MEDICARE: COMPARING CONGRESSIONAL RHETORIC WITH REALITY

October 2024

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Executive Summary

Opponents of Medicare made dire predictions when the program was being debated in Congress in the 1960s. They argued that it would degrade the quality of Americans' healthcare, slow medical progress, exacerbate existing shortages of physicians and nurses, undermine the economy, burden lower-wage workers, and threaten Americans' freedom. For example, they claimed that under Medicare:

- **"[A] deterioration in the quality of care is inescapable"** (Dr. Donovan Ward, President of the American Medical Association)
- **"[P]rogress in medicine will be stunted and shriveled by an excess of government control"** (Representative Durward Hall)
- **"Medical care in this country is heading for a real crisis. … Shortages of many kinds will be encountered"** (U.S. News and World Report)
- **"[There will be] a series of terrific jolts, not only to industry but to every individual working man and woman in America"** (Republican presidential candidate General Hanford MacNider)
- **"[I]ts ill effects will be felt in the … unwarranted, regressive tax burden on our citizens"** (Representative Edward Derwinski)

Ronald Reagan told a radio audience, **"We do not want socialized medicine. … [B]ehind it will come other federal programs that will invade every area of freedom as we have known it in this country. Until, one day, … you and I are going to spend our sunset years telling our children, and our children's children, what it was once like in America when men were free."**

As Medicare approaches its 60th birthday, however, it is abundantly clear that none of these doomsday projections were accurate. In fact, the opposite has occurred. Medicare has dramatically enhanced the care received by seniors, spurred medical innovation, boosted the medical workforce, addressed inequities in care, and helped protect seniors from crushing medical expenses.

Background

Medicare and Medicaid were enacted together in the Social Security Amendments of 1965. During congressional consideration of this legislation, Medicaid generated minimal controversy, as there was bipartisan consensus within Congress about helping poor Americans afford health care.[1] However, members of Congress disagreed strongly about the best way to provide care to retired workers.

The original Medicare program was composed of two parts. Part A established a hospital insurance program for Americans aged 65 and older that was funded primarily by a new payroll tax, similar to Social Security's payroll tax. Part B established an outpatient health insurance program for the same age

[1] Edward Berkowitz, Health Care Financing Review, *Medicare and Medicaid: The Past as Prologue* (Winter 2005) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194925/).

group. In contrast to Part A, Part B is primarily funded through general revenues and monthly premiums paid by beneficiaries.[2]

Medicare has been expanded and reformed several times over almost six decades, including these prominent changes:[3]

- The Social Security Amendments of 1972 added coverage for people with disabilities and those with end-stage renal disease (ESRD).[4]
- In 1982, legislation allowed private insurers to offer Medicare-approved plans, now known as Medicare Advantage or Part C plans.[5]
- In 2003, legislation established prescription drug coverage through Medicare Part D.[6]
- In 2010, the Affordable Care Act (ACA) lowered prescription drug costs for Medicare beneficiaries, saving them billions.[7] It also eliminated co-pays for preventative services, made value-based payment reforms, and extended the solvency of Part A's Hospital Insurance Trust Fund.[8]

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[2] Approximately 1% of Part A beneficiaries are not eligible for Social Security benefits and must pay a monthly premium to receive Part A benefits. *See* Centers for Medicare & Medicaid Services, *2024 Medicare Parts A & B Premiums and Deductibles* (October 11, 2023) (https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles).

[3] Numerous additional changes have been made to Medicare over its history. *See* Kaiser Family Foundation, *Medicare Timeline* (March 24, 2015) (https://www.kff.org/medicare/timeline/medicare-timeline/).

[4] Paul W. Eggers, Health Care Financing Review, *Medicare's End Stage Renal Disease Program* (Fall 2000) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194691/).

[5] Thomas G. McGuire, Joseph P. Newhouse, and Anna D. Sinaiko, The Milbank Quarterly, *An Economic History of Medicare Part C* (June 2011) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/).

[6] Congressional Research Service, *Medicare Part D Prescription Drug Benefit* (November 14, 2023) (https://crsreports.congress.gov/product/pdf/R/R40611).

[7] Co-Equal, *The Affordable Care Act: Comparing Congressional Rhetoric With Reality,* page 21 (March 2024) (https://cdn.prod.website-files.com/5cd036eb776bf651fcf12ee9/660162703b48c9d05300dae9_ACA%20Legislative%20Retrospective%20Final.pdf#page=21).

[8] Centers for Medicare & Medicaid Services, *Background: The Affordable Care Act's New Rules on Preventive Care* (September 10, 2024) (https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background) (preventative services); Commonwealth Fund, *The Impact of the Payment and Delivery System Reforms of the Affordable Care Act* (April 28, 2022) (https://www.commonwealthfund.org/publications/2022/apr/impact-payment-and-delivery-system-reforms-affordable-care-act) (value-based payment reforms); Kaiser Family Foundation, *What Are the Implications of Repealing the Affordable Care Act for Medicare Spending and Beneficiaries?* (December 13, 2016) (https://www.kff.org/affordable-care-act/issue-brief/what-are-the-implications-of-repealing-the-affordable-care-act-for-medicare-spending-and-beneficiaries/) (solvency of Medicare's Hospital Insurance Trust Fund). For more information on the ACA's impact on the solvency of Medicare's Hospital Insurance Trust Fund, *see* Kaiser Family Foundation, *FAQs on Medicare Financing and Trust Fund Solvency,* Figure 4 (May 29, 2024) (https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/).

