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Medicare Meets Mephistopheles

David A. Hyman

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Medicare Meets Mephistopheles

David A. Hyman*

*Difficile est saturam non scribere*¹

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* Professor of Law, University of Maryland, and Special Counsel, Federal Trade Commission. No one who reviewed this article in advance of publication wished to have that fact known. Even more than usual, none of the opinions expressed in this Article should be imputed to the Federal Trade Commission (FTC) or to any of its Commissioners. This article is dedicated to Nancy Sprague, who taught me how to write. Learning how to write satire and gothic horror (and this article qualifies as both) was just a bonus.

1. JUVENAL (DECIMUS JUNIUS JUVENALIS), SATIRES (I, 29) (110–130 A.D.) ("It is hard not to write satire.").

Several works inspired this Article. *See generally* STEPHEN VINCENT BENET, *THE DEVIL AND DANIEL WEBSTER* (1937); C.S. LEWIS, *THE SCREWTAPE LETTERS* (Harper San Francisco 2001) (1942); MARK TWAIN, *A CONNECTICUT YANKEE IN KING ARTHUR'S COURT* (Oxford University Press 1996) (1889); Uwe Reinhardt, *The Predictable Managed Care Kvetch on the Rocky Road from Adolescence to Adulthood*, 24 J. HEALTH, POL., POL'Y & L. 897 (1999); Todd J. Zywicki, *With Apologies to Screwtape: A Response to Professor Alexander*, 9 J. BANKR. L. & PRAC. 613 (2000).

However, the "seed-crystal" that precipitated what follows was an off-hand remark by Professor Uwe Reinhardt that the Devil must have designed our health insurance system. *See* Interview by Public Broadcasting System with Uwe E. Reinhardt, Professor of Health Economics, Princeton University, at <http://www.pbs.org/healthcarecrisis/experts.htm> (last visited Jan. 21, 2004) (suggesting that "the Devil systematically built our health insurance system [which] has the feature that when you're down on your luck, you're unemployed, you lose your insurance . . . only the Devil could ever have invented such a system. Humans of goodwill would never do this.") (on file with the Washington and Lee Law Review). Professor Reinhardt failed to consider that the Devil might have a diversified portfolio of projects and would not limit his efforts to the employment-based health insurance system.

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I. Introduction

Medicare is the 800 pound gorilla of American health policy. Covering approximately forty million (primarily elderly) Americans, it funnels \$250 billion per year into the pockets of physicians, hospitals, clinical laboratories, home health agencies, physical therapists, social workers, and a veritable army of other health professionals. Medicare's administered pricing system can, whether by accident or design, shower largesse on particular regions, provider groups, and device manufacturers while starving others—with predictable consequences on the availability of the underlying goods and services. Medicare's footprint is so large that its every move has spill-over effects on the rest of the market.

Given Medicare's centrality to health care and health policy, it is not surprising that it has attracted considerable academic attention. Amazon.com lists more than 800 books that mention Medicare.² Every year, approximately 500 law review articles are published that mention Medicare—100 in the title.³ The participants in this symposium account for numerous books and scores of articles on the subject.

Although I have written articles on fraud and abuse, patient dumping, and the quality of care received by Medicare beneficiaries, I am a comparative newcomer to the subject of Medicare.⁴ When I start working on an article, my

2. A web search on September 11, 2003 revealed 869 books that mention Medicare. <http://www.amazon.com> (last visited Sept. 11, 2003).

3. As of September 11, 2003, 369 law review articles mentioning Medicare had been published in 2003. <http://www.westlaw.com> (last visited Sept., 11, 2003).

4. See generally David A. Hyman, *Does Medicare Care About Quality?*, 46 PERSP. BIO. & MED. 55 (2003) [hereinafter Hyman, *Does Medicare Care About Quality?*]; David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and "the Trust Reposed in the Workmen"*, 30 J. LEGAL STUDIES 531 (2001) [hereinafter Hyman, *Market Change*]; David A. Hyman, *HIPAA and Health Care Fraud: An Empirical Perspective*, 22 CATO J. 151 (2002) [hereinafter Hyman, *HIPAA*]; David A. Hyman & Charles Silver, *Just What the Patient Ordered: The Case For Result-Based Compensation in Health Care*, 29 J. L. MED. & ETHICS

invariant strategy is to obtain and read as many prior writings on the subject as I can locate. In short order, stacks of books and articles on Medicare soon filled my office. After considerable research and many late nights, I completed an article for this Symposium. My article analyzed the Medicare program from a competition policy perspective, identified a few minor problems for correction, and lauded the contributions of Medicare to health policy and social justice.⁵ The article then waxed wroth about the vicious lies and calumny told about Medicare by its detractors.⁶

Word apparently got out that I was working on an article about Medicare. A mysterious document appeared in my inbox at the University of Maryland School of Law shortly before the conference. My secretary informed me that a courier clothed in black and red, driving a red Lamborghini Diablo, delivered the document.⁷ The mailer bears an official-looking sticker, warning those who handle it that the envelope is made with asbestos fibers. The mailer bears an extraordinary amount of stamps, each bearing the likeness of Rodin's Gates of Hell.⁸ The document within the mailer is written on black parchment, reeks of brimstone, and singes the fingers of those unwary enough to handle it without insulated gloves. The words on each page glow red against the black parchment. The cover of the document is stamped with the legend, "Abandon

170 (2001); David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L. J. 797 (1998); David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29 (1998) [hereinafter Hyman, *Past Imperfect/Future Shock*]; David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001) [hereinafter Hyman & Silver, *You Get What You Pay For*].

5. Of course, I found some things to kibitz about. I am a law professor after all. But, it was a major struggle to identify flaws with Medicare, let alone to generate the enthusiasm to propose doing something about them. (If you believe that, then I know some nice people at the FTC's Bureau of Consumer Protection who would like to talk with you about how you really, really should not be trusted with cash or credit cards, let alone be allowed to answer e-mails from bankers who worked for deposed dictators in Africa. Or did you already fall for one of those cons?) See U.S. SECRET SERVICE, PUBLIC AWARENESS ADVISORY REGARDING "4-1-9" OR "ADVANCE FEE FRAUD" SCHEMES, at <http://www.secretservice.gov/advisories.shtml> (last visited Jan. 21, 2003) (warning the public about Advance Fee Fraud schemes) (on file with the Washington and Lee Law Review).

6. On the dangers of waxing wroth, cf. HORSEFEATHERS (Paramount Pictures 1932):

Secretary: Sir, the Dean is waxing wroth.

Groucho: Well, tell the dean to stop waxing wroth, and let Roth go and wax the Dean for a while.

7. In an extraordinary noncoincidence, this was the exact make and model as the car driven by Elizabeth Hurley in *Bedazzled*. See BEDAZZLED (Twentieth Century Fox 2000) (depicting Elizabeth Hurley as the Devil driving a red Lamborghini Diablo with a black leather interior).

8. AUGUSTE RODIN, THE GATES OF HELL, Musee Rodin: Paris, France (1880-1917), available at <http://musee-rodin.fr/senfl-e.htm>.

Hope All Ye Who Read Further," and a reproduction of Hieronymus Bosch's infamous painting of the seven deadly sins.⁹ The document purports to be a memo from a junior bureaucrat (Underling Demon 666, Deputy Assistant Special Coordinator for Accelerating Recruitment (DASCAR) in the Department of Illness and Satanic Services (DISS)) to the chief executive of his organization (Satan) reporting on the progress of their plans to use Medicare to undermine the American republic.

After reading the document, I immediately forwarded a copy to the Centers for Medicare and Medicaid Services (CMS).¹⁰ I am told that they have "top men" studying the document.¹¹ CMS was unable to provide any indication of when or whether they would officially release the document, let alone their analysis—although one anonymous source suggested that it would not take any longer than the finalization of the EMTALA regulations.¹²

9. HIERONYMOUS BOSCH, TABLETOP OF THE SEVEN DEADLY SINS AND THE FOUR LAST THINGS, Museo del Prado: Madrid, Spain (1485), available at <http://www.abcgallery.com/bosch/bosch16.html>.

10. No one has been able to explain why the acronym is not CMMS. Perhaps CMMS was less euphonious than CMS? See Amy Goldstein, *Health Insurance Agency Gets New Name; Structure*, WASH. POST, June 15, 2001, at A31 ("In keeping with the agency's new, consumer-friendly ethos, however, HHS spokesman Tony Jewell said, 'they are dropping the second M to help your tongue get around it a little better.'"). Or perhaps the administrators didn't want to advertise their involvement with one of the two "M"s—only one guess as to which one it was. Alternatively, maybe program administrators were reluctant to introduce themselves as working for a program whose acronym sounded like a (routinely overcooked) dish made of stewed vegetables familiar to Jews of Eastern European extraction? Of course, since the early favorite to replace the old name (Health Care Financing Administration (HCFA)) was Medicare and Medicaid Agency, we should all be appreciative that we did not end up with MAMA running Medicare. See *infra* notes 80–81 and accompanying text (outlining the concern with avoiding maternalistic references in the agency's acronym).

11. See RAIDERS OF THE LOST ARK (Paramount Pictures 1981):

Bureaucrat: Well gentlemen, I guess that just about wraps it up.

Marcus Brody: Where is the Ark?

Bureaucrat: I thought we settled this. The Ark is somewhere very safe.

Indiana Jones: From who?

Marcus Brody: The Ark is a source of unspeakable power and it has to be researched.

Bureaucrat: And it will be. I assure you Dr. Brody, Dr. Jones. We have top men working on it right now.

Indiana Jones: Who?

Bureaucrat: Top . . . Men.

12. EMTALA is the Emergency Medical Treatment and Active Labor Act, which requires hospitals that have an emergency department and accept Medicare funding to examine and treat all comers with emergency medical conditions, regardless of their ability to pay. Health Insurance for Aged and Disabled Part D, 42 U.S.C. § 1395dd(a) (2000). EMTALA took effect on August 1, 1986 as part of the Consolidated Omnibus Budget Reconciliation Act. CMS

The document was clearly important and deserved circulation to as wide an audience as possible—if only to alert the public of the depths to which opponents of Medicare would stoop to slime this sacred pillar of intergenerational equity.¹³ I was faced with a wrenching decision. Do I submit my own article, providing yet another valentine to the virtues of Medicare, allowing me to take my rightful place at the head of the crowd of the program's adoring academic enthusiasts?¹⁴ Or, do I submit the demonic words (appropriately disclaimed, of course) to alert the populace of the crafty scheming by the insidious reactionary forces that oppose truth, justice, and the American way—all of which are exemplified in that pillar of the Great Society, Medicare?

Despite considerable misgivings, I ultimately decided to scrap my own article and submit the document I received in the mail for publication in its place. I hope readers will not judge me too harshly for passing on the opportunity to declaim the depths of my unceasing admiration for those who bequeathed us the Medicare program, those who legislatively tinker with it every year or two, those who do their best to administer it and those who view their role in life as worshipping its every feature. I particularly regret the fact that this submission will forever disqualify me from taking my rightful place in the forefront of the legions of Medicare's academic enthusiasts, as I fear this group will conclude that the observations contained herein are my own and not those of the prince of darkness and his minions.¹⁵

issued the proposed regulations in 1988 and the final regulations in 1994. You do the math. *But see* Hyman, *Past Imperfect/Future Shock*, *supra* note 4, at 29 n.1 (expressing skepticism about the ability of lawyers to do basic addition and subtraction). The best explanation for this failing (along with the dearth of empirical legal scholarship more generally) is the fact that most law professors had higher SAT verbal scores than math scores.

13. Inside the Washington Beltway, negative "sliming" has been raised to an art form. *But see* GHOSTBUSTERS 2 (Columbia Pictures 1989) (documenting existence of positive slime).

14. There is absolutely no truth to the rumors that the working title of my original article was "Medicare: The Triumph of Hope over Experience," let alone "Medicare, Schmedicare: The Politics of Medicare Deification."

15. To be sure, some of my colleagues in health law already have their doubts about me. *See* David A. Hyman, *Medicine in the New Millennium: A Self-Help Guide for the Perplexed*, 26 AM. J.L. & MED. 143, 152 (2000) (noting that my scholarly work was described at a conference as "the sort of views that caused the Irish potato famine"). Admittedly, even if I submitted the original article, it would probably have been difficult to elbow my way to the forefront of Medicare's academic enthusiasts, if only because there are so many of them, each striving for greater ideological purity than the next on the subject of Medicare. This dynamic predictably leads to group polarization, as the echo-chamber of cross-citation and cross-adulation seduces those involved into taking more and more extreme positions on the (supposedly self-evident) virtues of Medicare. At least that's my behavioral economic explanation for the current state of academic discourse on Medicare and I'm sticking to it. *See* ARTHUR CONAN DOYLE, *The Adventure of the Beryl Coronet*, in THE COMPLETE SHERLOCK

Readers can judge for themselves the bona fides of the document, which is reproduced in its entirety below, and the merits of the observations contained therein. As for an appropriate disclaimer to the document itself, it is hard to improve on Mark Twain:

Persons attempting to find a motive in this narrative will be prosecuted; persons attempting to find a moral in it will be banished; persons attempting to find a plot in it will be shot.¹⁶

* * * * *

MEMORANDUM

ABANDON HOPE ALL YE WHO READ FURTHER

To: His Most Exalted Satanic Majesty
Lucifer, the Prince of Darkness
King of the Damned
Beelzebub
His Nibs
Master of the Nether Regions
Scourge of the Self-Righteous (that is, Politicians and
Academics)
7th Circle of Hell
Hell

From: Underling Demon 666
Deputy Assistant Special Coordinator for Accelerating
Recruitment (DASCAR)
Department of Illness and Satanic Services (DISS)
North American Division
Washington, D.C.

