolvent without ever taking action. For this taboo 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 just its subject matter. Many laws address taboo or extreme outcomes—what to do if a person kills

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<sup>282</sup> 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.

<sup>283</sup> See Daniel J. Morgan, *The Overton Window and a Less Dogmatic Approach to Antibiotics*, 70 CLINICAL INFECTIOUS DISEASES 2439, 2439 (2020) (describing Joseph Overton’s “Overton window” as the concept that “there are a range of ideas considered acceptable to the public” and that “[f]or an idea to be politically viable, it needed to be within that range”).



another,<sup>284</sup> what to do if a president commits a felony,<sup>285</sup> and, of course, what to do if a municipality or individual becomes insolvent.<sup>286</sup> Thus, bankruptcy scholars have explained that the extent to which bankruptcy laws lessen the “stigma” surrounding personal financial distress, and therefore increase the likelihood of bankruptcy, depends on the content of those laws, not just their existence.<sup>287</sup> Following that same logic, concerns that addressing Medicare insolvency in law would serve to legitimize it fall flat. Instead, these concerns represent a reason to focus on the prefatory and expressive content of any law addressing Medicare bankruptcy.

A second reason to worry that creating a legal framework might make Medicare insolvency more likely is that, as described in Section III.A, it would reduce the harms and unfairness of insolvency if it comes.<sup>288</sup> Surely 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.<sup>289</sup>

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 legitimate, though normatively fraught. Nevertheless, this assumes that such a framework could not preserve or even increase the deterrent effect of the threat of insolvency. The next section explains why this assumption is incorrect.

### C. Medicare’s Least Cost Avoiders

In *Disappropriation*, I showed that reducing harms associated with congressional failure to fund an entitlement might make that failure more likely because the harms associated with inaction factor into congressional decision-

<sup>284</sup> See, e.g., 18 U.S.C. § 1111 (defining murder); see also Robert Weisberg, *Norms and Criminal Law, and the Norms of Criminal Law Scholarship*, 93 J. CRIM. L. & CRIMINOLOGY 467, 476 (2003) (“[W]hen lawmakers make law, they . . . hope to express certain social or cultural values they attach to that behavior.”).

<sup>285</sup> See, e.g., Restoring and Enforcing Accountability of Presidents (REAP) Act, H.R. 1153, 117th Cong. § 2 (2021) (describing the consequences for a former president’s felony conviction).

<sup>286</sup> See, e.g., Municipal Bankruptcy Act, 11 U.S.C. §§ 901–946 (describing the administration of municipal insolvency).

<sup>287</sup> See Rafael Efrat, *Bankruptcy Stigma: Plausible Causes for Shifting Norms*, 22 EMORY BANKR. DEVS. J. 481, 496–97 (2006) (noting how the Bankruptcy Reform Act of 1978 may have contributed to reduction in stigma surrounding personal bankruptcy by prohibiting discrimination against those who have declared bankruptcy).

<sup>288</sup> See discussion *supra* Section III.A (describing advanced Medicare insolvency planning as harm reduction).

<sup>289</sup> Whether Medicare actually becomes insolvent depends on many factors, the interaction of which might be modeled in different ways. It is hard, however, to imagine a model predicting whether the program will become insolvent in which the associated harms are not a paramount consideration.

making.<sup>290</sup> Accordingly, I encouraged caution about reforms that reduce the seriousness or credibility of the threat of disappropriation, while endorsing unequivocally reforms that diminish the *likelihood*, but not the *threat*, of disappropriation.<sup>291</sup> The benefits of establishing a legal framework to govern Medicare bankruptcy described in the last section—reducing the risk of bargaining failure in Congress—satisfy this criterion. But the benefits of establishing a legal framework described in Section A of this Part—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 impact 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 Medicare has never actually been insolvent.<sup>292</sup> The risk of insolvency has acted as what Professor David Kamin (who is now Deputy Director of President Joseph Biden’s National Economic Council) terms a “crisis device[.]”<sup>293</sup> This legislatively-created trigger forces preemptive action, pushing Congress to regulate on a subject it might otherwise leave alone at a time when it might otherwise do nothing.<sup>294</sup>

If Congress or HHS created a legal framework making insolvency effectively costless for everyone directly involved in the program—such as guaranteeing payment from general treasury revenues if 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 costs.<sup>295</sup> This might well be a good thing, in which case reducing the threat of insolvency is an end to be desired, and is an argument for, not against, legislation reducing insolvency’s costs.<sup>296</sup> This Article

<sup>290</sup> Lawrence, *supra* note 11, at 67 (noting the distinction between durability and entrenchment).

<sup>291</sup> *Id.* at 68–69.

<sup>292</sup> See Jennifer Conley, Note, *Medicare and Medical Tourism: Saving Medicare with a Global Approach to Coverage*, 21 ELDER L.J. 183, 185 (2013) (proposing reforms to “help save the Medicare HI Trust Fund from going bankrupt”); Jost, *Governing Medicare*, *supra* note 79, at 68–69 (describing the prominence of fiscal concerns in Medicare legislation); *supra* notes 56–62 and accompanying text (describing legislation enacted to resolve past solvency crises).