The ACA introduced several reforms to shift Medicare and Medicaid away from traditional "fee-for-service" payment arrangements, where medical providers are paid based solely on the number of services provided, to "value-based" payments that link reimbursement to the quality of care delivered. For more information, *see* Centers for Medicare & Medicaid Services, *Value-Based Care* (accessed on September 30, 2024) (https://www.cms.gov/priorities/innovation/key-concepts/value-based-care) (general overview); Douglas Jacobs, et al., Health Affairs, *The Medicare Value-Based Care Strategy: Alignment, Growth, and Equity* (July 21, 2022)

- In 2022, the Inflation Reduction Act further enhanced Part D coverage. As of 2023, beneficiaries who rely on insulin have their costs capped at $35 a month, co-pays on adult vaccines were eliminated, and inflation rebates penalize drug manufacturers that raise prices faster than inflation. Beginning in 2024, beneficiaries' out-of-pocket prescription drug costs are now capped, and starting in 2026, they will have access to lower-priced brand-name drugs negotiated by Medicare.[9]

As of June 2024, 67.5 million Americans – nearly one in five – were enrolled in Medicare, and 60.4 million of those beneficiaries were aged 65 or older.[10]

Claim: Medicare Would Cause a Deterioration in the Quality of Health Care

"Under our system of medicine as we have always known it, treatment of the individual has come first and financing second. The physician has exercised his knowledge and skill to his greatest capacity in each case. But with the emphasis shifting from quality to cost, as it must under a publicly financed program, a deterioration in the quality of care is inescapable."

– Dr. Donovan Ward, President of the American Medical Association, June 1965[11]

"Profit is the only motivation for excellence. We are going to have a decline in the quality and the quantity of medicine in America. … Let us not go on the assumption here that we are not destroying the quality and the quantity of medicine and that we are not socializing medicine, because that is exactly what we are doing."

– Representative James Utt, April 8, 1965[12]

"[W]e cannot stand idly by now, as the Nation is urged to embark on an ill-conceived adventure in Government medicine, the end of which no one can see, and from which the patient is certain to be the ultimate sufferer."

– Representative Durward Hall, April 8, 1965[13]

(https://www.healthaffairs.org/content/forefront/medicare-value-based-care-strategy-alignment-growth-and-equity) (Medicare's ongoing value-based reform efforts).

[9] Centers for Medicare & Medicaid Services, *Inflation Reduction Act and Medicare* (September 2023) (https://www.cms.gov/inflation-reduction-act-and-medicare).

[10] Centers for Medicare & Medicaid Services, *Medicare Monthly Enrollment* (September 30, 2024) (https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment).

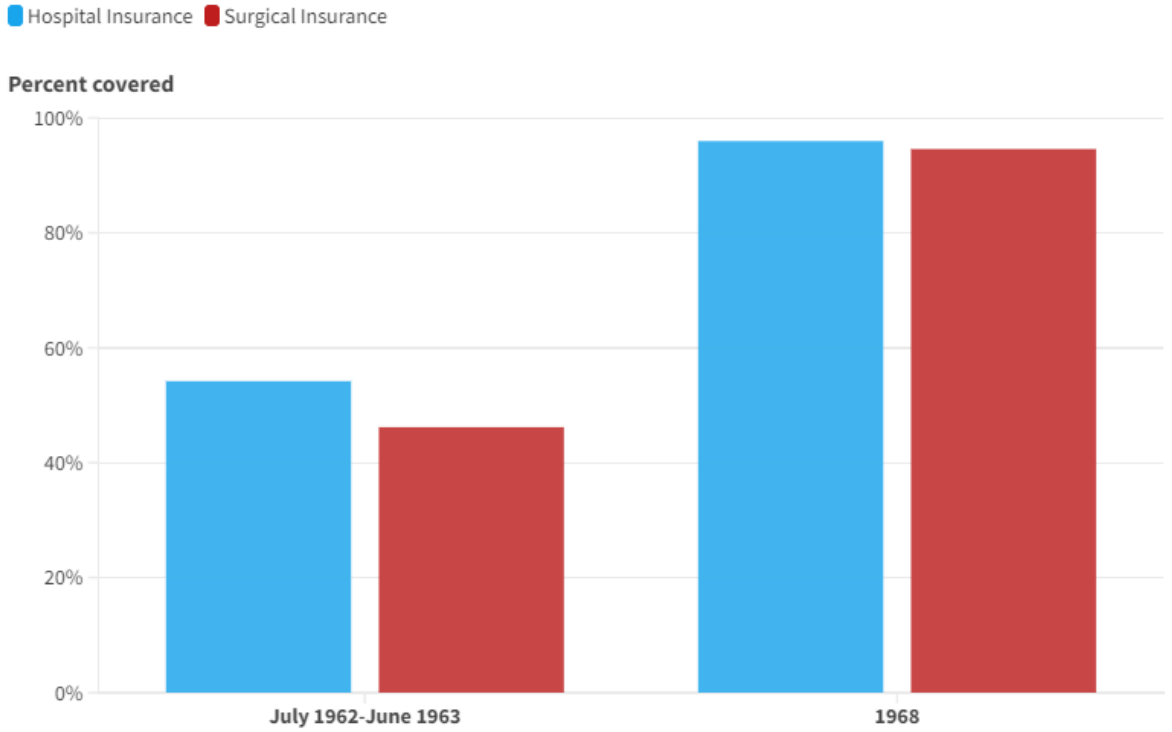
[11] American Metal Market, *Doctors' Remedy for Medicare* (June 7, 1965), reproduced in the *Congressional Record,* page 15939 (July 8, 1965) (https://www.congress.gov/89/crecb/1965/07/08/GPO-CRECB-1965-pt12-2-1.pdf#page=88).

[12] *Congressional Record,* page 7390 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=40).

[13] *Congressional Record,* page 7392 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=42).

Critics of Medicare predicted that the federal government's involvement would reduce the quality of care received by America's seniors. The opposite happened. In 1963, just 54% of Americans aged 65 and older had hospital insurance, and only 46% had surgical insurance.[14] Following the enactment of Medicare in 1965, coverage for Americans 65 and older jumped to nearly 100% for both types of insurance.[15] See Figure 1.