Re: Market Share Report—United States of America

HOLMES 301, 315 (Doubleday 1905) (1893) ("It is an old maxim of mine that when you have excluded the impossible, whatever remains, however improbable, must be the truth.")

16. MARK TWAIN, THE ADVENTURES OF HUCKLEBERRY FINN Introductory Page (Harper & Bros. 1901) (1884).

Per your request, I report herein on behalf of DISS on the progress of our attempts to corrupt the American republic. Happily, our market share in the United States grows with every passing day. Our growth has been particularly precipitous since we repackaged our product in 1965.

As you know, the recipe we have used for centuries (avarice, gluttony, envy, sloth, lust, anger and vanity—known collectively hereafter as the "Seven Deadly Sins") has worked perfectly well in most of the known world.¹⁷ Unfortunately, Americans have proved curiously resistant to the charms of the Seven Deadly Sins, even though your status as an American citizen should have been quite helpful in this regard.¹⁸ Through almost two centuries, Americans persisted in doing unto others as they would have done unto themselves, working hard and playing by the rules, staying in school, saving for a rainy day, going to church, donating to charities, volunteering their time to worthy causes, and generally behaving like goody-two-shoes at every conceivable occasion. Although we have long had considerable success with our recruiting efforts among some groups of Americans (that is, members of Congress and lawyers), these groups were unable to do serious damage as long as the rest of the population behaved themselves.¹⁹

17. We have had considerable success in corrupting the virtues of most countries. I will not address our worldwide market share except to note that our results have been particularly satisfactory in France. On the other hand, how much credit can we take for a good catch when the fish enthusiastically jump into the boat?

18. I refer your majesty to the unfortunate incident with Daniel Webster in New Hampshire:

"Foreign?" said the stranger. "And who calls me a foreigner?"

"Well, I never yet heard of the dev-- of your claiming American citizenship," said Dan'l Webster with surprise.

"And who with better right?" said the stranger, with one of his terrible smiles. "When the first wrong was done to the first Indian, I was there. When the first slaver put out for the Congo, I stood on her deck. Am I not in your books and stories and beliefs, from the first settlements on? Am I not spoken of, still, in every church in New England? 'Tis true the North claims me for a Southerner, and the South for a Northerner, but I am neither. I am . . . an . . . American."

BENET, *supra* note 1, at 173.

19. Indeed, our success with these groups is so well known that jokes to that effect are abundant. For example, there was the time your eminence approached a lawyer to discuss our most common business transaction:

Devil: I can promise you extraordinary success in your chosen profession, along with anything else you attempt.

Lawyer: In exchange for my soul, right?

Devil: No, we've owned that outright for many years. What we want, is the soul of your wife, your children, and your grandchildren. All of them will burn in hell for eternity in exchange for your success.

As such, it was a stroke of evil genius for your eminence to come up with the idea of creating a governmental program that would corrupt everything and everyone it touched.²⁰ The program works insidiously so that the citizenry is unaware of its evils until it is too late. Indeed, they vigorously defend the program against all criticism, and, ironically enough, believe the program's critics are allied with us!

I refer, of course, to the Medicare program, whose every feature bears the distinctive stamp of your subtle genius. Permit me to catalog (in Part II of this memo) how the features of the program reflect each of the Seven Deadly Sins. Part III of this memo outlines how Medicare also undermines two distinctively American virtues: thrift and truthfulness. Part IV of this memo offers a brief conclusion.

II. Medicare and the Seven Deadly Sins

As you know, the Seven Deadly Sins were first cataloged by Pope Gregory and have since been analyzed by such luminaries as St. Thomas Aquinas, Dante, Chaucer, and C.S. Lewis.²¹ They have also been featured in recent Hollywood movies and a wide array of advertisements.²² The remarkable thing is that your Satanic majesty was able to develop a program incorporating each and every one of the Seven Deadly Sins, while simultaneously persuading the populace that it included none of them. This memo reviews each of the Seven

Lawyer: So what's the catch?

Of course, your Satanic majesty is widely known as the king of lawyers, so we had a built-in advantage with that group. See BENET, *supra* note 1, at 173 ("[W]e know who's the King of Lawyers, as the Good Book tells us.").

20. See generally SATAN, DESTABILIZING THE AMERICAN REPUBLIC WITH A GOVERNMENT-MANDATED INTERGENERATIONAL PYRAMID SCHEME (Brimstoneware Press 1964) (generally unavailable, at least in this life).

21. See generally DANTE ALIGHIERI, THE INFERNO (John Ciardi trans., Signet Classic 2001) (n.d.); ST. THOMAS AQUINAS, THE "SUMMA THEOLOGICA" (Fathers of the English Dominican Province trans., Burns & Oates Wasbourne 1920) (n.d.); GEOFFREY CHAUCER, THE CANTERBURY TALES (Nevill Coghill Trans., Penguin Books 2003) (n.d.); LEWIS, *supra* note 1; POPE GREGORY I, MORALIA IN JOB (Turnholt: Brepols 1979) (n.d.).

22. See BEDAZZLED, *supra* note 7 (listing the Seven Deadly Sins and displaying Satan's preferred mode of transportation, the Lamborghini Diablo); BEDAZZLED (Twentieth Century Fox 1967) (same, except no Lamborghini Diablo in evidence); SEVEN (NewLine Studios 1995) (depicting a serial killer who selects victims based on the Seven Deadly Sins). Perhaps the most ingenious recent use of the Seven Deadly Sins is an ad for Las Vegas, your home away from home, currently appearing in in-flight magazines. The ad features a poker chip that bears the legend "Seven Deadly Sins, One Convenient Location." (copy on file with author).

Deadly Sins and details the ways in which the Medicare program incorporates and reinforces each one.

A. Avarice

Avarice primarily affects the 1.3 million providers, ranging from physicians and podiatrists to hospitals, nursing homes, and home health agencies, who collectively deliver goods and services to Medicare beneficiaries and receive more than \$250 billion per year for their trouble.²³ Some of these providers were wary of the long-term consequences of inviting the federal government to become a major purchaser of health care services. However, the government bought them off with promises of staggering amounts of money and no interference in their professional autonomy. Of course, you broke both of these promises, the latter first.²⁴

Medicare has resulted in extraordinary wealth for providers—not quite beyond the dreams of avarice, but close. Yet, the whole point of avarice is that more than most is never quite enough, and providers ceaselessly agitate for increases in Medicare payments. As a concentrated special interest, providers have had considerable success in extracting ever-increasing sums from the federal fisc, in many instances convincing Congress to specify payment rates well in excess of those that would prevail in a free market.²⁵ Consistent with our larger goals, Medicare's compensation arrangements pay providers based on their inputs (procedures performed or time spent) and not their outputs (high

23. There are approximately 6,100 hospitals, 15,000 skilled nursing facilities, 9,300 home health agencies, 167,000 clinical laboratories, 400 prepaid organizations, and 920,000 physicians who submit bills to Medicare. William Brewbaker, Overview of the Health Care Marketplace: Structural, Legal & Policy Issues, Slides used in an Address Before the FTC Health Care Workshop, at <http://www.ftc.gov/ogc/healthcare/agenda.htm> (Sept. 9, 2002) (archiving slides that contain information from the Healthcare Financing Administration, 1999 Data Compendium used by Professor Brewbaker in his remarks) (on file with the Washington and Lee Law Review).

24. Cf. BENET, *supra* note 1, at 170 ("Well, you couldn't expect fair play from a fellow like this Mr. Scratch.").

25. See William Sage, *The Lawyerization of Medicine*, 26 J. HEALTH, POL., POL'Y & L. 1179, 1187–89 (2001) (noting the impact of Medicare on the attitudes and behavior of physicians and physician groups); Bruce Vladeck, *The Political Economy of Medicare*, HEALTH AFF., Jan./Feb. 1999, at 22, 26–31 (1999) (discussing the role that provider interest groups play in the ever-increasing price of Medicare). As Professor Vladeck aptly notes, "There are plenty of \$400 toilet seats in the Medicare program, because Medicare cannot deliver services to its beneficiaries without providers and because providers are major sources of . . . campaign contributions in every congressional district in the nation." *Id.* at 26.

quality care actually delivered)—with predictable results on the quality and cost of care actually delivered.²⁶

To be sure, Congress recognized that some providers would be more avaricious than others. Congress accordingly enacted a series of fraud control provisions (anti-kickback, self-referral, and civil false claims) creating substantial criminal and civil penalties for fraud and abuse, along with a multidimensional enforcement initiative.²⁷ Although this fraud control program was well-intended, we have, through a variety of skillful measures, successfully redirected it to encourage our larger goals.

First, we ensured that the reach of the fraud statutes would exceed their (functionally defensible) grasp by criminalizing conduct well beyond that which was necessary to protect the program. Indeed, we criminalized conduct that results in benefits to patients without fiscal harm to the program. In short order, a "speakeasy" norm developed among otherwise law-abiding lawyers and providers, with predictable consequences as this social norm came into conflict with the norms of fraud control personnel.²⁸ The *qui tam* provisions of the False Claims Act added fuel to the fire.²⁹

26. See Hyman & Silver, *You Get What You Pay For*, *supra* note 4, at 1443 (stating that the critical failing of Medicare and most health insurance coverage is "the failure to tie compensation to quality of service or to patients' health"). These problems were recognized shortly after Medicare was introduced. Indeed, in 1968, President Johnson sent a special message to Congress requesting the authority to "employ new methods of payment as they prove effective in providing high quality medical care more efficiently and at lower cost." JOSEPH CALIFANO, *AMERICA'S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS?* 53 (1986). Medicare's subsequent payment strategies represent CMS's (and Congress's) ongoing efforts to address these problems.

27. See Hyman, *Market Change*, *supra* note 4, at 534–36 (discussing the antikickback statute, the self-referral provisions, and the Civil False Claims Act); Paul E. Kalb, *Health Care Fraud and Abuse*, 282 JAMA 1163, 1164–67 (1999) (same).

28. See James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 218 (1996) (comparing the American health care industry to a speakeasy). As Professor Blumstein states:

The American health care industry is akin to a speakeasy—conduct that is illegal is rampant and countenanced by law enforcement officials because the law is so out of sync with the conventional norms and realities of the marketplace and because respected leaders of the industry are performing tasks that, while illegal, are desirable in improving the functioning of the market.

Id. at 218.

29. Knowing your preference for puns, allusions, and impertinent remarks, I littered this memo with them. Congratulations on spotting the allusion to your immolating inferno. For a discussion of how the *qui tam* provisions create incentives to file and settle suits alleging violations of the False Claims Act, see Hyman, *HIPAA*, *supra* note 4, at 153–54.

Second, we whipped up a frenzy among the public about health care fraud and created the widespread belief that fraud and abuse are pervasive.³⁰ Indeed, 72% of the American public reportedly believes that Medicare would have no financial problems if fraud and abuse were eliminated, a perspective utterly uninformed by any connection with reality, but one that serves our purposes nonetheless.³¹ Over time, Americans will begin to doubt the good faith and reputation for fair dealing that has hitherto prevailed among health care providers. This demoralization will ultimately redound to our benefit.³²

B. Gluttony

Gluttony primarily affects Medicare beneficiaries. At the outset of the Medicare program, the costs of care (both per-beneficiary and total) were relatively modest, and beneficiaries were responsible for a substantial percentage of the cost of the care that they received from nonhospital sources.³³ However, the politics of Medicare created a one-way ratchet, shifting the distribution of costs of the Medicare program to the working population and away from Medicare beneficiaries. Because the working population is, as a group, less well off than those on Medicare, our efforts have resulted in a reverse-Robin Hood health care scheme that robs from the (working) poor and gives to the middle class and the rich.³⁴ The ceaseless lobbying of the elderly

30. To be sure, there is plenty of out-and-out fraud in Medicare—although quantification has proven difficult. *See id.* at 158–60 (explaining the difficulties in calculating the magnitude of fraud and abuse in health care).

31. *Id.* at 152.

32. Condemnation proceedings routinely result in similar demoralization costs—particularly when private property is taken for nonpublic purposes (for example, a shopping mall or a parking lot for limousines at a private casino), let alone when the government (inevitably) offers less-than just compensation. South Carolina provides a particularly egregious and illustrative example of the incentives to under-compensate property owners in condemnation proceedings—with the extent of the under-compensation only manifesting itself after courts accurately categorized the "regulatory taking" as an actual taking. *See* David A. Hyman, *Regulating Managed Care: What's Wrong With a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 249, n.93 (2001) ("Thus, once it owned the property, SCCC was unwilling to take a loss of \$77,500 to keep one lot unimproved, but it was perfectly happy in its role as regulator to impose a cost of more than ten times that amount on Mr. Lucas to keep both lots vacant.").

33. *See* RICHARD EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 149–51 (1997) ("The original program was laced with caveats and reeked prudence from every pore.").