<sup>293</sup> Kamin, *supra* note 276, at 36; see also Lawrence, *supra* note 11, at 60.

<sup>294</sup> Kamin, *supra* note 276, at 35.

<sup>295</sup> MARMOR, *supra* note 8, at 136.

<sup>296</sup> 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 the “moral hazard” described here. See *infra* note 297 and accompanying text.

assumes, however, that insolvency will continue to entail harms, and that the threat of insolvency will continue to play an important role in the program.

The creation of a legal framework governing Medicare bankruptcy presents the chance 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: (1) the short term (by better motivating compromises in Congress necessary to resolve insolvency crises); and (2) the long term (by more powerfully steering Medicare policy to maintain solvency, preventing insolvency crises).

This point requires some unpacking. In theorizing how the risk of insolvency in Medicare might be assigned, it is helpful to conceptualize the insolvency of the Medicare program as analogous to that 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.”<sup>297</sup> This principle asserts that if those who are responsible for the policy direction of a municipality expect to receive the benefits of spending without the costs, the municipality will spend more than it brings in, ultimately leading to insolvency.<sup>298</sup> This concern is the most important source of reluctance among scholars and policymakers for “bail[ing] out” insolvent municipalities.<sup>299</sup> They fear that by helping municipalities facing insolvency, the federal government might inadvertently encourage other municipalities to put themselves in the same position.<sup>300</sup> Thus, a focus of this literature is to find ways “to internalize” the costs of municipal profligacy by directing them toward the voters and politicians responsible for municipal spending and revenue decisions.<sup>301</sup>

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, is the question

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<sup>297</sup> See Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 238 (1996) (“What moral hazard means is that, if you cushion the consequences of bad behavior, then you encourage that bad behavior.” (quoting Jamea K. Glassman, *Drop Budget Fight, Shift to Welfare*, ST. LOUIS POST-DISPATCH, Feb. 11, 1996, at B3)).

<sup>298</sup> Schleicher, *supra* note 27, at 5–6 (discussing the federal government’s options in avoiding state debt dilemmas).

<sup>299</sup> *Id.* at 8.

<sup>300</sup> *Id.*

<sup>301</sup> See Clayton P. Gillette, *Fiscal Federalism, Political Will, and Strategic Use of Municipal Bankruptcy*, 79 U. CHI. L. REV. 281, 287 (2012) (“The current legal structure . . . insulates local decisions from centralized influence and reduces the need for distressed localities to internalize the consequences of fiscal decisions.”).

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 use that risk to combat moral hazard and ultimately make 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 for a risk ex-post should be assigned to whoever is best positioned to manage that risk ex-ante.<sup>302</sup> 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 doubtful that the asset-poor hospitals and financially-distressed patients who would be impacted most by a temporary disruption in Medicare payments under current law are the program’s “least cost avoiders.” In other words, it is doubtful 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.<sup>303</sup> This is especially true considering that Judgment Fund liability, if granted, would ultimately come with a generous payment of interest.<sup>304</sup> Instead, the most acute impacts would be on the least economically-powerful hospitals and providers and, in turn, the low-income patients they serve.<sup>305</sup> 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 prompt congressional compromise and motivate reforms to protect the program’s long-term solvency if it were directed instead at all hospitals and insurers, regardless of financial status. There would be a similar result were it expanded to target pharmaceutical

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<sup>302</sup> See, e.g., Guido Calabresi & Jon T. Hirschoff, *Toward a Test for Strict Liability in Torts*, 81 YALE L.J. 1055, 1060 (1972) (“Liability would be placed on the party initially free of responsibility only if the *decider* found the benefits of avoidance (*i.e.*, not incurring the cost of the accident) to be greater than the costs of such avoidance to that party.”).

<sup>303</sup> See *supra* notes 264–267 and accompanying text (noting the harms of abrupt Medicare insolvency would be unequally born by precarious providers serving vulnerable communities).

<sup>304</sup> See 42 U.S.C. § 1395h(c)(2)(C) (charging interest to HHS for delayed Medicare payments to providers).

<sup>305</sup> See discussion *supra* Section III.A (discussing the inequitable distribution of harms resulting from an unplanned Medicare insolvency).

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, it should be the economically-powerful health care industry players whose lobbying influences the short- and long-term course of the program. These include the hospital and nursing home industry, the health insurance industry, and the pharmaceutical and device manufacturing industry.

These 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.<sup>306</sup> The significant influence they play in the development of health policy has been studied in depth by historians,<sup>307</sup> political scientists,<sup>308</sup> and law professors.<sup>309</sup>

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 pharmaceutical companies might also be given “skin in the game” of Medicare’s solvency. This might look like the promise of a positive, upward adjustment in their payment rates, for example, to be triggered if, and only if, the program’s solvency was projected to extend past ten years.<sup>310</sup>

A positive adjustment would have significant benefits from a policy perspective, as well. Numerous scholars have noted that reducing health care costs will be impossible unless pharmaceutical companies, hospitals, and other health care industry players can be incentivized to invest in technologies and reforms that make health care cheaper in the long term.<sup>311</sup> Giving these indus-

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<sup>306</sup> Erin Duffin, *Leading Lobbying Industries in the United States in 2020*, by *Total Lobbying Spending*, STATISTA (Mar. 4, 2021), <https://www.statista.com/statistics/257364/top-lobbying-industries-in-the-us/> [<https://perma.cc/8RLB-T986>].