Figure 1. Health Insurance Coverage for Americans 65 and Older



Source: Centers for Disease Control and Prevention, National Center for Health Statistics

The quality of beneficiaries' coverage improved substantially too. Prior to Medicare, most plans for seniors were "extremely minimalist in nature."[16] Many seniors faced restrictive caps on coverage (as little as $10 per hospital day, which is $105 in 2024 dollars), limits on the frequency of care, and the possibility of canceled insurance policies if they were deemed too risky for coverage.[17] Under Medicare, by

[14] National Center for Health Statistics, *NHIS Health Insurance Coverage Estimates – Table A* (November 2015) (https://web.archive.org/web/20240521073508/https:/www.cdc.gov/nchs/health_policy/healthcare_coverage_tablea.htm).
[15] Ibid.
[16] Amy Finkelstein, The Quarterly Journal of Economics, *The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare,* page 5, note 1 (February 2007) (https://economics.mit.edu/sites/default/files/2022-08/The%20Aggregate%20Effects%20of%20Health%20Insurance-%20Evidenc.pdf#page=5).
[17] Mark McClellan and Jonathan Skinner, Journal of Public Economics, *The Incidence of Medicare,* pages 266-267 (January 2006) (https://www.sciencedirect.com/science/article/abs/pii/S0047272705000885) (coverage limitations); Social Security Administration, *History of SSA During the Johnson Administration 1963-1968* (accessed on September 30, 2024) (https://www.ssa.gov/history/ssa/lbjmedicare1.html) (canceled insurance policies); Bureau of Labor Statistics, *CPI Inflation Calculator* (accessed on September 30, 2024)

contrast, seniors could receive up to 90 days of hospital care per malady, followed by additional post-hospital rehabilitation care if needed.[18] Unlike many private plans, Medicare eligibility for seniors was not conditioned on health status or the absence of pre-existing conditions.[19]

Seniors benefited from the enhanced coverage. From 1964 to 1973, the level of hospital inpatient care provided to seniors increased by over 80%.[20] Not surprisingly, life expectancy rose as well. Using 1967, the first full year of Medicare coverage, as a benchmark:

- Women's life expectancy at age 65 increased by 2.2 years from 1967 to 1982, compared to a 1.3-year increase over the previous 15-year period (1952-1967).[21]
- Men at age 65 saw an even more pronounced increase, gaining 1.5 years in life expectancy from 1967 to 1982 after no growth over the previous 15-year period.[22]

The high-quality care received by Medicare beneficiaries is reflected in the program's consistently favorable ratings in beneficiary surveys. In 1989, the Department of Health and Human Services's Office of Inspector General surveyed Medicare beneficiaries and concluded that beneficiaries "appear very satisfied with the Medicare program."[23] In 2003, the Commonwealth Fund's Health Insurance Survey reported that Medicare was rated better than private insurance on satisfaction with healthcare quality, with over two-thirds of beneficiaries rating their insurance as "Excellent/Very Good."[24] In 2023, a Kaiser Family Foundation survey found that 91% of Medicare beneficiaries rated their insurance "excellent" or "good," compared to 80% of individuals with employer-sponsored insurance.[25] Medicare won even more

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(https://data.bls.gov/cgi-bin/cpicalc.pl?cost1=10&year1=196201&year2=202407) (inflation calculation, calculated from January 1962 to July 2024 and rounded to the nearest dollar).

[18] Social Security Amendments of 1965 (P.L. 89-97), Sections 1812-1813 (July 30, 1965) (https://www.congress.gov/89/statute/STATUTE-79/STATUTE-79-Pg286.pdf#page=6). Today, Medicare Part A still covers 90 days of inpatient care per hospital stay, and beneficiaries also have 60 "lifetime reserve days," which can be used over the course of their lives if a hospital stay extends beyond 90 days. *See* Department of Health and Human Services, *What Part A Covers* (accessed on September 30, 2024) (https://www.medicare.gov/providers-services/original-medicare/part-a).

[19] Karen Davis and Cathy Schoen, Health and the War on Poverty, pages 100-101 (1978).

[20] Marilyn Moon, Health Care Financing Review, *What Medicare Has Meant To Older Americans,* page 54 (Winter 1996) (https://www.ssa.gov/history/pdf/WhatMedicareMeant.pdf#page=9).

[21] Social Security Administration, Office of the Actuary, *Table V.A3.—Period Life Expectancies, Calendar Years 1940-2001* (2002) (https://www.ssa.gov/OACT/TR/TR02/lr5A3-h.html). Comparison based on the work of Frank R. Lichtenberg, National Bureau of Economic Research, *The Effects of Medicare on Healthcare Utilization and Outcomes,* page 31 (January 2002) (https://www.nber.org/system/files/chapters/c9857/c9857.pdf#page=6).

[22] Ibid.

[23] Department of Health and Human Services, Office of Inspector General, *A Survey of Medicare Beneficiary Satisfaction 1989,* page 11 (October 1989) (https://oig.hhs.gov/documents/evaluation/1455/OEI-04-89-89040-Complete%20Report.pdf#page=15).

[24] Karen Davis and Sara R. Collins, Health Care Financing Review, *Medicare at Forty*, Table 1, page 55 (Winter 2005-2006) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/05-06Winpg53.pdf#page=3).

[25] Kaiser Family Foundation, *KFF Survey of Consumer Experiences with Health Insurance,* Figure 2 (June 15, 2023) (https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/).

handily in the "excellent" category, with half of beneficiaries rating their health insurance as such, compared to only 33% of enrollees with employer coverage.[26]

Claim: Medicare Would Stunt Medical Progress

"[T]his conflict is testing again whether the art and science of medicine will be permitted to grow and flourish in freedom, or whether progress in medicine will be stunted and shriveled by an excess of Government control."

– Representative Durward Hall, April 8, 1965[27]

"Medicare would initiate what would ultimately become a Federal monopoly in regard to the financing and rendering of health care with respect to our aged to the detriment of endeavors of the private sector; this result would impair the quality of health care, retard the advancement of medical science, and displace private insurance."

– Representative Joel Broyhill, March 29, 1965[28]

American contributions to medical science loomed large during the Medicare debates, with some legislators claiming that Medicare would impede medical innovation through government overreach. These fears did not materialize, however. The United States leads the world in medical innovation. It is dominant in pharmaceutical innovation and the world's leading provider of medical technology.[29]

Medicare and Medicaid helped drive America's global leadership in medical innovation by increasing demand for prescription drugs and medical equipment and devices. After those programs were enacted, the share of American patents for medical equipment increased much faster than the corresponding share of foreign patents.[30] This has paid dividends even decades later, with one analysis estimating that Medicare, Medicaid, and subsequent U.S. insurance expansions are responsible for one-quarter of "recent global medical-equipment innovation."[31]

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[26] Ibid.

[27] *Congressional Record,* page 7392 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=42).

[28] U.S. House Committee on Ways and Means, *Social Security Amendments of 1965,* page 259 (March 29, 1965) (H. Rept. 89-213) (https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Amendments%20of%201965%20Vol%201.pdf#page=272).