34. This is actually a complicated issue because Medicare beneficiaries as a group have accumulated considerable assets but are not typically in the work force. Thus, a simple comparison of income is misleading. Census Bureau data on poverty rates among those older and younger than sixty-five provide one benchmark. *See* U.S. CENSUS BUREAU, *POVERTY IN THE*

population and the advocates for a Medicare prescription drug benefit, when most of the elderly already receive far more from the public trough than they ever paid in (and more than is economically sustainable regardless of whether a prescription drug benefit is added), further demonstrate the gluttony that Medicare evokes.³⁵

The best confirmation of the gluttony evoked by Medicare was the repeal of the Medicare Catastrophic Coverage Act of 1988.³⁶ Congress passed this Act with good intentions, overwhelming bipartisan support, and the enthusiastic endorsement of groups purporting to represent the elderly. The Act created coverage against catastrophic medical expenditures for Medicare beneficiaries—and coverage against catastrophes is, after all, the core purpose of insurance.³⁷ The Act also provided for prescription drug coverage, a subject which continues to vex Congress fifteen years later.³⁸ In a humiliating about-face, Congress, under immense public pressure, repealed the Catastrophic Coverage Act less than a year after enacting it. One of the most searing images for a risk-averse Congressman desirous of re-election was the spectacle of Dan Rostenkowski, House Ways and Means Chairman and one of the most powerful men in Congress, fleeing a crowd of irate senior citizens protesting

UNITED STATES: 2000, at 4 fig. 2 (Sept. 2001) (demonstrating that, since 1994, poverty rates for those sixty-five years and over have been lower than or approximately equal to those eighteen to sixty-four and, since 1974, substantially lower than those under eighteen), *available at* <http://www.census.gov/prod/2001pubs/p60-214.pdf>. Because those under eighteen are typically supported by those between eighteen and sixty-four, there is some indication that the subsidies flow in the direction indicated in the text. For those interested in a less intuitive approach, see MARK McCLELLAN & JONATHAN SKINNER, *THE INCIDENCE OF MEDICARE* (Nat'l Bureau of Econ. Research Working Paper w6013, 1997) (finding that relatively regressive financing mechanisms, higher expenditures and longer survival times of wealthier beneficiaries have led to net transfers from the poor to the wealthy).

35. See C. EUGENE STEUERLE & ADAM CARASSO, *LIFETIME SOCIAL SECURITY AND MEDICARE BENEFITS* (The Urban Institute, Straight Talk Policy Brief No. 36, March 2003) (stating that the amount of payroll taxes paid by current retirees is "dwarfed" by the amount of benefits received), *available at* http://www.urban.org/uploadedpdf/310667_straight36.pdf.

36. See ROBERT E. MOFFIT, *THE LAST TIME CONGRESS REFORMED HEALTHCARE: A LAWMAKERS GUIDE TO THE MEDICARE CATASTROPHIC COVERAGE DEBATE* (The Heritage Foundation, Backgrounder No. 996), *at* <http://www.heritage.org/Research/HealthCare/BG996.cfm> (Aug. 4, 1994) (discussing the repeal of the Medicare Catastrophic Coverage Act) (on file with the Washington and Lee Law Review); see also RICHARD HIMMELFARB, *CATASTROPHIC POLITICS: THE RISE AND FALL OF THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988*, at 1 (1995) (explaining the events surrounding the passage and repeal of the Catastrophic Coverage Act).

37. See Medicare Catastrophic Coverage Act of 1988, H.R. 2470, 100th Cong. § 101 (expanding the scope of Medicare coverage under Part A).

38. See *id.* § 202 (allowing prescription drug coverage under some circumstances).

the Catastrophic Coverage Act.³⁹ One senior citizen even jumped on the hood of Congressman Rostenkowski's car—a visual image beyond even our wildest expectations.⁴⁰ The fact that Congressman Rostenkowski lost his bid for re-election shortly after this incident reinforced the risks of "messing with Medicare" for even the dullest members of Congress. The principal sin of the Catastrophic Coverage Act (and I use the term ironically because the bill was actually exceedingly virtuous and we benefited greatly from its repeal) was that it imposed the costs of expanded coverage on the population that would benefit from the expansion.⁴¹ Predictably enough, gluttony turns out to be less appealing if one must foot the bill.

Thankfully, the voting power of the elderly has ensured that the "mistake" of the Catastrophic Coverage Act will never be repeated. Every subsequent election cycle has featured shameless pandering by both political parties to the preferences of the elderly for more extensive (and expensive) Medicare coverage. Of course, this gluttony only accelerates the day of reckoning that we have worked toward since you first proposed the Medicare program.

C. Envy

Envy has been the most disappointing of the Seven Deadly Sins. We have been, at best, only moderately successful at evoking envy among the nonelderly

39. See Fred Brock, *A Health Care Revolt, Remembered*, N.Y. TIMES, Apr. 7, 2002, at BU15 (describing senior citizen protest of Catastrophic Coverage Act). As the article notes,

In the summer of 1989, Mr. Rostenkowski, then a congressman from Illinois and the powerful chairman of the House Ways and Means Committee, was besieged by a crowd of 50 senior citizens in Chicago. According to The Chicago Tribune, the protesters—shouting "coward," "recall" and "impeach"—forced him to sprint through a gas station to his car, where minutes earlier an elderly demonstrator had been sprawling across the hood. The protesters were angry about a new law that provided catastrophic coverage for Medicare recipients, but with an income-tax surcharge of up to \$800 a year that was set to rise to \$1,050 in 1993. That law was soon repealed. But the television images of Mr. Rostenkowski under assault struck fear in the hearts of politicians that remains to this day. Few want to be pitted against older people on issues involving Medicare.

Id.; see also Dick Thompson, *The Third Rail of U.S. Politics*, TIME, Feb. 27, 1995, at 21 ("[P]revious attempts to tinker with the health insurance enjoyed by 36.3 million aging voters have earned Medicare the title of 'the third rail of American politics.' Touch it and you're dead.").

40. See Brock, *supra* note 39, at BU15 (recounting Congressman Rostenkowski's encounter with an irate senior citizen).

41. See MOFFIT, *supra* note 36, at 33–34 (explaining the financing of the Catastrophic Coverage Act).

population. Those not covered by Medicare have certainly grown tired of the restrictions and limitations imposed by the private coverage market. As the last bastion of fee-for-service health care, Medicare is routinely presented as if it offers open-ended affordable access to all necessary goods and services without government red-tape. Yet popular envy has been tempered by the realization that Medicare is only "affordable" because of the infusion of billions and billions of dollars in cross-subsidies from the rest of the population. Despite our best attempts to package it as "Medicare for all," there has been no popular uprising in favor of a one-payor system.

Part of our problem is that it has proven difficult to persuade people that Medicare is "hassle-free," particularly when providers and prominent Congressmen routinely complain about the inadequacies and inefficiencies of CMS and promise to eliminate it.⁴² We can take some credit for this outcome

42. Indeed, at a recent Federal Trade Commission/Department of Justice hearing, CMS Administrator Tom Scully, with his tongue thoroughly in his cheek, suggested that the Administration had actually changed the name of HCFA to CMS because everyone hated HCFA and changing the name would confuse people. See *Healthcare and Competition Law and Policy: Hearing Before the FTC* 26 (Feb. 26, 2003) (statement of Thomas Scully, CMS Administrator) (discussing the decision to rename HCFA), available at <http://www.ftc.gov/ogc/healthcarehearings/030226trans.pdf>. As Administrator Scully reported:

The fact is, the health care market, whatever there is in health care, is extremely muted and extremely screwed up and it's largely because of my agency. For those of you who don't follow CMS, which used to be called HCFA, we changed the name because it was so well loved. I always say it's kind of like when Enron comes out of bankruptcy, they'll probably change their name. So, HCFA—Secretary Thompson and I decided to confuse everybody. We changed the name to CMS for a couple of years so people wouldn't realize we're actually HCFA. So far, it's worked reasonably well.

Id.; see also Goldstein, *supra* note 10, at A31 ("The Health Care Financing Administration—the corner of the federal government that, perhaps more than any other, politicians loved to hate—is a relic of the past."); Ellen Nakashima & Ceci Connolly, *Wanted: A HCFA By Any Other Name*, WASH. POST, June 12, 2001, at A23 (noting the name change). Nakashima and Connolly wrote:

The \$436 billion agency oversees Medicare and Medicaid programs, and is said to have three times as many regulations as the IRS. Not surprisingly, it is disliked by nearly everyone except its beneficiaries. It's too restrictive, requires too many forms to be filled out, takes ages to reimburse claims, go the complaints.

Id. Robert Pear, *Medicare Agency Changes Name in an Effort to Emphasize Service*, N.Y. TIMES, June 15, 2001, at A26 (expanding on the practical effect of HCFA's name change). Pear stated:

But it will take more than a name change to alter the culture of the agency, which has been harshly criticized by members of Congress from both parties, who describe it as a rigid, heavy-handed regulator, more eager to set prices than to encourage competition or reward efficient providers of care.

Id.

because we persuaded Congress to increase the obligations of CMS while simultaneously starving them of resources, all the while encouraging Medicare's proponents to brag about its low administrative overhead.⁴³

We have also had some success creating envy within the Medicare population by carefully designing the program to maximize hard feelings along geographic lines. Because local costs of production and treatment patterns directly affect reimbursement, the cost to the Medicare program (and hence the amount of resources spent per beneficiary) varies greatly among the several states, as well as within those states.⁴⁴ In the nation as a whole, average Medicare payments per beneficiary were \$5,994 in Fiscal Year 2001, but they ranged from a high of \$8,099 in Louisiana to a low of \$3,414 in Iowa.⁴⁵ One group of commentators has estimated that we could buy each and every Medicare beneficiary in Florida who agreed to receive their health care in Minnesota a fully-loaded Lexus and the Medicare program would still come out

43. See GEN. ACCOUNTING OFFICE, GAO-01-817, *MEDICARE MANAGEMENT: CMS FACES CHALLENGES TO SUSTAIN PROGRESS 2* (2001) (concluding that CMS's administrative budget has not kept pace with its workload); Hyman, *Does Medicare Care About Quality?*, *supra* note 4, at 63-64 ("CMS's 'overhead' to run [Medicare] is a shockingly low two percent—barely enough to keep the lights on and certainly not enough to pay for aggressive oversight of the quality of care."); see also Stuart M. Butler et al., *Open Letter to Congress & the Executive: Crisis Facing HCFA & Millions of Americans*, HEALTH AFF., Jan./Feb. 1999, at 8 (asserting that HCFA is under-funded). As the open letter explained:

Over the past decade Congress has directed the agency to implement, administer, and regulate an increasing number of programs that derive from highly complex legislation. While vast new responsibilities have been added to its heavy workload, some of its most capable administrative talent has departed or retired; other employees have been reassigned as a consequence of reductions in force. At the same time, neither Democratic nor Republican administrations have requested administrative budgets of a size that were in any way commensurate with HCFA's growing challenge.

Id.

44. See IOWA CARES ABOUT MEDICARE, CHART: MEDICARE PROGRAM PAYMENTS PER ENROLLEE BY STATE, at <http://www.iowamedicare.org/charts/payment.pdf> (last visited Jan. 21, 2004) (using data from the Centers for Medicare and Medicaid Services to graphically demonstrate state-by-state variations in Medicare payments per beneficiary) (on file with the Washington and Lee Law Review).

45. *Id.* These figures are deceptive because many Iowa residents receive their health care in Minnesota. These expenditures do not appear in the numerator (health expenses in Iowa), but the residents are counted in the denominator (Medicare beneficiaries in Iowa). See *State-level variation in Medicare spending: preliminary observations*, Public Meeting of the Medicare Payment Advisory Commission 1-4 (April 26, 2002) (statement of David Glass) (explaining that payment differences between states may be misleading because many beneficiaries go outside their home state to use health care services), available at http://www.medpac.gov/public_meetings/transcripts/0426_statelevelvariations_DG_transc.pdf.

ahead.⁴⁶ Although the Dartmouth Atlas⁴⁷ helped surface some of these disparities, most of the credit goes to Medicare managed care, which required CMS to determine and publish the average payments per Medicare beneficiary per county in order to calculate the (somewhat-lesser) amount that should be paid to a Medicare+Choice Organization (MCO) providing services to a Medicare beneficiary in that county.⁴⁸ To the extent the non-risk-adjusted premium exceeded the competitive level of payment, MCOs dissipated payments through non-price competition, resulting in visibly high MCO benefits for Medicare beneficiaries in some counties and "bare-bones" benefits for beneficiaries in others.⁴⁹

This geographically-driven envy has precipitated a "formula fight" among the several states, complete with litigation,⁵⁰ coalitions of aggrieved states and senior citizens,⁵¹ and coverage in newspapers and editorials.⁵² We are particularly lucky

46. See generally John E. Wennberg et al., *Geography and the Debate Over Medicare Reform*, HEALTH AFF. WEB EXCLUSIVE (Feb. 13, 2002) (demonstrating substantial regional variation in Medicare expenditures and treatment patterns, without discernable positive effect on outcome or health status), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.96v1.pdf> (on file with the Washington and Lee Law Review).

47. DARTMOUTH MEDICAL SCHOOL'S CENTER FOR THE EVALUATIVE CLINICAL SCIENCES, THE DARTMOUTH ATLAS OF HEALTHCARE, at <http://www.dartmouthatlas.org/> (last visited Jan. 21, 2004) (on file with the Washington and Lee Law Review).

48. See Note from Centers for Medicare and Medicaid Services, to Medicare and Choice Organizations and Other Interested Parties, at <http://cms.hhs.gov/healthplans/rates/2004/cover.asp> (May 12, 2003) (noting that § 1853(b)(4) of the Social Security Act requires CMS to release county-specific per capita fee-for-service expenditure information on an annual basis) (on file with the Washington and Lee Law Review).

49. See William M. Sage & Peter J. Hammer, *Competing on Quality of Care: The Need to Develop a Competition Policy For Health Care Markets*, 32 U. MICH. J.L. REFORM 1069, 1073 n.7 (1999) ("[T]he resulting windfall is often transformed into higher enrollee benefits, such as outpatient prescription drug coverage, as Medicare HMOs competed with one another on non-price grounds."); see also Medicare Justice Coalition, Statement of Rose Grigsby, Victim of Medicare Injustice, at <http://www.mnseniors.net/mjcgrigsby.html> (Nov. 17, 1999) (discussing her personal experiences with benefit variation between Arizona and Minnesota) (on file with the Washington and Lee Law Review); Peter Wyckoff, Medicare Justice Coalition Opening Comments, at <http://www.mnseniors.net/mjcwycloff.html> (last visited Jan. 21, 2004) (providing concrete examples of benefit disparities between counties caused by nonprice competition) (on file with the Washington and Lee Review).