<sup>307</sup> See, e.g., PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 401–02 (1982).

<sup>308</sup> See, e.g., JACOBS & SKOCPOL, *supra* note 83, at 144 (describing the role of health care industry lobbyists in drafting the Affordable Care Act and then in the development of regulations implementing its provisions, and their focus on costs); OBERLANDER, *supra* note 9.

<sup>309</sup> See, e.g., David A. Hyman, *Follow the Money: Money Matters in Health Care, Just Like in Everything Else*, 36 AM. J.L. & MED. 370, 371 (2010) (arguing that “misaligned economic incentives” are to blame for the current state of the Medicare program).

<sup>310</sup> 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.

<sup>311</sup> See Nicholas Bagley & Rachel E. Sachs, *Limiting State Flexibility in Drug Pricing*, 379 NEW ENG. J. MED. 1002, 1003 (2018) (describing how HHS’s denial of Massachusetts’s request to exclude some drugs from Medicaid coverage was justified ex-post by reasoning eerily similar to that of the pharmaceutical industry who also opposed the request); Bagley, *supra* note 20, at 533 (“[T]he urgent and interesting question is . . . [H]ow 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.”); Sukhatme & Bloche, *supra* note 65, at 992 (arguing that health care cost growth is driven in part by lack of innovation incentives for cost-reducing drugs and technologies); William M. Sage, *Be a Transfor-*

tries’ 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.<sup>312</sup> 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 the impact of insolvency on Medicare payments in advance would naturally re-direct its harms by reducing temporary disruption to the extent it 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. These might include a modest reduction in reimbursement rates for the duration of insolvency (akin to sequester), an automatic reduction of rates necessary to protect the program’s solvency (or perhaps automatically raising payroll taxes at the same time),<sup>313</sup> 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 more effective than the current uncertain threat as a tool to promote compromise and cost control. Despite this, upon further inspection, neither actually undermines the case for such a framework.

To start, skeptics might argue that the extent to which tying hospital, insurance, and pharmaceutical reimbursements to Medicare’s solvency would alter lobbying behavior—let alone the effects of that lobbying—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.

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*mational 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/> [<https://perma.cc/4CLA-YKJN>] (“The U.S. health care system will not change without permission from health professionals, especially America’s physicians.”).

<sup>312</sup> This approach builds on proposals by Professor Nicholas Bagley and Professor Isaac 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 20, at 521–23. Professor Buck proposes that providers be understood to have a fiduciary duty to Medicare as a payer. Buck, *supra* note 20, at 1065. 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.

<sup>313</sup> 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 26 U.S.C. § 36B(b)(3)(A)(ii)(III) (providing an indexing provision triggered “only if” ACA subsidy costs “exceed[] an amount equal to 0.504 percent of the [GDP] for the preceding calendar year”).

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 to generate political buy-in for the program from constituents and voters,<sup>314</sup> and this is believed to have worked.<sup>315</sup> The “doc fix”—a statutorily-scheduled cut to provider reimbursements until its repeal in 2015—saw the health care industry lobbying Congress every year for an extension through legislation that served to force compromise from the industry.<sup>316</sup> The Medicare Modernization Act expanded privatization of Medicare, resulting in a powerful lobby of insurers working to privatize Medicare further or make insurer payments more generous.<sup>317</sup> And the creation of the “Recovery Audit Contractor” (RAC) program very clearly illustrated the endogeneity of law to economics and economics to politics. This pilot program created RACs, private entities

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<sup>314</sup> As President Franklin D. Roosevelt put it regarding the Social Security trust fund financing structure on which Medicare's is based: “We put those payroll contributions there so as to give the contributors a legal, moral, and political right to collect their pension[s] . . .” JOST, *supra* note 125, at 50 (quoting President Franklin D. Roosevelt) (citing 2 ARTHUR M. SCHLESINGER, JR., *THE AGE OF ROOSEVELT: THE COMING OF THE NEW DEAL* 308–09 (1959)); OBERLANDER, *supra* note 9, at 80 (quoting same); *see also* JOST, *supra* note 125, at 50 (“Protecting the Medicare program from future political attack was one factor motivating the trust fund financing of the program.” (citing ERIC M. PATASHNIK, *PUTTING TRUST IN THE US BUDGET: FEDERAL TRUST FUNDS AND THE POLITICS OF COMMITMENT* 96 (2000))).

<sup>315</sup> JOST, *supra* note 125, at 51 (“[T]rust 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.” (citing Eric Patashnik & Julian Zelizer, *Paying for Medicare: Benefits, Budgets, and Wilbur Mills's Policy Legacy*, 26 J. HEALTH POL., POL'Y & L. 7 (2001))).

<sup>316</sup> *See* Stuart Guterman, *The “Doc Fix”—Another Missed Opportunity*, 370 NEW ENG. J. MED. 2261, 2262–63 (2014) (describing how numerous small cuts were imposed “to offset the cost” of year-long delay in “[d]oc [f]ix” in 2014); J. Michael McWilliams, *MACRA: Big Fix or Big Problem?*, 167 ANNALS INTERNAL MED. 122, 122 (2017) (noting that significant permanent change in Medicare reimbursement, MACRA, was enacted in exchange for change in law permanently eliminating the “doc fix”).