[29] Yuanjia Hu, et al., PloS One, *Is the United States Still Dominant in the Global Pharmaceutical Innovation Network?* (November 5, 2013) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3818371/) (dominance in pharmaceutical innovation); Peter Herman, Jeff Horowitz, and Mihir Torsekar, U.S. International Trade Commission, *Competitive Conditions Affecting U.S. Exports of Medical Technology to Key Emerging Markets,* Figure 3, page 8 (August 2018) (https://www.usitc.gov/publications/332/working_papers/competitiveness_of_medtech_exports.pdf#page=8) (world's leading provider of medical technology).

[30] Jeffrey Clemens, National Bureau of Economic Research, *The Effect of U.S. Health Insurance Expansions on Medical Innovation,* page 22 (December 2013) (https://www.nber.org/system/files/working_papers/w19761/w19761.pdf#page=23).

[31] Ibid, page 1.

Medicare's enactment also played a critical role in pushing new technologies into the mainstream. In the 1960s, heart attacks were by far the leading cause of death in the United States.[32] Medicare helped speed the widespread adoption of open heart surgery facilities and cardiac intensive care units in hospitals across the country, saving lives by bringing innovative cardiac care to its beneficiaries.[33] Likewise, Medicare advanced the treatment of kidney failure. In the 1960s, treatment was expensive, and dialysis machines were scarce, forcing hospitals to triage renal care.[34] In 1972, all patients under the age of 65 with ESRD became eligible for Medicare, and over 90% of Americans with ESRD were enrolled in a matter of years.[35] This was a breakthrough in the treatment of the disease. The number of ESRD treatment facilities more than doubled within a decade, and over 1 million people had received life-saving care by 2000.[36] As of 2022, Medicare provides coverage to approximately 290,000 individuals with ESRD.[37]

Medicare also helped drive the adoption of other critical medical technologies. Because Medicare permitted hospitals to include equipment depreciation as an "allowable cost," they were incentivized to make investments in new technologies.[38] The certainty of Medicare reimbursement also made it easier for hospitals to finance these investments. Additionally, Medicare and Medicaid reduced the share of hospital patients who could not afford their care, providing hospitals with more funds to invest in new technologies.[39] More recently, the introduction of Medicare's New Technology Add-on Payment (NTAP) in

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[32] *See* Centers for Disease Control and Prevention, *Leading Causes of Death, 1960-64* (accessed on September 30, 2024) (https://archive.nytimes.com/www.nytimes.com/specials/women/data/60-64_f_2.htm) and Centers for Disease Control and Prevention, *Leading Causes of Death, 1964-69* (accessed on September 30, 2024) (https://archive.nytimes.com/www.nytimes.com/specials/women/data/64-69_f_2.htm). The New York Times published these data.

[33] Amy Finkelstein, The Quarterly Journal of Economics, *The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare,* pages 3 and 26 (February 2007) (https://economics.mit.edu/sites/default/files/2022-08/The%20Aggregate%20Effects%20of%20Health%20Insurance-%20Evidenc.pdf).

[34] Paul W. Eggers, Health Care Financing Review, *Medicare's End Stage Renal Disease Program* (Fall 2000) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194691/).

[35] U.S. Congress, Office of Technology Assessment, Medicare Technology and the Costs of the Medicare Program, Ch. 2: "Medicare Policies Affecting Medical Technology," pages 26-27 (July 1984) (https://www.princeton.edu/~ota/disk3/1984/8419/841904.PDF#page=6).

[36] David Gibson and Michael McMullan, Health Care Financing Review, *End-Stage Renal Disease: A Profile of Facilities Furnishing Treatment* (Winter 1984) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191463/) (ESRD facility growth); Paul W. Eggers, Health Care Financing Review, *Medicare's End Stage Renal Disease Program* (Fall 2000) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194691/) (number of patients who have received care).

[37] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, page xviii (March 15, 2024) (https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-2.pdf#page=20).

[38] U.S. Congress, Office of Technology Assessment, Medicare Technology and the Costs of the Medicare Program, Ch. 2: "Medicare Policies Affecting Medical Technology," page 31 (July 1984) (https://www.princeton.edu/~ota/disk3/1984/8419/841904.PDF#page=11).

[39] Ibid, page 38. In addition to reimbursing hospitals for Medicare beneficiaries' medical care, Medicare also covers hospitals' "uncompensated care" costs that they incur when patients cannot pay for their share of medical care (known as "bad debts") or when they provide charity care (often referred to as "financial assistance"). *See* American Hospital Association, *Fact Sheet: Uncompensated Hospital Care Cost* (2022) (https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost).

2001 has boosted payment rates for new technologies that demonstrate significant clinical benefits, driving the adoption of new life-saving technologies.[40] Finally, the addition of prescription drug coverage to Medicare in 2003 led to significant increases in research and development of new drugs in therapeutic classes frequently used by Medicare beneficiaries.[41]

Claim: Medicare Would Exacerbate the Shortage of Healthcare Providers

"Medical care in this country is heading for a real crisis. ... [T]he medical machinery of this nation is not now geared to take care of the increased demand for medical care that seems sure to follow. Shortages of many kinds will be encountered."

– U.S. News and World Report, July 26, 1965[42]

"*There are already shortages all down the line in medicine. … I wouldn't hazard a guess as to how long it will be before we catch up, in medical manpower, with the pressure that seems certain to build up from [M]edicare."*

– Dr. W. Palmer Dearing, executive director of the Group Health Association of America, July 26, 1965[43]

"Quality medicine would be dealt a further blow by the loss of able entrants in the health field because young men, viewing a profession under partial or total Government domination, could be expected to seek careers in other fields. These things will not happen tomorrow, or the day after, or next week, or next month. But as surely as the tides move tonight in Chesapeake Bay, they will come if this measure is enacted into law."