50. See generally *Minn. Senior Fed'n, Metro. Region v. United States*, 273 F.3d 805 (8th Cir. 2001) (challenging unsuccessfully a Medicare payment formula that resulted in geographic variation in payment levels on the grounds that it interfered with the constitutional right to travel), *cert. denied*, 536 U.S. 939 (2002).

51. See, e.g., THE GEOGRAPHIC COALITION HOMEPAGE FOR A FAIR MEDICARE REIMBURSEMENT SYSTEM, <http://www.mnmed.org/images/Gc/index.html> (last visited Aug. 24, 2003) (summarizing the Geographic Coalition) (on file with the Washington and Lee Law Review); Medicare Justice Coalition, Statement of Barbara Kaufman, Medicare Justice Coalition Spokesperson, at <http://www.mnseniors.net/mjckaufman.html> (Nov. 17, 1999) (describing the goals of the Medicare Justice Coalition, a grassroots, senior consumer coalition)

that the Senate Finance Committee is disproportionately composed of Senators from low-cost states who are extremely aggrieved that the Medicare money train does not unload a "fair share" of Medicare money in their states.⁵³ We expect this issue to become even more salient if Medicare MCOs in high-cost areas start attracting patients by paying them cold hard cash and not just offering enhanced benefits.

We have also had considerable success with envy among providers. Those currently included within Medicare compare their payment rate to that of other covered providers and ceaselessly agitate to have "their" services compensated more highly. Providers who are excluded from Medicare agitate to be included. Medical device manufacturers lobby to have their devices covered and lobby against Medicare's attempts to impose a cost-effectiveness test on coverage.⁵⁴ Interestingly, pharmaceutical manufacturers are the only organized group that has no real interest in expanding their presence in Medicare and they have lobbied heavily against adding an outpatient prescription drug benefit.⁵⁵

(on file with the Washington and Lee Law Review); MMA ONLINE, GEOGRAPHIC COALITION LINKS TO STATE HOMEPAGES FOR A FAIR MEDICARE REIMBURSEMENT SYSTEM, at <http://www.mnmed.org/images/GC/members.html> (last visited Jan. 21, 2004) (providing web-links to the Geographic Coalition State homepages) (on file with the Washington and Lee Law Review). The Geographic Coalition is comprised of twenty-four states who believe that they receive inadequate Medicare payments. See Press Release, University of Wisconsin Cooperative Extension, Wisconsin's Suit Against Medicare, at <http://www.uwex.edu/ces/flp/health/wimedicarelawsuit.html> (last updated May 1, 2002) (noting that "[g]rassroots organizing is expanding with consumer and provider groups from Oregon, California, North Dakota, Iowa, South Dakota, and Wisconsin") (on file with the Washington and Lee Law Review).

52. See IOWA CARES ABOUT MEDICARE COALITION, MEDICARE EQUITY IN THE NEWS, at <http://www.iowamedicare.org/news.shtml> (last visited Sept. 30, 2003) (providing web-links to over forty news articles and editorials regarding Medicare fairness) (on file with the Washington and Lee Law Review).

53. Senator Chuck Grassley from Iowa is the Majority Leader on the Senate Finance Committee. Senator Max Baucus from South Dakota is the Minority Leader on the Senate Finance Committee. Both Iowa and South Dakota are members of the Geographic Coalition. See *supra* note 51 (discussing the Geographic Coalition). Of the remaining nineteen members, nine are from states that are members of the Geographic Coalition. See <http://finance.senate.gov/sitepages/committee.htm> (last visited Sept. 30, 2003) (listing Senate Finance Committee members and their respective states) (on file with the Washington and Lee Law Review). For those who cannot do the math, that means 48% of the states belong to the Geographic Coalition, but 58% of the members of the Senate Finance Committee are from those states—including both the Majority and Minority Leaders.

54. See Susan Bartlett Foote, *Why Medicare Cannot Promulgate a National Coverage Rule: A Case of Regula Mortis*, 27 J. HEALTH POL., POL'Y & L. 707, 708–20 (2002) (explaining how the medical device industry has prevented the implementation of cost-effective coverage rules through the process of *regula mortis*). "Regula Mortis occurs when a mobilized interest group blocks legitimate administrative agency action, causing a regulatory stalemate." *Id.* at 707.

55. Of course, to the extent that the pharmaceutical companies' products are already covered by Medicare, they maneuver just like any other provider to enhance their revenues and

D. Sloth

Sloth affects two important groups: legislators and program administrators. To be sure, Congress tinkers with numerous aspects of Medicare on a more-or-less annual basis, but it has paid almost no attention to the long-term financial problems facing Medicare. As outlined in Part III, Medicare's financing is a ticking time-bomb that will explode within the next two generations. The sooner this problem is addressed, the less severe the resulting dislocations will be. Yet legislative sloth, confirmed by past history, ensures that any solution will be deferred until a true crisis emerges—and by the time the crisis emerges, legislators will have more difficulty solving the problem. So much for the oft-heard claims about the superior ability of government to mind the interests of future generations and attend to long-term problems.⁵⁶ Your efforts in selling this myth have been particularly effective.

Program administrators are also affected by sloth, at least with regard to quality and, to a lesser extent, fraud control. When one is purchasing health care, cost, quality, and access are all important. Yet, Medicare program administrators care a lot about cost, less about access, and, at least historically, not at all about quality.⁵⁷ This sloth is no accident. Indeed, at your behest, Medicare was designed at every turn to focus program administrators on cost and access and to discount quality.⁵⁸ The Medicare statute explicitly provides that any provider who meets the entry requirements is entitled to participate in the program, and that patients are free to choose any provider who will have them.⁵⁹ Thus, CMS has very little ability to exclude providers who deliver poor

shrink those of their rivals. See Denise Gellene, *Drug-Firm Rivalry Spills into Congress*, L.A. TIMES, Apr. 9, 2003, at C1 (noting a battle between Amgen, Inc. and Johnson & Johnson over payments for anemia medication).

56. Belief in this particular fairy tale is particularly pervasive among enthusiasts of progressive causes. Yet, neither theory nor practice provide any basis for believing that the political system will protect the interests of future voters—let alone future nonvoters. See Richard A. Epstein, *Why Is Health Care Special?*, 40 U. KAN. L. REV. 307, 311 (1992) ("It would be easy to assume that collective responses are preferred when markets are corrupt and governments virtuous. It is far harder to reach that conclusion when self-interest and corruption creates difficulties from both quarters.").

57. See Hyman, *Does Medicare Care About Quality?*, *supra* note 4, at 56 (arguing that the Medicare program does not place enough value on quality).

58. See *id.* at 63 ("By training, history, and inclination, CMS administrators are interested in the prompt and efficient processing payment of claims Quality of care has never really been on CMS's agenda Indeed, the original Medicare Statute explicitly prohibits any federal employee from interfering with the practice of medicine.").

59. *Id.*

quality care or to reward providers whose quality is exemplary.⁶⁰ Similarly, the administrative structure of Medicare—all bills are processed by carriers and intermediaries, who view their job as paying bills as quickly and cheaply as possible—also helped contribute to administrative sloth.⁶¹

It was also an act of inspired genius to draw the original administrators of Medicare from the ranks of the Social Security Administration. Social Security administrators had considerable experience and expertise in running a program that was based on the payment of a sum certain to qualified beneficiaries and no experience whatsoever with purchasing health care services. The predictable result was that CMS personnel were extremely focused on whether beneficiaries had access to the statutorily-specified services, the total amount of money required to accomplish that objective, and the prompt and efficient processing and payment of claims, and they paid relatively little attention to everything else. Shoveling money out the door to purchase health care services is, of course, not the same thing as purchasing high-quality health care.

These patterns have continued to the present day. Even if program administrators were inclined to exercise their marketing muscle on behalf of program beneficiaries, the basic structure of Medicare—the "good government/due process" requirement for public notice and comment on virtually everything it does, the chronic under-funding of administrative capacity, and the multiplicity of tasks that CMS is charged with—means that sloth will continue to prevail regardless of the enthusiasm, hard work, and promises made by program administrators.⁶²

Finally, in a diabolical stroke of genius, we have succeeded in undermining all attempts to rouse administrators from their sloth through the

60. *Id.* Indeed, CMS's minimal efforts to steer patients by designating "centers of excellence" for cardiac and orthopedic surgery have triggered extensive lobbying and discontent. See David Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 35 (2001) ("Medicare has had limited success with its attempts to designate 'centers of excellence' for cardiac and orthopedic surgery, as providers have claimed that the centers are being selected primarily on grounds of cost, rather than quality."); AM. HOSP. ASS'N, POLICY BRIEF 99-3, IMPLICATIONS OF PRESIDENT CLINTON'S PLAN TO MODERNIZE THE TRADITIONAL FEE-FOR-SERVICE MEDICARE PROGRAM, at http://www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/resources/policy_brief82799.html (Aug. 27, 1999) (detailing AHA criticisms of initiative) (on file with the Washington and Lee Law Review).

61. See Hyman, *Does Medicare Care About Quality?*, *supra* note 4, at 60 (analyzing incentives created by the administrative structure of Medicare).

62. See *id.* at 64 (analyzing the difficulties in leveraging Medicare's purchasing power given the administrative structure of Medicare). Ex post enforcement strategies, including fraud prosecutions for low quality care, do not solve these problems, and in important respects, run the risk of making them worse. See Hyman, *Market Change*, *supra* note 4, at 540 (questioning the effectiveness of ex post sanctions in dealing with the problems facing Medicare).

judicious use of political oversight.⁶³ Any attempt by CMS to transform itself from a passive payor of bills to an active manager with broad responsibility for beneficiary health by using tools such as selective contracting and payment for performance, among others, will necessarily result in shifts in patient flows (and payments) among providers. Adversely affected providers lobby heavily to forestall this fate, with the outcome dictated by the political power of those providers instead of the quality and efficiency with which the underlying services are delivered.⁶⁴ Demonstration projects have triggered similar dynamics, when a demonstration project is successful, CMS lacks the authority to implement it more broadly, and when a demonstration is not successful, political constraints can make it impossible to terminate.⁶⁵ Political opposition killed at least one demonstration project before it ever got off the ground.⁶⁶

63. See Vladeck, *supra* note 25, at 22–31 (analyzing the political restraints on Medicare administrators and administration).

64. See NAT'L ACAD. OF SOC. INS., STUDY PANEL ON FEE-FOR-SERVICE MEDICARE, FROM A GENERATION BEHIND TO A GENERATION AHEAD: TRANSFORMING TRADITIONAL MEDICARE, at http://www.nasi.org/usr_doc/med_report_gen_behind.pdf (Jan. 1998) ("The fee-for-service program has been open to all qualified providers; reforms that would limit the number or type of participating providers . . . could result in substantial, or even fatal losses to some provider organizations. This could clearly generate major political problems in specific areas.") (on file with the Washington and Lee Law Review; see also AM. HOSP. ASS'N, *supra* note 60 (arguing for "fairness" in public programs). The AHA Brief explained:

"It is essential that there be an element of fairness in public programs. Given [CMS's] market share, the extent to which it is authorized to selectively contract with providers could cause large shifts in patient volumes among providers, resulting in the potential for significant financial losses, closures, and other changes in the delivery system. The financial losers would look to Congress for new protections."

Id.

65. *Comparing the Traditional Medicare Program to Private Insurance: Hearing Before the Senate Finance Committee* (testimony of Paul Ginsburg), <http://finance.senate.gov/5-12gins.htm> (May 12, 1999) (on file with the Washington and Lee Law Review).

66. See Bryan Dowd et al., *A Tale of Four Cities: Medicare Reform and Competitive Pricing*, HEALTH AFF., Sept./Oct. 2000, at 9, 11 (explaining how Congress "acceded to industry pressure" and abandoned the Baltimore competitive-pricing demonstrations for Medicare Part C in 1996); see also *Lessons from the Competitive Pricing Advisory Committee Experience for the Medicare+Choice Program and Long Term Reform: Hearing Before the Senate Finance Committee* (testimony of Len Nichols), <http://www.urban.org/TESTIMON/nichols04-03-01.html> (last visited Aug. 24, 2003) (discussing Medicare pricing reform) (on file with the Washington and Lee Law Review). Nichols explained:

Once local opposition galvanized, CPAC [Competitive Pricing Advisory Committee] members and HCFA professional staff were not well equipped to solicit defensive support among Members of Congress. If one Member cares a lot, and most other Members are basically indifferent, he can get what he wants, eventually. So, Medicare pricing reform will occur only when the leadership decides it really wants to do that, and prevents amendments like the one that

Those advocating such efforts will also be legislatively savaged for their troubles. As such, sloth has predictably become the dominant strategy for risk-averse program administrators.

E. Lust

The Medicare program induces lust for program expansion and political power among members of the Democratic Party.⁶⁷ Democrats lust to extend the "security" of Medicare to the balance of the population and ceaselessly campaign to do so. These unknowing pawns write endlessly about the supposed virtues of a government-run health system, monopolizing the op-ed page of the *New York Times* and major medical journals.⁶⁸ In a real tribute to your powers, these advocates actually believe they are engaged in God's work! Although we occasionally encourage their efforts by allowing public referenda on the adoption of a one-payor system⁶⁹ and periodically tantalize them with proposals to add the "near-elderly" to Medicare,⁷⁰ we adhere to your original plan to resist program expansion at all costs. As you correctly perceived many years ago, allowing everyone into Medicare will immediately bankrupt the

stopped the CPAC demos in their tracks.

Id.