<sup>317</sup> *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/> [<https://perma.cc/9RD4-KMNB>] (“The top 10 Medicare Advantage companies in terms of enrollment unleashed as many as 145 lobbyists in 2013 . . . [Trade group] AHIP spent nearly \$2.5 million in the first quarter of 2013 lobbying senators and congressmen on health care issues . . .”). That said, a group's incentive to lobby for changes that benefit its members depends on a variety of factors. *See generally* MANCUR OLSON, JR., *THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS* (1965) (discussing the collective action challenge to interest group mobilization and approaches by which that challenge may be overcome as well as pointing to the AMA as an organization that surmounted collective action challenges through provision of selective benefits). Additionally, 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*, MOD. HEALTHCARE (Jan. 9, 2016), <https://www.modernhealthcare.com/article/20160109/MAGAZINE/301099969/big-insurer-defections-signal-ahip-s-fading-clout> [<https://perma.cc/W2U7-B92P>] (noting the departures of Aetna, Inc. and United Healthcare, Inc. from the trade group).

promised a share of any hospital overpayments they identify.<sup>318</sup> When the time came to consider extending the program, the RAC lobby had a seat at the table, arguing for an extension.<sup>319</sup>

Taking a different tack, a reader persuaded that Medicare bankruptcy rules could more effectively target the threat of insolvency may doubt that the economically powerful industry players can be reined in, given their power. Would not hospitals, insurers, and pharmaceutical companies ensure that they would be better off, not worse, under any Medicare bankruptcy framework? In other words, does this possibility run afoul of Professor Eric Posner’s and Professor Adrian Vermeule’s “inside/outside fallacy,” which highlights the difficulty of effectuating public-interested changes through a system governed by self-interested actors?<sup>320</sup>

As a preliminary matter, this objection is a reason to worry that a Medicare bankruptcy framework tailored to address the threat of insolvency may not come to fruition, but it is not a reason not to try. This objection also assumes that Medicare bankruptcy rules would make health care industry players worse off, but that is not necessarily true. As illustrated by the positive solvency adjustment, such rules need not necessarily *reduce* the expected profits of

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<sup>318</sup> Recovery Audit Contractors (RACs) are private entities that enter contracts with Medicare to review provider claims and identify overpayments. OFF. OF THE INSPECTOR GEN., DEP’T OF HEALTH & HUM. SERVS., *MEDICARE RECOVERY AUDIT: CONTRACTORS AND CMS’S ACTIONS TO ADDRESS IMPROPER PAYMENTS, REFERRALS OF POTENTIAL FRAUD, AND PERFORMANCE 1* (2013). For every overpayment an RAC identifies, it receives a fee. *Id.* at 2. RACs were created by Congress as an experimental way to identify and address waste in the Medicare program. *Id.* at 1. 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 U.S. S. SPECIAL COMM. ON AGING, 113TH CONG, *IMPROVING AUDITS: HOW WE CAN STRENGTHEN THE MEDICARE PROGRAM FOR FUTURE GENERATIONS 19–22* (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* Press Release, Council for Medicare Integrity, *FY2015 RAC Report to Congress: Recoveries Decline Due to Program Pause* (Dec. 12, 2016), [<https://perma.cc/VMU4-XU59>] (noting that “Medicare recoveries decreased by 91 percent due to constraints placed on the RAC program”).

<sup>319</sup> 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*, *INSIDE CMS*, Dec. 18, 2014, at 1, 1 (“[T]he American Coalition for Healthcare Claims Integrity, which represents RACs, slammed appropriators for being sympathetic to providers . . .”).

<sup>320</sup> Eric A. Posner & Adrian Vermeule, *Inside or Outside the System?*, 80 U. CHI. L. REV. 1743, 1745, 1789, 1796 (2013) (noting that in proposing changes to a system to alter the behavior of actors within that system, an “analyst must then confront the . . . question whether any relevant actors have both the capacity and motivation to change the rules of the system”).



hospitals, pharmaceutical manufacturers, or insurers—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 into rules governing the administration of insolvency, but again this is not necessarily true. Industry players' ability to win policy fights, besting counteracting fiscal and beneficiary interests, has historically been at its lowest ebb in the midst of insolvency crises.<sup>321</sup> Every insolvency crisis offers momentum for administrative change.<sup>322</sup> It also offers an opportunity for significant legislative change in Medicare that, absent reforms to the filibuster, an electoral landslide, or a fix capable of passage through reconciliation, would be difficult to achieve.<sup>323</sup> Special interests with the power to block structural "change" may well lack the power to dictate its terms if it is forced upon them.<sup>324</sup> As many key levers of power in the federal system, from the filibuster to rulemaking, operate as "vetogates," they give those who control them the ability to block changes from the status quo, not to steer changes when they must be made.<sup>325</sup> Medicare's current insolvency crisis therefore may offer an opportunity for reforms that might be impossible in a non-crisis environment.