– Representative Durward Hall, April 8, 1965[44]

During the 1965 Medicare debates, physicians and nurses were in short supply in America. The Department of Labor had declared a shortage of doctors the previous year.[45] Nurses were even harder to find, with 20% of hospital nursing positions unfilled and 10% of skilled nursing homes lacking even one "full-time professional or practical nurse."[46] Critics of Medicare claimed the program would exacerbate

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[40] Jacob R. Morey, et al., Journal of General Internal Medicine, *Adoption and Trends in the Medicare New Technology Add-On Payment Program* (June 24, 2020) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8298651/).
[41] Margaret E. Blume-Kohout and Neeraj Soud, Journal of Public Economics, *Market Size and Innovation: Effects of Medicare Part D on Pharmaceutical Research and Development* (January 1, 2014) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711884/).
[42] U.S. News and World Report*, Crisis Ahead in Medical Care?,* page 33 (July 26, 1965).
[43] Ibid, page 35.
[44] *Congressional Record,* page 7392 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=42).
[45] Eram Alam, Social History of Medicine, *Cold War Crises: Foreign Medical Graduates Respond to US Doctor Shortages, 1965–1975,* pages 1-2 (March 8, 2018) (https://academic.oup.com/shm/article-abstract/33/1/132/4924823?redirectedFrom=fulltext).
[46] U.S. News and World Report, *Crisis Ahead in Medical Care?,* page 34 (July 26, 1965).

these shortages in two different ways. First, it would increase demand for hospital and nursing home care and overwhelm already understaffed facilities. Second, it would drive people away from careers in medicine because of bureaucratic interference.

In fact, Medicare expanded medical education, which helped grow the medical workforce. Medicare significantly increased federal support for residency programs when it was enacted, covering administrative costs and compensation for residents and faculty, and it remains the largest single source of funding for those programs today.[47] This steady funding for medical training substantially expanded the physician training pipeline and the number of physicians.[48] The physician-to-population ratio in the United States grew 36% from 1965 to 1980 after creeping up by just 2.6% over the prior 15 years.[49] Medicare also allocated substantial funding to support nursing education. For example, Medicare supplied funds to hospitals to train nurses, lessening the financial burden on hospitals.[50] Also, by providing a significant funding stream to hospitals through patient coverage, Medicare helped increase wages for nurses, making that profession more appealing.[51] The nurse-to-population ratio rose by 74% from 1965 to 1980 after growing just 29% from 1950 to 1965.[52]

Reflecting these investments, Medicare beneficiaries have consistently reported excellent access to healthcare providers in almost 30 years of surveys on access to care. Based on data from the annual Medicare Current Beneficiary Survey from 1996-2019, fewer than 1 in 12 surveyed beneficiaries in each of those years reported "difficulty obtaining care."[53] In a 2023 Kaiser Family Foundation survey, 89% of

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[47] Institute of Medicine of the National Academies, Committee on the Governance and Financing of Graduate Medical Education, Graduate Medical Education That Meets the Nation's Health Needs, Ch. 3: "GME Financing" (September 30, 2014) (https://www.ncbi.nlm.nih.gov/books/NBK248024/) (significant increase in federal support and covered program costs); National Conference of State Legislatures, *Graduate Medical Education Funding* (January 9, 2024) (https://www.ncsl.org/health/graduate-medical-education-funding) (largest source of funding).
[48] Medicare funding was complemented by the Health Professions Educational Assistance Act of 1963, the 1965 amendments to the law, and other policies that supported medical education. *See* Edward H. Forgotson, American Journal of Public Health, *1965: The Turning Point in Health Law—1966 Reflections,* page 939 (June 1967) (https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.57.6.934#page=6).
[49] U.S. Census Bureau, Statistical Abstract of the United States 1984, No. 160, page 109 (December 1983) (https://www2.census.gov/library/publications/1983/compendia/statab/104ed/1984-02.pdf#page=109).
[50] Linda H. Aiken and Marni E. Gwyther, Journal of the American Medical Association, *Medicare Funding of Nurse Education,* page 2 (May 17, 1995) (https://www.nursing.upenn.edu/live/files/860-aiken1995medicarefundingofnurseeducationjamapdf#page=2).
[51] Penn Nursing, *Where Did All the Nurses Go?* (accessed on September 30, 2024) (https://www.nursing.upenn.edu/nhhc/workforce-issues/where-did-all-the-nurses-go/).
[52] U.S. Census Bureau, Statistical Abstract of the United States 1984, No. 160, page 109 (December 1983) (https://www2.census.gov/library/publications/1983/compendia/statab/104ed/1984-02.pdf#page=109).
[53] Centers for Medicare & Medicaid Services, *Medicare Current Beneficiary Survey (MCBS): Data Tables* (accessed on September 30, 2024) (https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-tables). For 1996-2013, *see* "Difficulty Obtaining Care" in Table 5.1 of "Characteristics and Perceptions of the Medicare Population" for each year. Survey data is not available for 2014. For 2015-2019, *see* the "Medicare Current Beneficiary Survey Annual Chartbook and Slides" for each year and refer to these table numbers: 3.10 (2015), 3.10 (2016), 3.13 (2017), 3.11 (2018), 3.11 (2019). Surveys were limited to beneficiaries living in the community.

Medicare beneficiaries aged 65 and older rated the availability of medical providers as excellent or good.[54]

Claim: Medicare Would Disrupt the Economy and Harm Small Businesses

"No one can predict what this tax on America's production will do to the American economy or to our ability to hold down the cost of living and still make a market here and abroad for what we can offer in food, goods, and services. When that program [Medicare] really gets underway, it will bring a series of terrific jolts, not only to industry but to every individual working man and woman in America."

– General Hanford MacNider, August 30, 1965[55]

"*The economic thrust of the higher employment taxes necessitated by the [M]edicare programs would have immediate adverse impact on job opportunities and the problem would be further aggravated by the certain expansion of the program once started."*

– Representative Joel Broyhill, March 29, 1965[56]

"I want to call attention to the plight of the small businessman. How can he continue to meet the employer's share of increasing [Medicare payroll] taxes? It is a situation which is spelling doom to many of these great figures in our economy. They have been fighters in the frontlines for our free enterprise system and I, for one, do not want to be a party to their economic extinction."

– Representative Jackson Betts, April 7, 1965[57]

The Social Security Amendments of 1965 included a payroll tax rate increase and wage base expansion to fund Medicare Part A. Critics of Medicare were concerned about the adverse consequences for workers and small businesses. In fact, the American economy has prospered since the enactment of Medicare.