67. No cheap shots about Medicare and Viagra here. No sir. We draw the line at that kind of easy laugh. Well, maybe just one. Did you hear the one about the guy who joined a Medicare HMO because he thought it covered his Viagra? It did not. See *In the Case of Blue Shield of California, Medicare Appeals Council* (June 20, 2003) (denying coverage to a beneficiary seeking Viagra), <http://www.hhs.gov/dab/macdecision/blueshieldca.htm> (on file with the Washington and Lee Law Review).

68. See, e.g., David U. Himmelstein & Steffie Woolhandler, *A National Health Program for the United States: A Physician's Proposal*, 320 *NEW ENG. J. MED.* 102, 102-08 (1989) (proposing a national health care program that covers all medical services); Marcia Angell, *The Forgotten Domestic Crisis*, *N.Y. TIMES*, Oct. 13, 2002, at WK13 (arguing that the United States needs a national, single-payor system). The most zealous advocates are found in two groups: Physicians for a National Health Program, and Everybody In, Nobody Out. See *EVERYBODY IN, NOBODY OUT . . . THE ESSENCE OF UNIVERSAL HEALTHCARE*, at <http://www.everybodyinnobody.org/MissState.html> (last visited Jan. 21, 2004) (providing an overview of an organization with the goal of guaranteeing universal access to health care) (on file with the Washington and Lee Law Review); *PHYSICIANS FOR A NATIONAL HEALTH PROGRAM*, at <http://pnhp.org/> (last visited Jan. 21, 2004) (describing a program that will purportedly pay for all health care) (on file with the Washington and Lee Law Review).

69. Not surprisingly, these efforts have focused on "Blue America," with referenda held at various times in Maine, Massachusetts, and Oregon.

70. See Robert J. Samuelson, *Salesman in Chief*, *WASH. POST*, Feb. 4, 1998, at A19 (noting Clinton's proposal to allow sixty-two to sixty-four-year olds to buy into Medicare).

program because the cross-subsidies that sustain Medicare are only achievable if there are sufficient marks *outside* the program to pay the necessary funds *into* the program. Program beneficiaries understand this point perfectly well. The demise of the Clinton plan was inevitable once it became clear that the plan would "take" from the elderly and "give" to the uninsured.⁷¹ We are far better off delaying the day of reckoning by a few years and allowing the gluttony of Medicare beneficiaries and the passage of time to increase the number of unsustainable commitments, meaning that the fall of the American republic from grace will be even more precipitous.

Medicare also provides Democrats with the tools to satisfy their lust for power. Of course, the lust for power is innate in all politicians and political parties, but Democrats disproportionately emphasize Medicare in their appeals to the electorate. This strategy is consistent with the basic position of Democrats that the "highest purpose of government is to send people checks in the mail."⁷² The proof of these claims is in the pudding. Political polling has consistently demonstrated that voters trust the Democrats more than the Republicans when it comes to Medicare.⁷³ Exploiting this asymmetry, Democrats use Medicare as a bludgeon against their Republican adversaries at every conceivable turn regardless of the actual differences between the parties,

71. See EPSTEIN, *supra* note 33, at 200–02 ("At crunch time, AARP members and Medicare recipients stood four-square behind universal access to medical care—for all persons over 65. They rightly understood that the greatest peril to their care came from offering the same entitlements to persons under 65."). To be sure, an additional factor working in our favor is the skepticism of many Americans about government-run health care. *Id.* at 190–91. Notwithstanding initial favorable press coverage, the Clinton plan suffered substantial decreases in public support as its details became clear. *Id.* It was obvious that we passed the tipping point when bumper stickers appeared announcing "National Health Care?—The compassion of the IRS!—The efficiency of the post office!—All at Pentagon prices!" See THEDA SKOCPOL, BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS Introductory Page Preceding Preface (1996) (quoting a bumper sticker on an aging Chevrolet in 1994). Of course, once we completely take over the American Republic, we will be able to decisively address such impertinence instead of relying on our contacts in the media and academia to spread our message.

72. Nicholas Lemann, *America Right and Left*, THE ATLANTIC ONLINE (Apr. 1998), at <http://www.theatlantic.com/issues/98apr/leftrite.htm> (Apr. 1998) (book review) (on file with the Washington and Lee Law Review).

73. David Espo, *Parties Debate Medicare, Soc. Sec.*, AP ONLINE, June 18, 2002 (noting Democrat's edge in polling), at 2002 WL 22581318. Espo states:

Recent polling gives Republicans reason to be nervous, at least when it comes to Medicare and Social Security. A survey taken for Rep. J.C. Watts, R-Okla., reported that Democrats are favored, 48–34, on their handling of Social Security. On drugs and health care, the Democratic advantage was 48–31.

Id.

the bipartisanship of the effort, and the financial straits in which Medicare finds itself.

For example, in the 2002 Congressional election, one Maryland Democratic candidate argued that his Republican opponent was "anti-Medicare" because she voted for the 1986 Catastrophic Coverage Act—along with the rest of the Maryland Congressional delegation and an overwhelming majority of Congress.⁷⁴ More generally, the Democratic party's "talking points" for the 2002 election reduced to the claim that the Republicans did not care about the elderly, a fact "demonstrated" by their refusal to enact a Medicare prescription drug benefit even though the (Republican) House had actually passed a Medicare prescription drug benefit—albeit one not to the taste of the Democrats. In the 2000 presidential election, Vice President Gore repeatedly accused the Republicans of planning to cut Medicare to pay for tax cuts.⁷⁵ In the previous two presidential elections, President Clinton was particularly effective at using Medicare to score political points against the Republicans, even using it to recover from the devastating losses suffered by the Democrats in the 1994 election.⁷⁶ Indeed, the basis for President Clinton's 1996 re-election campaign was referred to by party operatives as M²E², or Me-Me, short for Medicare, Medicaid, education and the environment.⁷⁷

74. See Andrew A. Green, *2nd District Debate Features Collegiality, Jabs*, BALT. SUN, Oct. 29, 2002, at 3B (noting that Democrat C. A. Dutch Ruppertsberger ran a negative television campaign criticizing Republican Helen Delich Bentley for voting to add Catastrophic Coverage to Medicare).

75. See Dana Milbank, *The Campaign Seasoning: The Flavor of the Week*, WASH. POST, Sept. 30, 2000, at C4 (discussing Vice President Gore's campaign strategy regarding Medicare).

76. See Noam Scheiber, *The Old Way*, NEW REPUBLIC, Feb. 11, 2002, at 20, 21 ("When Newt Gingrich proposed a \$270 billion tax cut just as Republicans were 'slowing the growth of Medicare' by roughly the same amount in 1996, Bill Clinton connected the dots—not only killing the tax cut, but reviving his presidency along the way."); Carl M. Cannon, *Medicare Fiscal Woes Accelerate*, BALT. SUN, June 6, 1996, at 1A (noting Medicare's political importance). Cannon reports:

For the past eight months, Clinton's popularity has been rising—and that of congressional Republicans plummeting—in the face of Democratic accusations that Republicans favor "extreme" cuts in Medicare and other social programs, far in excess of what is required, to help pay for tax cuts to benefit the wealthy.

Id.

77. See Bill Dauster, *The Election Is Over. Where Do We Go from Here?*, Remarks Before the American Association for Budget and Policy Analysis, at <http://www.geocities.com/democrat/newelection.html> (Nov. 21, 1996) ("You may well recognize the President's particular words: 'Medicare, Medicaid, education and the environment.' Democrats have, in the language of politics, stayed "on message." When politicians speak these words, staffers and reporters write 'MMEE' and refer to 'double-M, double-E' or 'M-squared, E-squared.'") (on file with the Washington and Lee Law Review); *News Hour with Jim Lehrer: Reaction to the Second Clinton/Dole Debate*, <http://www.pbs.org/newshour/debatingourdestiny/newshour/96reax>

These efforts have been extraordinarily successful. Significant portions of the elderly population distrust Republicans when it comes to Medicare, even though the financial differences between the Republican and Democratic proposals for Medicare are exceedingly modest.⁷⁸ The Democratic message has been quite effective in overcoming the collective action problems of organizing the elderly, but it has been less successful in creating broad-based confidence in the program. In a recent poll, approximately one-half of young women polled thought that the soap opera *General Hospital* would outlast Medicare.⁷⁹

From a larger philosophical perspective,

Chris Matthews has usefully divided the parties into the "mommy party," the Democrats, and the "daddy party," the Republicans. When times are good, you turn to mom, who promises to provide more services and more compassion, and demands less personal responsibility. But when threats loom, Americans turn to dad, who takes no guff from us but also reaches for the Winchester hanging over the front door when hostile strangers approach.⁸⁰

As the quintessential mommy party program, Medicare has been a critical part of the platform for Democrats and the key to victory in many swing districts. I note in passing that it was only with considerable last minute lobbying that we were able to forestall attempts to rename HCFA the Medicare and Medicaid Agency. The acronym for the new agency would have been MAMA—allowing even the dimmest to see the implications of your plans.⁸¹

_partisans_10-16.html (PBS television broadcast, Oct. 16, 1996) ("It's the me-me campaign, Medicare, environment, Medicaid, education. Me, me, me.") (on file with the Washington and Lee Law Review).

78. See, e.g., Uwe E. Reinhardt, *Demagoguery and Debate Over Medicare Reform*, HEALTH AFF., Winter 1995, at 101, 101 (detailing the similarities between Democrat and Republican budgetary proposals for Medicare).

79. See Memorandum from Rich Thau, Third Millenium, to Frank Luntz and Jeffrey Pollock, <http://www.thirdmil.org/publications/surveys/0103medicarefindings.html> (Mar. 14, 2001) (discussing a survey of 500 Americans ages eighteen to thirty-four in which a majority of young women believed that *General Hospital* will outlast the Medicare system) (on file with the Washington and Lee Law Review).

80. Mona Charen, *The Bumbler Bowls Them Over*, JEWISH WORLD REV. (Nov. 8, 2002), at <http://www.jewishworldreview.com/cols/charen110802.asp> (on file with the Washington and Lee Law Review).

81. See Pear, *supra* note 42, at A26 (discussing alternative acronym). Pear stated:

Mr. Thompson said he had considered naming the agency the Medicare and Medicaid Administration—MAMA, for short. But, he said, women found that acronym insulting. Also, it reinforced an image of the agency as paternalistic, or in this case maternalistic, at a time when President Bush wants Medicare beneficiaries to take more responsibility for their health insurance options.

Id.; see also *supra* note 10 (providing additional background on the dispute as to whether to

To be sure, there is some evidence that Medicare has become an equal-opportunity club for use against one's political opponents, regardless of party affiliation. As a former Democrat Congressman ruefully observed,

[T]here is no better subject for effective negative campaigning than a vote to slow the growth of the Medicare program with whatever cost cutting or benefit denying or premium increasing it may involve.

Any member knows that however good or decent a Medicare reform bill may be, his opponent in his next campaign will use a vote for that bill against him. It does not take a clairvoyant to see what the television commercial will be: "When he had the chance to protect Medicare, the program that provides health care to all of us in our vulnerable old age, our congressman, [your name here], voted instead to protect the special interests by increasing the premiums." Forget about all the cuts in payment to doctors and hospitals, which pay for 90 percent of the funding changes. "He voted to protect the special interests by increasing the premiums we all must pay for doctor and hospital care." An opponent has to be an idiot not to make campaign hay with that vote.⁸²

Thus, Medicare has proven to be a cost-effective scourge of both political parties, allowing each to satisfy their lust for power, while simultaneously undermining their ability to govern effectively once in office.

F. Anger

Medicare triggers anger among members of the Republican Party. As previously noted, the Democrats have been quite successful at positioning themselves as the protectors of the Medicare program and of program beneficiaries. The Republicans cannot "outbid" the Democrats on Medicare without busting the budget, and Democrats have routinely and effectively demagogued Republican efforts to make even minor revisions to the financing of Medicare and its delivery options. Not surprisingly, Republicans are angry about the effectiveness with which a large command-and-control program, which is inexorably gobbling up an ever increasing share of federal tax revenues, has become a sacrosanct feature of American politics.⁸³ The madder

rename HCFA to MaMA, CMMS, or CMS). Thankfully, "top men" were on hand to resolve the matter. See *supra* note 11 (quoting *Raiders of the Lost Ark*).

82. Anthony Beilenson, *Leadership and Politics: Four Views, in MEDICARE: PREPARING FOR THE CHALLENGES OF THE 21ST CENTURY* 261, 263 (Robert D. Reischauer et al. eds., 1998).

83. As a fan of the original *Star Trek*, you have undoubtedly already noticed the analogies to "The Trouble with Tribbles." Per your request, I confirmed that the screenwriter who forced William Shatner to utter the line "who put the tribbles in the quadrotriticale?" was on our

they get, the less credible their efforts to escape the box in which your eminence has placed them.

The poisoning of legislative politics, which results from the combination of Democratic lust and Republican anger, ensures that any reforms to Medicare will not address its fundamental structural flaws. As such, the program remains on auto-pilot, rather like the Titanic bearing down on an iceberg.⁸⁴ Of course, the sinking of the Titanic closed relatively few of our open accounts. The implosion of the Medicare program and the resulting demoralization costs imposed on the American republic will add tens of millions to our ranks.

G. Vanity

I close with your favorite sin, vanity.⁸⁵ To some extent, this sin affects virtually everyone touched by Medicare, but the group whose vanity is most greatly affected is health policy analysts.⁸⁶ Almost without exception, health policy analysts have hailed the virtues of Medicare and excused its dysfunctions, reasoning *sub silentio* that a program offering a rotten benefit package and mediocre quality health care is better than no program at all.⁸⁷ Of course, it is no accident that virtually every one of these health policy analysts is an enthusiastic member of the Democratic Party, for whom the 1960s remain the best of times.⁸⁸ Among this group, we actually get a two-for-one effect, as lust and vanity work together in a synergistic fashion.

payroll.