Finally, looking beyond Medicare, the possibility elaborated in this Part represents a novel means of overcoming a thorny problem at the heart of much scholarship on law and political economy. In short, it is an opportunity to overcome the distorting influence of economic interests in the policymaking and political processes.<sup>326</sup> Scholars are pessimistic about the prospects of preventing economically powerful interests from influencing regulatory and legislative processes.<sup>327</sup> Connecting the revenues of health care industry players to Medicare costs would accept the influence of hospitals, insurers, and pharmaceutical manufacturers in the political and regulatory processes as inevitable.

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<sup>321</sup> JOST, *supra* note 125, at 78.

<sup>322</sup> See generally Frank & Neuman, *supra* note 7 (recounting past instances of Medicare insolvency and suggesting solutions for the next crop of reforms).

<sup>323</sup> See generally MOLLY E. REYNOLDS, EXCEPTIONS TO THE RULE: THE POLITICS OF FILIBUSTER LIMITATIONS IN THE U.S. SENATE (2017) (evaluating circumstances in which special rules allows the senate majority to bypass the filibuster).

<sup>324</sup> See Jost, *Governing Medicare*, *supra* note 79, at 80 ("[T]hough interest groups generally have limited success in effectuating Medicare policy initiatives, they are much more successful in blocking or delaying change." (first citing CAROL S. WEISSERT & WILLIAM G. WEISSERT, GOVERNING HEALTH: THE POLITICS OF HEALTH POLICY 104 (1996); and then citing KAY SCHLOZMAN & JOHN T. TIERNEY, ORGANIZED INTERESTS AND AMERICAN DEMOCRACY (1986))).

<sup>325</sup> See William N. Eskridge, Jr., *Vetogates*, *Chevron*, *Preemption*, 83 NOTRE DAME L. REV. 1441, 1443–46 (2008) (identifying nine "vetogates" throughout the legislative process).

<sup>326</sup> See generally Britton-Purdy et al., *supra* note 23 (describing the field).

<sup>327</sup> See, 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 the powerful to utilize alternative such means).

Simultaneously, it would temper 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, “[l]egal [p]rocess” question: Who decides?<sup>328</sup> What role should HHS, Congress, and the courts play in establishing rules for Medicare bankruptcy? Section A explains that although any clarification is helpful, from the standpoint of the likelihood, harm, and effectiveness of insolvency, it would be advantageous for Congress, rather than HHS, to set Medicare bankruptcy rules.<sup>329</sup> Section 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.<sup>330</sup>

##### *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 or all of the open questions discussed in Part II.<sup>331</sup>

Either regulation or legislation would reduce uncertainty about the effects of Medicare bankruptcy. This would both encourage whoever stands to lose during insolvency to work to prevent that result and reduce the risk of failure in bargaining over a solution.<sup>332</sup> Either process would also mitigate the confusion and chaos that would result from insolvency as well as the attendant harm to Americans’ confidence in their institutions, Medicare in particular.<sup>333</sup> 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.<sup>334</sup>

At this writing, insolvency is imminent, so the regulatory course is most likely the path of least resistance. The agency should proceed with setting forth

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<sup>328</sup> See Gil Seinfeld, *Article I, Article III, and the Limits of Enumeration*, 108 MICH. L. REV. 1389, 1450 (2010) (citing HENRY M. HART & HERBERT WECHSLER, *THE FEDERAL COURTS AND THE FEDERAL SYSTEM*) (explaining that “a defining feature of the Hart & Wechsler paradigm and the Legal Process school is that they . . . focus . . . on second-order questions of ‘who decides?’” (citing Richard H. Fallon, Jr., *Reflections on the Hart and Wechsler Paradigm*, 47 VAND. L. REV. 953, 964 (1994))).

<sup>329</sup> See *infra* notes 331–344 and accompanying text.

<sup>330</sup> See *infra* notes 345–363 and accompanying text.

<sup>331</sup> See discussion *supra* Part II.

<sup>332</sup> See discussion *supra* Sections III.B, III.C.

<sup>333</sup> See discussion *supra* Section III.A.

<sup>334</sup> See discussion *supra* Section III.A.

a Medicare bankruptcy plan by notice and comment rulemaking as soon as possible. In any event it should be no later than the annual spring and summer payment notices it will issue in the fiscal year preceding insolvency.<sup>335</sup> At the very least, doing so would make the deadline for congressional action and the consequences of inaction clear to Congress and the public.

Whether Congress enacts a short-term patch of one or two years or a longer-term fix, it should include a provision establishing a failsafe framework for administering insolvency, should it arise in the future. It should do so regardless of whether the agency promulgates a rule governing insolvency. 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 is the possibility of change. Regulations can be changed more easily than legislation, and often are when presidential administrations transition.<sup>336</sup> The possibility of change would dilute the ex-ante incentive effects of a Medicare bankruptcy regulation. This is because the incentive to act today to avoid a legal outcome tomorrow is only as strong as the actor's expectation that the law will still be in effect tomorrow.<sup>337</sup> Second is the likelihood of legal challenge. Regulations carry a risk of invalidation in court on statutory authority or administrative law grounds. This threat is impossible to eliminate until insolvency actually occurs, due to federal court justiciability doctrines.<sup>338</sup> Legislation can be challenged only on constitutional grounds, and so carries much less litigation risk.