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[54] Kaiser Family Foundation, *Overall Satisfaction with Medicare is High, But Beneficiaries Under Age 65 with Disabilities Experience More Insurance Problems Than Older Beneficiaries* (October 26, 2023) (https://www.kff.org/medicare/issue-brief/overall-satisfaction-with-medicare-is-high-but-beneficiaries-under-age-65-with-disabilities-experience-more-insurance-problems-than-older-beneficiaries/).

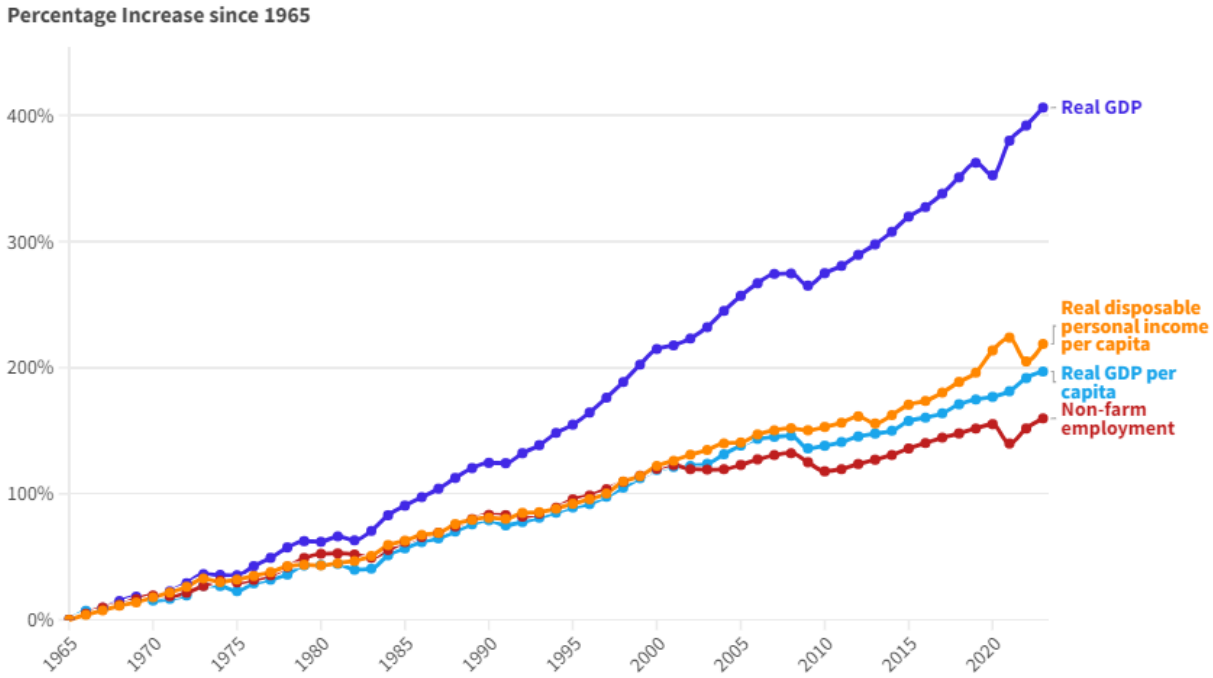
[55] Hanford MacNider, *Torrents of Billions,* reproduced in *Congressional Record – Appendix,* page A4888 (August 30, 1965) (https://www.govinfo.gov/app/details/GPO-CRECB-1965-pt30/GPO-CRECB-1965-pt30-1). In between distinguished service in both world wars, General MacNider worked for two Republican presidents – Calvin Coolidge (Assistant Secretary of War) and Herbert Hoover (U.S. Envoy to Canada) – and ran unsuccessfully for the Republican presidential nomination in 1940. *See* University of Iowa, The Biographical Dictionary of Iowa, "MacNider, Hanford 'Jack'" (accessed on September 30, 2024) (https://uipress.lib.uiowa.edu/bdi/DetailsPage.aspx?id=243).

[56] U.S. House Committee on Ways and Means, *Social Security Amendments of 1965,* page 259 (March 29, 1965) (H. Rept. 89-213) (https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Amendments%20of%201965%20Vol%201.pdf#page=272).

[57] *Congressional Record,* page 7241 (April 7, 1965) (https://www.congress.gov/89/crecb/1965/04/07/GPO-CRECB-1965-pt6-1-1.pdf#page=41).

In 1965, the real gross domestic product (GDP) of the United States was $4.5 trillion. In 2023, real GDP had grown to $22.7 trillion, a fivefold increase.[58] Measured on a per capita basis, real GDP tripled from $22,547 to $68,351.[59] Other measures of the economy also soared. The nonfarm workforce expanded from 59.6 million to 157.3 million.[60] Real disposable personal income per capita more than tripled to $50,871.[61] And the real value of exports of goods and services grew twentyfold.[62] See Figure 2.[63]

Figure 2. Domestic Economic Indicators in the Medicare Era



Source: U.S. Bureau of Economic Analysis and U.S. Bureau of Labor Statistics

[58] U.S. Bureau of Economic Analysis, *Real Gross Domestic Product [GDPCA],* retrieved from FRED, Federal Reserve Bank of St. Louis (accessed on September 30, 2024) (https://fred.stlouisfed.org/series/GDPCA) (annual data using chained 2017 dollars).

[59] U.S. Bureau of Economic Analysis, *Real Gross Domestic Product Per Capita [A939RX0Q048SBEA]*, retrieved from FRED, Federal Reserve Bank of St. Louis (accessed on September 30, 2024) (https://fred.stlouisfed.org/series/A939RX0Q048SBEA) (quarterly, seasonally adjusted data using chained 2017 dollars for the first quarter (Q1) of 1965 and fourth quarter (Q4) of 2023).

[60] U.S. Bureau of Labor Statistics, *All Employees, Total Nonfarm [PAYEMS]*, retrieved from FRED, Federal Reserve Bank of St. Louis (accessed on September 30, 2024) (https://fred.stlouisfed.org/series/PAYEMS) (monthly, seasonally adjusted data for January 1965 and December 2023).