84. As you know, we had a hand in the sinking of the Titanic—as well as the making of the resulting movie. Why else would Leonardo DiCaprio end up the star of a major motion picture? On the other hand, given the overwhelming number of souls we already have optioned in Hollywood, it was hard to decide among all the "worthy" candidates.

85. See *DEVIL'S ADVOCATE* (Warner Bros. 1997) (portraying Satan as a New York City attorney who describes vanity as "definitely my favorite sin").

86. Of course, Congressional vanity comes in second. But on the subject of Congressional vanity, like the sun rising in the East, what more can be said?

87. As Professor Mark Pauly has noted, Medicare's basic benefit package would not pass muster with most state insurance commissioners if one tried to offer it. As for the Quality of care provided Medicare beneficiaries, see *infra* notes 90–104 and accompanying text (describing the poor quality of care administered to Medicare beneficiaries). See generally Hyman, *Does Medicare Care About Quality?*, *supra* note 4, at 63–64.

88. But see CHARLES DICKENS, *A TALE OF TWO CITIES* 21 (G.F. Maine ed., W.W. Norton & Co. 1952) (1859) ("It was the best of times, it was the worst of times."). See also Lawrence D. Brown, *Public Health and the Missing Body Politic*, *HEALTH AFF.*, Sept./Oct. 1997, at 215, 217 (reviewing DAN E. BEAUCHAMP, *HEALTH CARE REFORM AND THE BATTLE FOR THE BODY POLITIC*: "[P]lain people have come to view their democratic populist proponents and protectors as part of the problem."); Hyman, *supra* note 15, at 152 ("[G]ood self-help advice should take

This vanity takes several distinct forms. One form of vanity is the refusal of health policy analysts to acknowledge the highly-variable quality of care provided to Medicare beneficiaries. Normally, policy analysts are stereotypical "goo-goos," insisting on the dotting of every "I" and the crossing of every "T" before allowing government money to be spent on anything.⁸⁹ Yet, in Medicare, the same analysts have bestowed their enthusiasm on a program that systematically and routinely pays (and frequently overpays!) for the mistreatment of the vulnerable Americans left in its charge.

Two recent studies offer a useful perspective of our success in these matters. The first study focused on the quality of care provided to Medicare beneficiaries on a state-by-state basis.⁹⁰ The study examined the care provided to Medicare beneficiaries using twenty-four process-based quality measures involving the prevention or treatment of six medical conditions.⁹¹ The six medical conditions (acute myocardial infarction, breast cancer, diabetes, heart failure, pneumonia, and stroke) accounted for a significant amount of morbidity and mortality in the Medicare beneficiary population.⁹² The process-based measures involved interventions for which there was a strong scientific basis.⁹³ The theoretical goal for each measure was for 100% of qualifying Medicare beneficiaries to receive the intervention.⁹⁴ In fact, depending on the measure, performance rates in the median state ranged from 24% to 99%. Median

advantage of the potential benefits of academic engagement with the real world, while simultaneously steering its efforts in a direction likely to be useful—with useful defined in light of the basic insight that the 60s are over").

89. As you know, a "goo-goo" is a "good-government type." We can count on goo-goos to write long, dull, scolding editorials in the *New York Times* and *Washington Post*, bemoaning the latest excesses of the free market and advocating for more and better regulatory oversight of whatever offends them. As Seventh Circuit Judge Frank Easterbrook has noted:

It is ironic that just as a global network and automation are reducing the costs of contracting, and moving us closer to the world in which the Coase Theorem prevails, people promote more and more contract-defeating schemes. One is tempted to think that they are concerned not about market failures but about market successes—about the prospect that the sort of world people prefer when they vote their own pocketbooks will depart from the proposers' ideas of what people ought to prefer. Next thing you know, why, economic transactions between consenting adults will break out right in public view!

Frank H. Easterbrook, *Cyberspace Versus Property Law?*, 4 TEX REV. L & POL'Y 103, 111 (1999).

90. Stephen F. Jencks et al., *Change In the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001*, 289 JAMA 305, 307 (2003).

91. *Id.* at 306.

92. *Id.*

93. *Id.* at 311.

94. *Id.* at 309.

performance in the median state was 73%.⁹⁵ The range of performance rates also varied widely depending on the measure.⁹⁶ The study clearly documented substantial under-provision of necessary care to Medicare beneficiaries.⁹⁷

The second study assessed underuse of necessary care in 345,253 randomly selected Medicare beneficiaries during 1994–1996.⁹⁸ An expert panel developed forty indicators of necessary care (including three indicators of preventive care) and six indicators of avoidable outcomes for fifteen common acute and chronic medical conditions.⁹⁹ For sixteen of the forty measures, beneficiaries received the indicated care less than two-thirds of the time.¹⁰⁰ Beneficiaries received the indicated care 90% of the time for only nine of the forty measures.¹⁰¹ For fourteen of the thirty-seven necessary nonpreventive care indicators, less than two-thirds of beneficiaries received care that a physician panel considered to meet a minimum quality standard.¹⁰²

These studies confirm that the quality of care received by Medicare beneficiaries as a group is thoroughly unimpressive. Better yet from our perspective, this rotten care does not come cheap. The Medicare program has such inadequate financial controls that it hemorrhages money. Indeed, the Office of the Inspector General for HHS (OIG) believes roughly 7% of Medicare payments, totaling approximately \$13 billion per year are "improper."¹⁰³ Although the General Accounting Office and OIG routinely issue reports condemning particular financial shenanigans and labeling Medicare a "high risk program," there has been only limited progress in bringing fiscal discipline to CMS.¹⁰⁴

The second form of vanity is the failure of health policy analysts to appreciate the "sauce for the goose" implications of the precedents they have

95. *Id.*

96. *Id.*

97. Because the study focused on fee-for-service Medicare, it did not include data for the 15% of Medicare beneficiaries covered by Medicare managed care (Medicare Part C). *Id.* at 310. The measures that were employed also resulted in under-sampling of care provided on an ambulatory basis and of interventional procedures. *Id.*

98. Steven M. Asch et al., *Measuring Underuse of Necessary Care Among Elderly Medicare Beneficiaries Using Inpatient and Outpatient Claims*, 284 JAMA 2325, 2329 (2000).

99. *Id.* at 2328–29.

100. *Id.*

101. *Id.*

102. *Id.*

103. See Hyman, *HIPAA*, *supra* note 4, at 167 (reporting and critiquing GAO findings that 7% of Medicare spending is attributable to "improper overpayment").

104. See generally U.S. GEN. ACCOUNTING OFFICE, No. 03-119, HIGH RISK SERIES: AN UPDATE (2003), available at <http://www.gao.gov/pas/2003/d03119.pdf>.

created around the use of Medicare's purchasing power. In most hospitals, Medicare is the single largest purchaser of health care services. As such, health policy analysts (consistent with their goo-goo inclinations) have eagerly tied the acceptance of Medicare money to a variety of our schemes. These schemes impose ancillary restraints on hospitals that undermine their continued viability (EMTALA),¹⁰⁵ condition payment on the satisfaction of every jot and tittle of the thousands of pages of rules and regulations surrounding Medicare (the drafting, interpretation and enforcement of which provide steady employment to the lawyers who have sold their souls to us in exchange for professional success) or simply impose substantial administrative burdens for no good result (PSDA).¹⁰⁶

Fortunately (at least from our perspective), the health policy community never realized that these precedents could be turned on their favorite causes, as the spending power can be used to bat from both sides of the political plate. Indeed, federal funding can be used to require private parties to implement activities that are anathema to health policy analysts, their patrons and supporters. Conversely, federal funding can be used to require private parties to terminate activities that are near and dear to the hearts of the same health policy analysts, their patrons, and supporters. For example, the Solomon Amendments¹⁰⁷ have been used to force universities and law schools to grant equal access to the military for recruiting purposes. The False Claims Act, which requires regulatory compliance with all federal laws, can be used against institutions whose affirmative action programs do not comply with strict constitutional requirements, and the billions of dollars at stake will encourage these institutions to settle on almost any terms.¹⁰⁸ The Baby Doe provisions can be repackaged and redeployed as explicit exercises of the spending power.¹⁰⁹

105. See *supra* note 12 (summarizing EMTALA).

106. PSDA is the Patient Self-Determination Act, which requires hospitals that accept Medicare funding to provide patients with written information concerning their preferences regarding end-of-life care. It is jarring, to say the least, to check into a hospital for the birth of one's child and be asked about one's plans regarding such matters.

107. See 10 U.S.C. § 983 (2000) (establishing the funding requirements of the Solomon Amendments).

108. See 31 U.S.C. § 3730 (2000) (listing the requirements of the False Claims Act). Compare *Luckey v. Baxter Healthcare Corp.*, 2 F. Supp. 2d 1034, 1046 (N.D. Ill. 1998) (declining to use the False Claims Act to enforce regulatory compliance) with *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899 (5th Cir. 1997) (allowing plaintiff to pursue use of the False Claims Act to enforce regulatory compliance).

109. The Baby Doe regulations instructed health care providers that Section 504 of the Rehabilitation Act made it unlawful for all hospitals receiving federal financial assistance to withhold nutrition or medical or surgical treatment from handicapped infants if such treatment was required to correct a life-threatening condition. The Supreme Court struck down these

Of course, each change in administration will bring about a dramatic shift in the substantive obligations imposed on all recipients of federal funds. Over time, all recipients will be forced to implement some activities inconsistent with their self-framed missions. This campaign will further our larger agenda of spreading misery and despair, and will dishearten even the strongest advocates of Medicare.

The third manifestation of the vanity of health policy analysts is their enthusiasm for asymmetric arguments. When the Medicare trust fund is "flush," analysts rebut critics of the program with the observation that Medicare is on sound fiscal footing. When the projected insolvency date grows closer, the same analysts rebut critics by claiming that the trust fund is a meaningless accounting convention and financial projections are inherently unreliable.¹¹⁰

Another example of this approach involves the "case" for prescription drug coverage. Many health policy analysts juxtapose the presence of prescription drug coverage in the private employment-based coverage market with its absence in Medicare and assume that they have made the case for program modification. Yet, when critics argue that the private coverage market has embraced an array of supply-and-demand side restrictions on access to care and that it might be prudent to reform Medicare in an analogous fashion to control program costs, health policy analysts routinely respond that changes in the private market need not be reflected in Medicare. It remains unexplained why taxpayers should subsidize a system for the elderly that has coverage features that are more generous than those the taxpayers are willing and able to buy for themselves. "Sauce for the goose," anyone?

The final form of vanity is the inability of health policy analysts to perceive the importance of exit and exit rights. In a normal market, vendors decide whether to deal or not. Refusal to deal sends a useful signal about the terms that are being offered. Indeed, exit is a critical component of well-functioning markets, as resources are diverted from lower- to higher-valued uses. Yet, in Medicare, health policy analysts treat exit as a mark of disloyalty (as when Medicare managed care organizations decide to pull out of Part C), or as an overt attempt to subvert the self-evident virtues of the program (as when physicians decline to accept new Medicare patients or try to contract with them separately). The criticisms leveled at "concierge" programs reflect a similar

regulations in *Bowen v. American Hospital Association*, 476 U.S. 610 (1986).

110. And right they are. Unfortunately, when it comes to Medicare, they turn out to be unreliable because they are unduly conservative. The original projections for Medicare dramatically underestimated the actual cost of the program. See EPSTEIN, *supra* note 33, at 149 (showing a dramatic mismatch between original projections and actual expenditures, despite testimony at hearings that cost estimates were overly optimistic).

lack of understanding of the importance of exit rights (as well as of basic economics).

Admittedly, it is unclear whether the opposition of health policy analysts to exit rights is attributable to their complete ignorance of economics, their position as academics (who developed tenure in order to constrain the exercise of exit rights) or both. It is difficult to determine which effect predominates because most health policy analysts are academics and most academics are ignorant of economics. Regardless of where one comes out on this issue, vanity clearly plays a role in the willingness of health policy analysts to hail Medicare's "virtues," whitewash its faults, and attack those who do not share their faith in the "self-evident virtues" of Medicare.

III. Medicare and the Undermining of American Virtues

As you presciently recognized in your memo proposing Medicare, a program incorporating the Seven Deadly Sins would never attain its intended objectives unless we also undermined the American virtues that would otherwise impede our plans. The two distinctively American virtues that most directly threatened our plans were thrift and truthfulness. These virtues figured prominently in the lives of the Founders. Benjamin Franklin celebrated the importance of thrift in numerous influential writings, and George Washington was renowned as the politician who could not tell a lie. American politicians celebrate these virtues, reasoning that they are unelectable if they promise anything else to their constituents. The near-universality of these virtues in the American population made it much more difficult for our plans to proceed on schedule. Thus, we have attacked these virtues on several fronts, using entitlement programs as our principal weapon.