Further, legislation brings legitimacy that regulation lacks. Legislation is made through the constitutionally-appointed mechanism of bicameral approval by elected representatives, followed by presentment to an elected President—the hallmark of democratic accountability.<sup>339</sup> Although the transparency and

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<sup>335</sup> See 42 U.S.C. § 1395ww(j)(5) (requiring final hospital payment notice to be “publi[shed] in the Federal Register[] on or before August 1 before each fiscal year,” necessitating notice of a proposed rule in spring); *id.* § 1395w-23(b)(1)(B)(i)–(2) (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”); see also *supra* note 123 and accompanying text.

<sup>336</sup> See, e.g., Exec. Order No. 14,009, 86 Fed. Reg. 7793, 7793 (Jan. 28, 2021) (ordering agencies to “review all existing regulations” for possible changes the day after President Biden’s inauguration). Statutes can be changed, of course, but unlike a regulation, statutory changes require action not only by the executive branch but also the House and the Senate. See U.S. CONST. art. I, § 7 (requiring action by both houses of the legislature as well as the executive branch to make law).

<sup>337</sup> David S. Law, *The Paradox of Omnipotence: Courts, Constitutions, and Commitments*, 40 GA. L. REV. 407, 415–16 (2006) (describing a need “to ensure the government’s ability to make persuasive commitments”).

<sup>338</sup> See *supra* notes 151–155 and accompanying text (describing the ripeness doctrine).

<sup>339</sup> U.S. CONST. art. I, § 7 (“Every Bill which shall have passed the House of Representatives and the Senate, shall, before it becomes a Law, be presented to the President of the United States; If he ap-

regularity of this process varies greatly,<sup>340</sup> legislation carries inherent legitimacy by virtue of these democratic and constitutional bona fides.<sup>341</sup>

The legitimacy benefits of legislation would be especially important for Medicare bankruptcy 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 that this question demands. These include weighing the interests of younger generations, taxpayers, and other programs, on the one hand, and the interests of Medicare claimants and beneficiaries, on the other. HHS’s expertise does not include the resolution of such inter-generational, inter-class, and inter-industry tradeoffs.<sup>342</sup> Thus, although the details of Medicare bankruptcy certainly raise technical questions well-suited for HHS—questions that Congress could well leave to the agency—the broad contours do not.

Finally, legislation is preferable to regulation because Congress could do things that HHS could not 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.<sup>343</sup> Additionally, Congress could insulate the most vulnerable hospitals and communities, whereas HHS would be more limited in doing so.<sup>344</sup>

### 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.<sup>345</sup> Under current law, insolvency would leave courts with a lot of work to do. Important questions courts might face include: (1) HHS’s authority to adjust payment rates for insolvency; (2) its authority to triage among claimants; (3)

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prove he shall sign it, but if not he shall return it, with his Objections to that House in which it shall have originated, who shall enter the Objections at large on their Journal, and proceed to reconsider it.”).

<sup>340</sup> See Gluck et al., *supra* note 133, at 1865 (noting “great variation” in pathways legislation takes to enactment).

<sup>341</sup> See Lawrence B. Solum, *Procedural Justice*, 78 S. CAL. L. REV. 181, 276 (2004) (“The connection between participation and legislative legitimacy is a strong one.”).

<sup>342</sup> Cf. *Indus. Union Dep’t, AFL-CIO v. Am. Petroleum Inst.*, 448 U.S. 607, 687 (1980) (Rehnquist, J., concurring) (discussing reasons “fundamental policy” judgments should be made by Congress rather than agencies).

<sup>343</sup> See *supra* notes 297–305 and accompanying text (using the concepts of least cost avoider and moral hazard to determine proper risk allocation in Medicare bankruptcy).

<sup>344</sup> 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 Medicare Parts D and B for the first time. See *supra* notes 206–207 and accompanying text (describing extent of and limitations on HHS adjustment authority).

<sup>345</sup> See discussion *supra* Part II (noting that courts have little guidance in administering insolvency at present).

the availability of judicial relief; (4) which court would hear insolvency claims; and (5) the applicability of various justiciability doctrines to different potential agency choices.<sup>346</sup> Although Part II predicted how courts would resolve these open questions using interpretation and precedent, the lack of explicit law made those predictions unavoidably tentative.<sup>347</sup>

As explained by this Article, uncertainty is itself a problem, and reducing it would make Medicare insolvency less unfair, less harmful, less likely, and more effective. Although HHS and Congress must do the important work to reduce the uncertainty surrounding Medicare bankruptcy, courts nonetheless can help by respecting predictability as a particularly important value in the Medicare program. Specifically, in resolving Medicare controversies, courts should consider whether the precedents they set will make Medicare's administration more predictable in the future, and should favor doctrines 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 existing doctrinal balancing tests.<sup>348</sup> The value of predictability can also be inferred from the structure of the Medicare statute.<sup>349</sup> As I have written elsewhere, Congress relinquishes its "power of the purse" when it creates a mandatory entitlement like Medicare, so choosing to do so manifests a congressional intent to prioritize reliance.<sup>350</sup> Uncertainty about the existence or scope of rights and obligations under the statute undermines reliance, whereas 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."<sup>351</sup>

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<sup>346</sup> See discussion *supra* Part II (describing the important determinations courts will most likely be faced with making while administering a Medicare insolvency).