[61] U.S. Bureau of Economic Analysis, *Real Disposable Personal Income: Per Capita [A229RX0A048NBEA],* retrieved from FRED, Federal Reserve Bank of St. Louis (accessed on September 30, 2024) (https://fred.stlouisfed.org/series/A229RX0A048NBEA) (annual data using chained 2017 dollars).

[62] U.S. Bureau of Economic Analysis, *Real Exports of Goods and Services [EXPGSC1],* retrieved from FRED, Federal Reserve Bank of St. Louis (accessed on September 30, 2024) (https://fred.stlouisfed.org/series/EXPGSC1) (quarterly, seasonally adjusted data using chained 2017 dollars for Q1 1965 and Q4 2023).

[63] Real GDP and real per capita disposable personal income are based on annual data. Real per capita GDP is based on seasonally adjusted data from the first quarter of each year. The size of the non-farm workforce is based on seasonally adjusted data from January of each year.

Small businesses have likewise thrived since the passage of Medicare, refuting critics' claims. The number of small businesses in the United States has increased sevenfold since 1965.[64] Small businesses' contributions to real GDP (in 2024 dollars) have grown from $3 trillion in 1965 to $7.9 trillion in 2014.[65]

Claim: Medicare Would Unfairly Burden Lower-Wage Workers

"[W]e should not support a plan that saddles the wage earners of America with an increase in the regressive payroll taxes they pay. To force these wage earners to finance medical assistance for every senior citizen, regardless of whether it is needed, is unconscionable."

– Representative Odin Langen, April 8, 1965[66]

"[Medicare] is also not entirely fair to taxpayers, because a payroll tax is a regressive tax. It hits the lower and middle income people the hardest. No consideration is given to an individual's ability to pay."

– Representative William Jackson "Jack" Edwards, April 8, 1965[67]

"[Medicare's] ill effects will be felt in the ultimate crippling of our medical services and unwarranted, regressive tax burden on our citizens."

– Representative Edward Derwinski, April 8, 1965[68]

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[64] The American Presidency Project, University of California Santa Barbara, *Proclamation 3648—Small Business Week, 1965* (March 24, 1965) (https://www.presidency.ucsb.edu/documents/proclamation-3648-small-business-week-1965) (1965 number of small businesses); U.S. Small Business Administration Office of Advocacy, *Frequently Asked Questions About Small Business, 2023* (March 7, 2023) (https://advocacy.sba.gov/2023/03/07/frequently-asked-questions-about-small-business-2023/) (2023 number of small businesses). The 33 million small businesses in 2023 are very slightly more than seven times the 4.7 million small businesses in 1965.

[65] The real GDP amounts used here are in 2024 dollars, while the real GDP amounts used in the previous paragraph are in chained 2017 dollars. These small business contributions refer to private non-farm GDP. Joel Popkin and Company, *Small Business Share of Private Nonfarm Gross Domestic Product,* Appendix Table A9 (February 1997) (PDF available from https://ntrl.ntis.gov/NTRL/, Accession Number PB97180723) (1965 amount); Kathryn Kobe and Richard Schwinn, *Small Business GDP 1998-2014,* page 3 (December 2018) (https://advocacy.sba.gov/wp-content/uploads/2018/12/Small-Business-GDP-1998-2014.pdf#page=4) (2014 amount); Bureau of Labor Statistics, *CPI Inflation Calculator* (https://data.bls.gov/cgi-bin/cpicalc.pl?cost1=302%2C122.00&year1=196501&year2=202407 and https://data.bls.gov/cgi-bin/cpicalc.pl?cost1=5%2C900%2C000&year1=201401&year2=202407) (inflation calculation, calculated from January 1965 and January 2014 dollars to July 2024 dollars and rounded to the nearest $0.1 trillion).

[66] *Congressional Record,* page 7353 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=3).

[67] *Congressional Record,* page 7363 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=13).

[68] *Congressional Record,* page 7379 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=29).

"[I]n good conscience can I …. place our children and our children's children under the grinding yoke of taxation which this bill promises and, to complete the calumny of the situation, take heaviest by comparison from the 'have-nots' rather than the 'haves'? Mr. Chairman, my conscience does not allow it."

– Representative Albert Quie, April 8, 1965[69]

Opponents of creating Medicare claimed it would adversely affect lower-income workers because its financing was regressive. In fact, just the opposite is true: Medicare is a highly progressive policy.

Medicare is a good investment for enrollees regardless of income level, but it is especially so for low-income enrollees. Medicare beneficiaries with high incomes can expect to receive more than twice as much in benefits as they contribute in Medicare taxes during their working lives.[70] Since low-income beneficiaries pay less in Medicare taxes than high-income beneficiaries, they can expect to receive even greater benefits per dollar of contributions.[71] Moreover, subsequent legislation has increased the program's progressiveness. For example, the Earned Income Tax Credit, first enacted in 1975, has helped offset low-income households' payroll tax liability.[72] The Medicare Savings Programs and the Low Income Subsidy, enacted between 1986 and 2003, have helped lower-income Medicare beneficiaries with premiums and out-of-pocket spending for Part B and Part D, respectively.[73] More recently, the 2010 ACA enhanced Medicare's progressivism by imposing an additional 0.9% Medicare tax on high-income households ($200,000 for single taxpayers and $250,000 for married taxpayers filing jointly).[74]

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[69] *Congressional Record,* page 7388 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=38).

[70] For example, a married couple earning a combined $153,700 (in 2021 dollars) annually and entering retirement at age 65 in 2025 can expect to receive $583,000 of Medicare benefits after paying $242,000 in lifetime Medicare taxes. *See* C. Eugene Steuerle and Karen E. Smith, The Urban Institute, *Social Security & Medicare Lifetime Benefits and Taxes: 2021,* Table 16, page 20 (February 2022) (https://www.urban.org/sites/default/files/2022-02/social-security-medicare-lifetime-benefits-and-taxes-2021.pdf#page=26). Benefit value is based on expected present value net of premiums. Due to data limitations, these projections assume that beneficiaries' mortality does not vary by income.

[71] For example, a married couple earning a combined $53,200 (in 2021 dollars) annually and entering retirement at age 65 in 2025 can expect to receive $583,000 of Medicare benefits after paying $84,000 in lifetime Medicare taxes. *See* ibid, Table 13, page 17.