A. Thrift

DISS is simultaneously submitting a detailed memorandum on the impact of Social Security on our recruitment efforts and its undermining of the virtue of thrift, so this memorandum focuses on Medicare. As you know, Medicare's financing provides that revenues secured from current taxpayers fund the medical expenses of current beneficiaries, frequently referred to as "pay as you go."¹¹¹ Demographic projections and the ever-increasing cost of health care

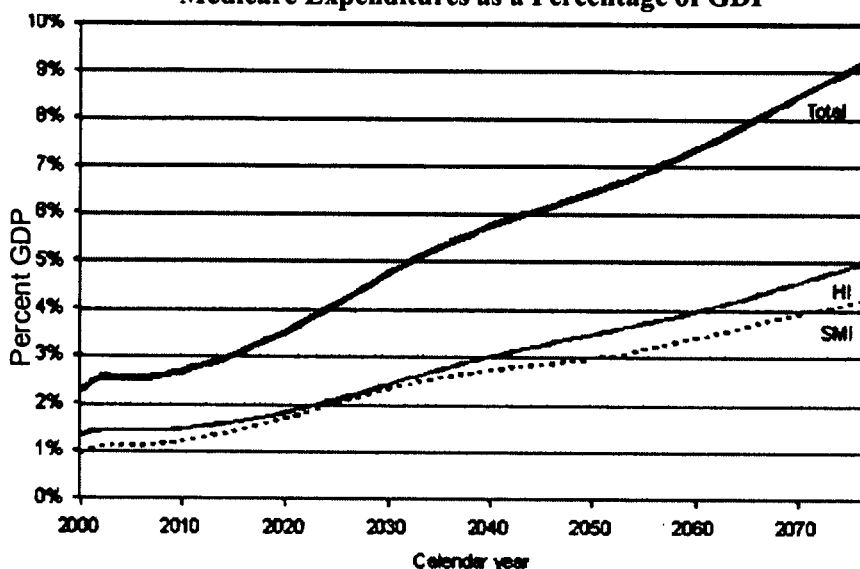
111. See Vicki Kemper, *Benefits Outlook Is Mixed Bag; Social Security Picture Is Brighter, While Future for Medicare Is Dimmer, Trustees' Reports Show*, L.A. TIMES, Mar. 18, 2003, at A20 (describing Medicare's financing structure).

ensure that the program's economics are simply unsustainable, even without the addition of a prescription drug benefit. As the summary of the most recent report from the (ironically named) Trustees of the (also ironically named) Part A trust fund stated:

[T]he fundamentals of the financial status of Social Security and Medicare under the intermediate economic and demographic assumptions remain highly problematic Growing deficits will lead to rapidly mounting pressures on the Federal budget in a decade and exhaustion of trust funds beginning in little more than two decades In the long run, these deficits are projected to grow at unsustainable rates.¹¹²

Figure 1, which presents Medicare expenditures as a percentage of GDP, documents these phenomena graphically. HI stands for hospital insurance (Part A). SMI stands for Supplemental Medicare Insurance (Part B).

Figure 1
Medicare Expenditures as a Percentage of GDP



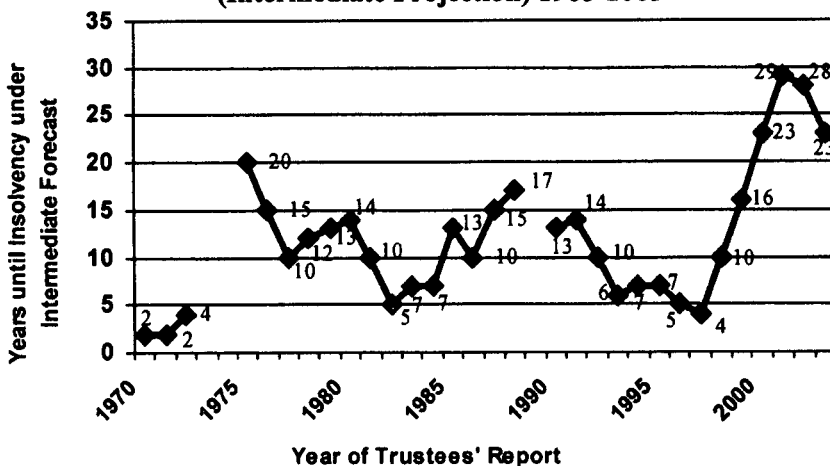
The striking thing about these observations is that they have become so routine that they are routinely ignored.¹¹³ Only the imminent

112. SOC. SEC. & MEDICARE BD. OF TRS., A SUMMARY OF THE 2003 ANNUAL REPORTS, at <http://www.ssa/OACT/TRSUM/trsummary.html> (2003) (on file with the Washington and Lee Law Review).

113. See Kemper, *supra* note 111, at 20 ("The new numbers are generally followed by much rhetorical hand-wringing and little political action.").

"bankruptcy" of the Part A trust fund (less than seven years) is sufficient to rouse the political process from its sloth.¹¹⁴ The consistent approach when attempting "reform" is to fix the short term and ignore the (far more problematic) long term.¹¹⁵ To be sure, Medicare's short-term financial prospects are the best they have been in some time, but that is because, as Figure 2 demonstrates, Medicare has always been on a tenuous financial footing. Indeed, the Part A trust fund has not been on actuarially sound footing (such as what would be expected of a private annuity) at any time since its creation.¹¹⁶

Figure 2
Number of Years until Part A Trust Fund Insolvency
(Intermediate Projection) 1965-2003



The extent to which Medicare, with its "promise now, pay later" approach, has succeeded in undermining the distinctively American virtue of thrift becomes obvious only by examining the program's long-term

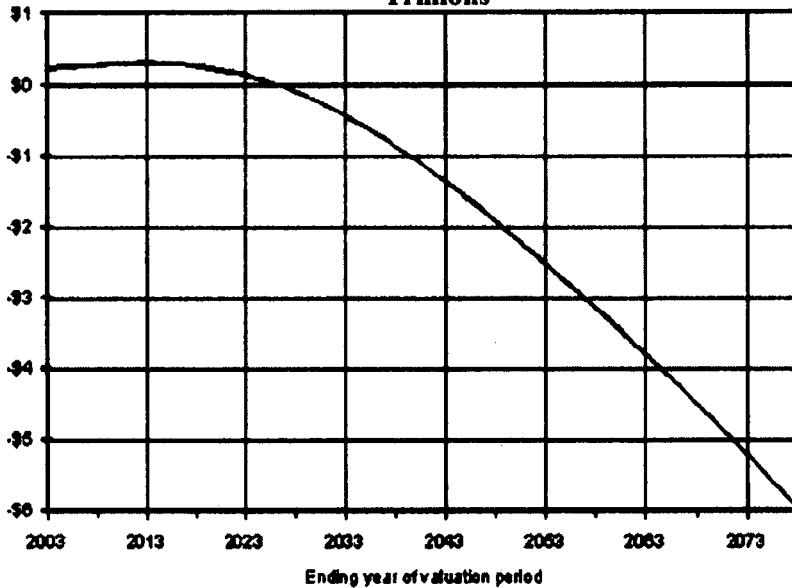
114. See Theodore R. Marmor, *How Not to Think About Medicare Reform*, 26 J. HEALTH, POL., POL'Y & L. 107, 113-14 (2001) (discussing how the political equivalent of "being hanged in a fortnight" has the power to concentrate legislative attention on Medicare reform).

115. See Robert M. Ball, *The Sky Isn't Falling on Medicare*, L.A. TIMES, July 24, 2001, at B13 (discussing acceptance of short term solutions because of unreliability of long term projections).

116. To be fair, private pensions need not be fully funded either, but the failure of companies to fully fund their pensions is routinely criticized by the most enthusiastic supporters of Medicare. As before, it is hard to have it both ways on this issue—particularly when the goose has long since drowned in sauce. See 29 U.S.C. § 1082(b) (2000) (establishing the funding requirements for private pensions).

projections. Figure 3 shows the present value of the Medicare trust fund across differing periods, and documents a \$5.9 trillion deficit using a seventy-five year projection.

Figure 3
Present Value of Medicare HI Commitments in
Trillions



The Medicare Trustees estimate that this long-term actuarial imbalance can be corrected by immediately cutting benefits by 42% or increasing the taxes that fund Medicare by 71% or some combination of both.¹¹⁷ Of course, given the political dynamics of Medicare, neither of these eventualities will occur. Indeed, as the current controversy over adding a prescription drug benefit to Medicare makes clear, all of the pressures are to expand the program, not to bring its finances into long-term actuarial balance.

To summarize, we are lucky that no one has (so far) "connected the dots" of the following fundamental features of Medicare:

1. Short-term viability dependent on continuous addition of new participants/funds;

117. See SOC. SEC. & MEDICARE BD. OF TRS., *supra* note 112 (examining the future of Medicare).

2. Unsustainable long-term promises;
3. Early "investors" paid off with subsequent "investor" contributions;
4. Arguments from security/fidelity/solidarity to ensure continued participation.

Once these dots are connected, people will realize that Medicare is a pyramid scheme structured on an intergenerational basis.¹¹⁸ Pyramid schemes are invariably shut down by the authorities as soon as they are discovered on the grounds that those who were suckered at the outset have no right to share their misery with others. The legal system imposes harsh penalties on pyramid scheme organizers because defrauding hundreds or thousands of people is much worse than defrauding a handful of people. Indeed, if anyone other than the United States government were running the Medicare program, those responsible would already be serving long prison terms for fraud. However, you cleverly positioned Medicare as a sacred intergenerational trust, with the result that all the political pressures are to preserve, if not expand, the pyramid scheme.

Despite our repeated efforts to disguise the truth about Medicare through the endless repetition of misleading rhetoric (principally the phrases "trust fund" and "lockbox"), many Americans are coming to realize that Medicare is, in fact, an elaborate intergenerational pyramid scheme. Indeed, no less a "New Democrat" authority than the *New Republic* has been forced to observe, "[I]f there's a big problem with Medicare these days, it's the program's lack of long-term financial viability."¹¹⁹ Thankfully, our framing of the Medicare program as a sacred intergenerational trust has significantly dampened the outrage that would otherwise result; the *New Republic* would not have been nearly as complacent had the sentence been: "If there's a big problem with Enron these days, it's the company's lack of long-term financial viability." Of course, the principal difference between Medicare and Enron is that Medicare's "lack of long-term financial viability" is much worse than Enron's.¹²⁰

118. See generally JAMES WALSH, YOU CAN'T CHEAT AN HONEST MAN: HOW PONZI SCHEMES AND PYRAMID FRAUDS WORK . . . AND WHY THEY'RE MORE COMMON THAN EVER (1988); Peter J. Vander Nat & William W. Keep, *Marketing Fraud: An Approach for Differentiating Multilevel Marketing from Pyramid Schemes*, 21 J. PUB. POL'Y & MARKETING 139 (Spring 2002).

119. Jonathan Cohn, *The Single Guy*, NEW REPUBLIC ONLINE ¶ 12, Nov. 22, 2002, at <http://www/tnr.com/doc.mhtml?i=express/sc=cohn112202> (on file with the Washington and Lee Law Review). Normally, this defect would be dispositive, but self-styled sacred intergenerational trusts are apparently subject to different rules.

120. As Figure 3 documents, the present value of Medicare's unfunded liabilities in Part A

Although we have largely stifled the criticisms that pyramid schemes usually engender, we must expect the Medicare program (and its financing) to come under increasing scrutiny in the coming years. We have already contacted our affiliates on K Street and at various think tanks, who stand ready to defend the "virtue" of the Medicare program from its all-too-correct critics. The good news is that our efforts at destroying public education in the United States (along with our systematic resistance to vouchers) has rendered a large chunk of the population functionally innumerate.¹²¹ The impassioned defenses of Medicare offered by most health policy analysts¹²² will accordingly be resolved at the level of rhetoric, instead of through simple addition and subtraction.¹²³

Our success using entitlement programs to undermine thrift has benefited from our separate initiative discouraging the repayment of debts, which has borne fruit in the tax law. The tax code only allows the deduction of "ordinary and necessary" business expenses.¹²⁴ In an influential opinion, the Supreme Court ruled that post-discharge repayment of debt was nondeductible because such conduct was not "ordinary and necessary."¹²⁵ Of course, if Americans

over the next seventy-five years is approximately \$6 trillion. If one includes the projected expenditures attributable to government payment of the majority of Part B expenditures and does not impose an arbitrary seventy-five year cap, the figure is substantially larger. *See* JAGADESH GOKHALE & KENT SMETTERS, FISCAL AND GENERATIONAL IMBALANCES: NEW BUDGET MEASURES FOR NEW BUDGET PRIORITIES 3-4 (2003) (noting that the fiscal imbalance of Medicare totals \$36.6 trillion out of a total federal fiscal imbalance of \$44.2 trillion and that fixing it will require additional annual payroll taxes of 16.6%, a 66% increase, beginning immediately), available at http://www.aei.org/publications/bookID.426.filter/book_detail.asp.

At the time of its bankruptcy filing, Enron claimed liabilities of \$27 billion and assets of \$61 billion. Even if one (implausibly) assumes that Enron had no assets whatsoever, its liabilities are only 0.3% of Medicare's unfunded liabilities in Part A. Yet, the *New Republic* has been the scourge of all those associated with Enron (no matter how distantly), even as it suggests that we should reconfigure the nation's health care along the lines of Medicare. Go figure (or not, if you are a lawyer). *See supra* note 12 (discussing the subpar math skills of the average lawyer).

121. Lawyers do not count, because they are innumerate to begin with. *See supra* note 12 (lambasting the average lawyer's math skills).

122. *See supra* Part II.G (discussing vanity of health policy analysts and their unflinching defense of Medicare).

123. Of course, as every political campaign involving Medicare illustrates, "Figures don't lie, but liars figure."

124. *See* I.R.C. § 162 (2002) ("There shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business . . .").

125. *See* *Welch v. Helvering*, 290 U.S. 111, 115 (1933) (stating that the repayment of debts previously discharged in bankruptcy was not deductible because it was not ordinary and necessary). Welch and his father owned a grain brokerage business in Minnesota, which went

retained their traditional virtues such behavior would have been not only "ordinary and necessary," but appropriate, if not essential. Yet, Justice Cardozo's opinion made repayment of debt less likely, reinforcing lax attitudes rewarding indebtedness.