<sup>347</sup> See discussion *supra* Part II (conceding that a lack of explicit guidance makes any predictions regarding the outcome of litigation purely speculative).

<sup>348</sup> Predictability is directly relevant to the ripeness doctrine's "hardship to the parties of withholding court consideration." *Abbott Lab's v. Gardner*, 387 U.S. 136, 149 (1967), *abrogated by Califano v. Sanders*, 430 U.S. 99 (1977); see discussion *supra* Section III.A (describing the harms of a delay in resolution). And the Supreme Court in *Bowen v. Massachusetts* 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. 487 U.S. 879, 905 (1988) (finding that prospective relief was necessary in light of the "complex ongoing relationship between" the states and the federal government).

<sup>349</sup> See, e.g., 42 U.S.C. § 1395g(a) (requiring payment to providers irrespective of congressional appropriation); *id.* § 1395u(c)(2) (mandating the timely payment of claims).

<sup>350</sup> See Matthew B. Lawrence, *Congress's Domain: Appropriations, Time, and Chevron*, 70 DUKE L.J. 1057, 1073, 1077, 1093 (2021) ("But when Congress creates a permanent appropriation, it destroys that power to refuse funding as it applies to the subject of the appropriation.").

<sup>351</sup> *Knopf v. Esposito*, No. 17cv5833, 2021 WL 867584, at \*3 (S.D.N.Y. Mar. 5, 2021) (first citing *Ramos v. Louisiana*, 140 S. Ct. 1390, 1403 (2020); then citing *Davis v. Blige*, 505 F.3d 90,

This predictability criterion may seem abstract compared to the prior discussion in this Article. Yet, this is a necessary reflection of how courts bound by the rule of law would engage with questions about the modalities of doctrinal and interpretive argument. It would, despite its abstraction, have concrete, determinative implications for the adjudication of individual Medicare controversies, as well as for the program’s potential insolvency.

Contrasting two looming Supreme Court cases illustrates this point. In July 2021, the United States Supreme Court surprised the health policy world by taking up two significant Medicare cases that it later heard in fall 2021: *Becerra v. Empire Health Foundation (Empire Health)*, and *American Hospital Ass’n v. Becerra (AHA)*.<sup>352</sup> *Empire Health* challenges HHS’s calculation of Disproportionate Share Hospital (DSH) payments,<sup>353</sup> and *AHA* challenges HHS’s adjustment of 340B payments to hospitals.<sup>354</sup> Neither *Empire Health* nor *AHA* is specifically about Medicare bankruptcy. Even so, the Supreme Court’s resolution of a key question regarding the *Chevron* deference in Medicare could profoundly influence the likelihood and course of insolvency, as well as 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 cases to invalidate or hobble the doctrine.<sup>355</sup> This line of thinking assumes that *Chevron* applies across-the-board to the Medicare statute. Support for this assumption comes from circuit court statements and decisions applying *Chevron* to interpretations of the Medicare statute, or even indicating that heightened deference is owed to such interpreta-

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104–05 (2d Cir. 2007); then citing *Manning v. Utils. Mut. Ins. Co.*, 254 F.3d 387, 398 (2d Cir. 2001); then citing *Gregory v. Chehi*, 843 F.2d 111, 116 (3d Cir. 1988); and then citing *Deutsche Bank Nat’l Tr. Co. v. Barclays Bank PLC*, 140 N.E.3d 511, 518 (N.Y. 2019)) (“[L]itigation is less expensive and more efficient when there is predictability . . . .”); see also Amanda L. Tyler, *Continuity, Coherence, and the Canons*, 99 NW. U. L. REV. 1389, 1461 (2005) (endorsing “consistent[] appl[ication of] interpretive guides that advance continuity and coherence”). See generally Evan H. Caminker, *Precedent and Prediction: The Forward-Looking Aspects of Inferior Court Decisionmaking*, 73 TEX. L. REV. 1 (1994) (recommending that courts focus on predictability in developing jurisprudence).

<sup>352</sup> Thomas Barker, *Supreme Court Will Hear Several Health Care Cases in 2022 Term*, JDSUPRA (July 20, 2021), <https://www.jdsupra.com/legalnews/supreme-court-will-hear-several-health-7051728/> [<https://perma.cc/5XUJ-RXY2>] (reporting on cases the Supreme Court has scheduled for the 2022 term); see also *Empire Health Found. v. Azar*, 958 F.3d 873 (9th Cir., 2020), cert. granted sub nom. *Becerra v. Empire Health Found.*, 141 S. Ct. 2883 (2021); *Am. Hosp. Ass’n v. Azar*, 967 F.3d 818 (D.C. Cir. 2020), cert. granted sub nom. *Am. Hosp. Ass’n v. Becerra*, 141 S. Ct. 2883 (2021).

<sup>353</sup> See generally 958 F.3d at 873.

<sup>354</sup> See generally 967 F.3d at 818.