B. Truthfulness

As you predicted, entitlement programs have provided numerous opportunities for political dissembling. As noted previously, the ceaseless use of misleading terminology (for example, trust-fund and lock-box) is one aspect of the phenomenon. This terminology is used to suggest that Medicare administrators "save" contributions even though the administrators spend all the money as soon as they receive it or loan it to the Treasury in exchange for a commitment that is binding on future taxpayers. So much for the purported superior ability of government to balance the interests of future generations against current voters!¹²⁶ Politicians display a similarly flexible acquaintance with the truth when they assert that beneficiaries deserve enhanced benefits (such as a prescription drug benefit) simply because, at some time in the past, they paid some amount into the system. Such strategies are an invitation to disaster. Indeed, pyramid schemes self-destruct precisely because everyone takes out of the pot more than they put in.

The full effect of Medicare on political truthfulness is demonstrated by the whoppers politicians will tell to justify their attempts to "save" the program from self-destruction or to extract political advantage from the "reform" proposals of their opponents. Both Republicans and Democrats know they are unelectable if they speak candidly about the economic problems facing Medicare. Republicans accordingly package their reform proposals as attempts to "modernize" the Medicare benefit package and offer beneficiaries more options. Democrats focus their efforts on price caps and prayer. Neither approach is likely to produce even the minimum

bankrupt in 1922. *Id.* at 112. Welch talked to three Minneapolis bankers who told him, if he ever wanted to be accepted by the business community again, he would have to repay his discharged debts. *Id.* Welch repaid his debts, but his attempts to deduct the repayments were turned away by Justice Cardozo, who reasoned that repayment was not "ordinary and necessary." *Id.* at 115. Justice Cardozo failed to consider that his conclusion would undermine the likelihood of further repayments—making them even less ordinary, let alone necessary.

126. See *supra* note 56 (expressing skepticism that the political system will safeguard the interests of future voters, let alone nonvoters).

expected of a private insurance plan or investment—actuarially sound and economically sustainable promises to purchasers/investors.

Consider a concrete example. As you know, Medicare has two parts: Part A, which is paid for with payroll contributions, and Part B, which is paid for with general revenues and beneficiary contributions. Part A has been subject to periodic crises, as the Medicare trustees dutifully announce that the Part A trust fund will go bankrupt in a few years. There are only two possible strategies to address this problem: increase the flow of revenues into the Part A trust fund or decrease the flow of payments out of the Part A trust fund. Part B provides a seeming "third way"—shifting costs from Part A to Part B. This approach appears to solve the problem but actually makes it worse by hiding the severity of the problem and suggesting that Medicare's problems can be addressed through sleight of hand.

One recent use of this strategy exemplifies the opportunities for mischief. In 1997, the Clinton Administration announced a plan to "save" Medicare. The plan included a broad array of statutory and regulatory changes, the most significant (and least noticed) of which was to transfer home health care from Part A to Part B.¹²⁷ For most people, an expenditure is an expenditure, regardless of where the money comes from. Budgeting in the government works differently. Moving home health care out of Part A "saved" Medicare almost \$100 billion and extended the life of the trust fund even though the budget absorbed the same cost elsewhere and the exact same amounts still had to be paid.¹²⁸ When asked about this strategy, HHS Secretary Donna Shalala replied that the change was appropriate because it was consistent with the original structural design of Medicare.¹²⁹

127. See George Rodrigue, *Largest Saving Would Be \$100 Billion from Medicare; Clinton Says the Vulnerable Will Be Protected*, DALLAS MORNING NEWS, Feb. 7, 1997, at 1A ("Mr. Clinton reached his Medicare savings target partly by shifting about \$85 billion in home health-care costs from Medicare's Part A trust fund—which faces bankruptcy—to its Part B program which is funded mostly by general tax revenues").

128. It is unfortunate that Max Bialystock was unable to exploit similar accounting rules, but at least his travails have resulted in a popular movie and Broadway show that allowed us to reposition the Third Reich in a more favorable light. MEL BROOKS, *THE PRODUCERS* (2002) ("Don't be stupid/be a smarty/come and join the Nazi party.").

129. See Dan Freedman, *Home Health Care Is Focus of Medicare Battle*, SUN-SENTINEL (Fla.), Feb. 16, 1997, at 3A ("Shalala argued that the plan conforms to the original intent of the 1965 law establishing Medicare: Let the trust fund take care of major hospital expenses and have the supplementary insurance program cover everything else."). In theory, one could keep this strategy up indefinitely and maintain the trust fund in surplus simply by transferring out expenses that can no longer be covered by Part A contributions. This "wishing makes it so" approach to program expenditures hides and, by deferring, increases the severity of Medicare's fiscal crisis.

As you know, the road to hell is a superhighway paved with such stratagems and justifications.

Such behavior is, of course, bipartisan. We fully expect that the debate in the 108th Congress over creating a Medicare prescription drug benefit will provide us with numerous additional examples of such conduct and rhetoric. Unfortunately, your deadline for submission of this memo precludes me from including what we at DISS fully expect to be the pinnacle of partisan political rhetoric.

IV. Conclusion

All of the building blocks are in place for our plans to destabilize the virtue of the American republic. Although actuarial estimates vary somewhat (regrettably, we have not succeeded in suborning all the actuaries), the Medicare budget is heading for a demographic brick wall at an accelerating rate. Every attempt to impose fiscal discipline triggers squeals of outrage from affected providers, beneficiary groups and true believers in the intergenerational pyramid scheme. To date we have forestalled every attempt to comprehensively reform Medicare and we are confident that we will be able to do so in the 108th Congress.

Our best calculation is that the Medicare program will completely implode within two generations. Efforts to "reform" Medicare will extend the process only slightly, while simultaneously breeding dissension and class warfare—confirming the predictions outlined in your original memo.¹³⁰ As long as no one learns of our plans, we look forward to an ever-increasing United States market share. Best of all, we obtain this increase in market share without any further promotional/recruiting expenditures on our part. You have replaced the virtuous circle at the heart of the American republic with a vicious circle.¹³¹ All of us in the North American division of DISS bow our horns in awe of your subtle genius.

Have a hellish day.

130. See SATAN, *supra* note 20, at 666 (detailing scheme to subvert American virtues).

131. See ROBERT D. PUTNAM ET AL., *MAKING DEMOCRACY WORK: CIVIC TRADITIONS IN MODERN ITALY* 177 (1993) (discussing markers of civic virtue in modern American society). Putnam wrote:

Stocks of social capital, such as trust, norms, and networks, tend to be self-reinforcing and cumulative. Virtuous circles result in social equilibria with high levels of cooperation, trust, reciprocity, civic engagement, and collective well-being Conversely, the absence of these traits in the uncivic community is also self-reinforcing. Defection, distrust, shirking, exploitation, isolation, disorder, and stagnation intensify one another in a suffocating miasma of vicious circles.

Id.

Underling Demon 666
DASCAR, DISS

Post-Script:

Of course, it is libelous to suggest that the most successful program of Johnson's Great Society is a demonic plot. However, satire provides a tool for exploring some of Medicare's problems in a less confrontational manner than would otherwise be the case. At least that's my story and I'm sticking to it.

To be sure, many of Medicare's defenders react to even the slightest criticism of their program with a ferocity that demonstrates that their enthusiasm has more to do with ideology than the actuarially sound/goo-goo approach they would insist on if we were talking about anything other than Medicare. Imagine the cries of righteous indignation that we would hear from Medicare's defenders if Congress established a program with similar spending projections and unimpressive quality to secure weapons for the military instead of health care for the elderly.

Satire has the potential to provoke the program's defenders to at least start to acknowledge some of Medicare's problems. Of course, it would be foolish to be overly optimistic about how much Medicare's defenders are likely to acknowledge. Indeed, it is likely that Medicare's defenders will get stuck at either stage 1 (denial) or stage 2 (anger), instead of progressing to bargaining (stage 3) or depression (stage 4)—let alone acceptance (stage 5).¹³²

Consider what happened when I presented some (considerably less pointed) remarks on Medicare at the conference at the Washington & Lee University School of Law. One of Medicare's most enthusiastic supporters responded by making an impassioned speech that it was improper to describe Medicare as a "Ponzi scheme," and the program should not be judged by the standards that would apply to a private pension because it was actually a "sacred bond" between the generations.¹³³ His words brought enthusiastic applause from those members of the audience who had heard enough bad news and were more than ready to ignore Medicare's problems on the basis of political sloganeering. Yet, this "explanation" provides no basis for believing that Medicare should not be judged by the standards of any other government expenditure or private investment, let alone a defensible theory for

132. See ELIZABETH S. KÜBLER-ROSS, *ON DEATH & DYING* 34-121 (MacMillan Co., 7th prt. 1971) (1969) (discussing the five stages of grief).

133. I never used the word "Ponzi" in my remarks. I did note that the Medicare program bore certain similarities to an intergenerational pyramid scheme. Of course, it is possible that the use of this term was simply a Freudian slip by a Medicare enthusiast who can't handle the truth. See *A FEW GOOD MEN* (Columbia Tri Star 1992) ("You can't handle the truth!").

understanding how any given act of Congress magically becomes a "sacred bond between the generations." Instead, this "explanation" is, at best, nothing more than an exercise in sophistry and, at worst, simply another example of the "wishing makes it so" approach to Medicare that is pathonemonic of the program's more vehement defenders.¹³⁴

If Medicare really were a sacred bond between the generations, Medicare reform would not be a live issue on the political agenda, which it is. There would not have been a bipartisan Commission on Medicare reform, which there was.¹³⁵ The bipartisan Commission would not have considered moving the program from a defined benefit to a defined contribution approach, which it did.¹³⁶ There certainly would not have been a clear majority (albeit not a supermajority) for this approach, which there was.¹³⁷ Stated simply, Medicare reform is a live issue because Medicare is *not* a sacred bond between the generations. It's just a program and a pretty mediocre one at that.

The depth and sincerity of Medicare defenders' faith in the program (and in centralized command-and-control administered pricing systems more generally) should not obscure the reality that Medicare's philosophical foundations are contested and up for reconsideration to a degree not seen since the program's enactment. Given this scrutiny, it is worth considering how Medicare fares in light of the parable that Milton Friedman told when he was honored for his lifetime achievement at the White House on May 9, 2002:

My views on government spending can be summarized by the following parable. If you spend your own money on yourself, you are very concerned about how much is spent and how it is spent. If you spend your own money on someone else, you are still very much concerned about how much is spent, but somewhat less concerned about how it is spent. If you spend someone else's money on yourself, you are not too concerned about how much is spent, but you are very concerned about how it is spent. However, if you spend someone else's money on someone else, you are not very concerned about how much is spent or how it is spent.¹³⁸

134. See Ball, *supra* note 115, at B13 (suggesting that dismal long-term projections for Medicare should be ignored because beneficiaries need help with prescription drug coverage now, and the future will take care of itself).

135. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 347 (establishing the National Bipartisan Commission on the Future of Medicare).

136. See National Bipartisan Commission on the Future of Medicare, Transcript of Commission Meeting (Mar. 16, 1999), at <http://medicare.commission.gov/medicare/trans.html> (outlining defined contribution strategy for reforming Medicare) (on file with the Washington and Lee Law Review).

137. *Id.*

138. Milton Friedman, Remarks at White House Ceremony in his Honor (May 9, 2002), in

Three guesses as to which of the four formulations best describes Medicare—although the answer does depend on one's position on the political spectrum and on whether one is currently a Medicare beneficiary or provider of services to the same. Of course, it is possible that Friedman's insight has nothing to do with the debate over Medicare and the preferences of Medicare's supporters.¹³⁹ It is also possible that the moon is made of green cheese. To be sure, literature provides a complementary explanation for the refusal of Medicare's proponents to face actuarial reality. As Saul Bellow once noted: "A great deal of intelligence can be invested in ignorance when the need for illusion is deep."¹⁴⁰

Another issue is whether the observations in the DISS memorandum are falsified or confirmed by the passage of the Medicare Prescription and Modernization Act of 2003 (the Act). As any fair minded reader must acknowledge, six of the seven deadly sins (avarice, gluttony, envy, lust, anger, and vanity) were on full display during legislative deliberations, and there is no question that the Act reflects the influences of each and every one of them.¹⁴¹ Sloth is the only one of the seven deadly sins that appears to be inconsistent with the Act—but there was legislative sloth in addressing Medicare's budgetary prospects. Indeed, if anything, the Act actually worsened Medicare's long-term financial outlook. Unfortunately, there has been no further communication from DISS, so it is impossible to say what Underling Demon 666 (let alone the Devil) make of the Act. Stay tuned for further developments.

Finally, during the symposium, Professor Oberlander accurately described Medicare as a flower-child—to which I retorted that it was the only flower-child I was aware of with \$250 billion per year with which to fix prices and interfere with the functioning of the market for health care services. A more devastating come-back escaped me at the time, but occurred to me later. In the immortal words of Dr. Evil, "There's nothing more pathetic than an aging hipster."¹⁴²

CATO POL'Y REPORT, July/Aug. 2002, at 11, available at <http://www.cato.org/pubs/policy-report/v24n4/cpr-24n4.pdf> (on file with the Washington and Lee Law Review). President Bush's remarks on the occasion may be found at <http://www.whitehouse.gov/news/releases/2002/05/20020509-1.html> (May 9, 2002) (on file with the Washington and Lee Law Review).

139. See *supra* note 72 and accompanying text (noting common belief in progressive circles that the highest purpose of government is to send people checks in the mail).

140. Quotation attributed to Saul Bellow, <http://www.quotemeonit.com/bellow.html> (last visited Jan. 22, 2004) (on file with the Washington and Lee Law Review).

141. Somewhat surprisingly, many Republicans and Democrats switched deadly sins during the course of the debate.

142. AUSTIN POWERS: INTERNATIONAL MAN OF MYSTERY (New Line Cinema 1997).