<sup>355</sup> Lydia Wheeler, *Chevron Deference Scope Tested in Supreme Court Medicare Case*, BLOOMBERG L. (May 21, 2021), <https://news.bloomberglaw.com/health-law-and-business/high-court-medicare-payments-case-challenges-agency-deference> [<https://perma.cc/RS6B-UEGA>].

tions.<sup>356</sup> As I explain in *Congress's 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.<sup>357</sup>

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.<sup>358</sup> This is the sort of question whose resolution could have implications for the \$5.3 trillion dollar Judgment Fund question.<sup>359</sup> As to that question, deference would undermine predictability. Judicial deference regarding the Medicare "entitlement," applied in the case of insolvency, would mean that the availability of the judgment fund—and so the future of the Medicare program—could change from administration to administration. It may even become a partisan question in future elections. Deference to the agency's resolution of that question would thereby increase and prolong the uncertainty surrounding the effects of insolvency. It would not eliminate the possibility of courts rejecting the agency's resolution, but would ensure that, if the courts accepted it, that interpretation would remain subject to change by the executive branch at any time.<sup>360</sup>

Meanwhile, *AHA* hinges on the meaning of a statutory condition on the agency's authority to set reimbursement rates for hospitals participating in the 340B drug discount program.<sup>361</sup> This case presents potential future implications for the agency's claimant triage authority. If deference is *unavailable* to the agency when it exercises explicit authority, it would be substantially limited in its ability to insulate claimants from the effects of insolvency, and to

<sup>356</sup> See, 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 . . ." (quoting *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994))).

<sup>357</sup> Lawrence, *supra* note 350, at 1106 ("[P]ermanent appropriations provisions shrink Congress's domain.").

<sup>358</sup> See 958 F.3d at 885–86 (analyzing and interpreting the meaning of the words "entitled to" within 42 U.S.C. § 1395ww(d)(5)(F)(vi)).

<sup>359</sup> See discussion *supra* Section II.C (contemplating whether the Judgment Fund might be available to satisfy Medicare claims during insolvency).

<sup>360</sup> See *King v. Burwell*, 576 U.S. 473, 485–86 (2015) (refusing deference to the agency interpretation of the ACA on the "question of deep 'economic and political significance'" that was "central to [the] statutory scheme" (quoting *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 324 (2014))).

<sup>361</sup> See *generally* *Am. Hosp. Ass'n v. Azar*, 967 F.3d 818 (D.C. Cir. 2020), *cert. granted sub nom. Am. Hosp. Ass'n v. Becerra*, 141 S. Ct. 2883 (2021). 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 survey data." § 1395l(t)(14)(A)(iii)(I); see *Am. Hosp. Ass'n*, 967 F.3d at 828 ("[T]he sole question before us is whether HHS had statutory authority to . . . '[A]djust[]' the amounts 'as necessary for purposes of this paragraph.'" (quoting 42 U.S.C. § 1395l(t)(14)(A)(iii)(II))).

reduce the harms of insolvency by addressing it through ex-ante rulemaking.<sup>362</sup> 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 the odds of judicial invalidation would be greatly reduced when the agency exercises that authority.

The predictability criterion, therefore, 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, 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 both *AHA* and *Empire Health*, grounded in inferences about congressional intent drawn from the Medicare statute, would honor the Court’s instruction in *United States v. Mead Corp.* “to tailor deference to variety.”<sup>363</sup> It would also allow the Court to resolve both cases on Medicare-specific grounds consistent with *Mead* that would not require the Court to affirm, reject, or otherwise weigh in on the future of *Chevron* more generally. Finally, it would begin to shift the role of courts in the development of Medicare from wildcard (and one-way ratchet) to peacemaker.

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<sup>362</sup> See discussion *supra* Sections II.A, II.C (describing agency statutory authorities).

<sup>363</sup> 533 U.S. 218, 236 (2001) (first citing *Christensen v. Harris Cnty.*, 529 U.S. 576, 587 (2000); then citing *EEOC v. Arabian Am. Oil Co.*, 499 U.S. 244, 257–58 (1991), *superseded by statute*, 42 U.S.C. § 2000e, *as stated in* *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 511–13 (2006); then citing *Christensen*, 529 U.S. at 589–91 (Scalia, J., concurring in part and concurring in judgment); then citing *Arabian Am. Oil Co.*, 499 U.S. at 259–60 (Scalia, J., concurring in part and concurring in judgment); and then citing *INS v. Cardoza-Fonseca*, 480 U.S. 421, 453–55 (1987) (Scalia, J., concurring)). 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 “expect the agency to be able to speak with the force of law,” on that question. *Id.* at 229 (citing *Chevron U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 845 (1984)). 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, *supra* note 350, 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 “expect the agency to . . . speak with the force of law” on that question. *Mead*, 533 U.S. at 229 (citing *Chevron*, 467 U.S. at 845). Thus, deference should be available in the one case, but not the other.



## CONCLUSION

This Article began with the fable of the boiled amphibian, comparing the metaphorical frog to Medicare. Of course, this analogy is oversimplified. As this Article has explained, the health and welfare of the entire country is at risk in Medicare's looming insolvency. Additionally, the speed and nature of the boil—whether insolvency has a clear deadline, 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, meaning 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 this goal. If successful, they would change the health care system for the better, while demonstrating that the endogeneity of politics to law can be not only a liability, but also an asset in institutional design.