[72] *See* Robert Greenstein and Isaac Shapiro, Center on Budget and Policy Priorities, *New Research Findings on the Effects of the Earned Income Tax Credit* (March 11, 1998) (https://www.cbpp.org/sites/default/files/archive/311eitc.htm).

[73] Centers for Medicare & Medicaid Services, *Medicare Savings Programs* (accessed on September 30, 2024) (https://www.medicare.gov/basics/costs/help/medicare-savings-programs) (Medicare Savings Program); Centers for Medicare & Medicaid Services, *Limited Income and Resources* (updated September 2023) (https://www.cms.gov/training-education/partner-outreach-resources/low-income-subsidy-lis) (Low Income Subsidy); Medicaid and CHIP Payment and Access Commission, *Legislative Milestones in Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries* (March 2016) (https://www.macpac.gov/legislative-milestones-in-medicaid-coverage-of-premiums-and-cost-sharing-for-low-income-medicare-beneficiaries/) (history of cost-sharing assistance programs).

[74] Internal Revenue Service, *Questions and Answers for the Additional Medicare Tax* (August 22, 2024) (https://www.irs.gov/businesses/small-businesses-self-employed/questions-and-answers-for-the-additional-medicare-tax). The ACA also established higher Part D premiums for high-income Part D enrollees and froze the income-based thresholds that determine Part B and Part D high-earner premiums until 2020. *See* Kaiser Family

Claim: Medicare Would Encroach on Americans' Freedom

"[W]e do not want socialized medicine. … [B]ehind it will come other federal programs that will invade every area of freedom as we have known it in this country. Until, one day, … you and I are going to spend our sunset years telling our children, and our children's children, what it was once like in America when men were free."

– Ronald Reagan, 1961[75]

"There will be a day of reckoning when this country will have to decide what we can do with the most appalling mass of swarming bureaucracy in our history, and how we can protect ourselves against it."

– General Hanford MacNider, August 30, 1965[76]

"What would begin as 'socialized medicine for the elderly,' would become 'socialized medicine' for every man, woman, and child in the country."

– Representative Durward Hall, April 8, 1965[77]

In 1961, a precursor to Medicare called the King-Anderson bill outlined government-sponsored health insurance for Americans 65 and older.[78] The American Medical Association firmly opposed the bill and recruited Ronald Reagan to deliver a radio address warning about the dangers of socialized medicine, previewing the group's eventual opposition to Medicare.[79] But predictions about Medicare heralding the end of freedom in America never came to pass. Medicare did not interfere with the rights of patients and doctors to make medical decisions. Instead, it expanded access to care and enhanced beneficiaries' economic freedom by helping protect them from catastrophic medical costs, while also preserving their

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Foundation, *Medicare's Income-Related Premiums Under Current Law and Proposed Changes* (November 2, 2017) (https://www.kff.org/medicare/issue-brief/medicares-income-related-premiums-under-current-law-and-proposed-changes/).

[75] Ronald Reagan Presidential Foundation & Institute, *Socialized Medicine* (May 19, 2020) (https://web.archive.org/web/20230706113239/https://www.reaganfoundation.org/programs-events/webcasts-and-podcasts/podcasts/words-to-live-by/socialized-medicine/).

[76] Hanford MacNider, *Torrents of Billions,* reproduced in *Congressional Record – Appendix,* page A4888 (August 30, 1965) (https://www.govinfo.gov/app/details/GPO-CRECB-1965-pt30/GPO-CRECB-1965-pt30-1).

[77] *Congressional Record,* page 7394 (April 8, 1965) (https://www.congress.gov/89/crecb/1965/04/08/GPO-CRECB-1965-pt6-2-1.pdf#page=44).

[78] Kaiser Family Foundation, *Timeline: History of Health Reform in the U.S.* (March 2011) (https://www.kff.org/wp-content/uploads/2011/03/5-02-13-history-of-health-reform.pdf#page=8).

[79] Social Security Administration, *Social Security History, Chapter 4: The Fourth Round – 1957-1965* (accessed on September 30, 2024) (https://www.ssa.gov/history/corningchap4.html) (opposition to the King-Anderson bill); Jeffrey St. Onge, Rhetoric & Public Affairs, *Operation Coffee Cup: Ronald Reagan, Rugged Individualism, and the Debate over "Socialized Medicine"* (June 1, 2017) (https://scholarlypublishingcollective.org/msup/rpa/article-abstract/20/2/223/174954/Operation-Coffeecup-Ronald-Reagan-Rugged) (recruitment of Ronald Reagan); Ronald Reagan Presidential Foundation & Institute, *Socialized Medicine* (May 19, 2020) (https://web.archive.org/web/20230706113239/https://www.reaganfoundation.org/programs-events/webcasts-and-podcasts/podcasts/words-to-live-by/socialized-medicine/) (Ronald Reagan radio address).

dignity at the end of their lives. Additionally, it promoted equality by desegregating healthcare systems across the South.

The first three sections of the original Medicare legislation prohibited the federal government from exercising "any supervision or control over the practice of medicine," guaranteed patients' ability to "obtain health services from any [qualified medical] institution, agency, or individual," and protected their ability to purchase additional health insurance coverage.[80] These provisions preserved beneficiaries' freedom to choose their doctor and make their own medical decisions. In fact, a forty-year retrospective of Medicare reported that more Medicare beneficiaries (84%) said that they had "[a] great deal/fair amount" of "choice in where to go for medical care" than did enrollees of employer-based health insurance (80%) or individual health insurance (69%).[81]

Beyond ensuring beneficiaries' freedom to make their own medical decisions and vastly improving their access to medical care, Medicare advanced economic freedom for older Americans by protecting them against devastating medical expenses, delivering the largest financial savings for those with the highest medical costs.[82] These financial protections, along with Social Security, contributed to a substantial decline in the poverty rate among seniors, from 29.5% in 1967 to 9.7% in 2023.[83]

The very oldest and sickest Americans have seen their freedom enhanced in another way. Prior to Medicare's enactment, there was no hospice care in the United States.[84] Terminally ill patients who sought medical attention were often ignored by hospital staff based on the attitude that medicine had already failed them.[85] Congress addressed this issue by adding hospice services to Medicare in 1983, providing beneficiaries with appropriate and compassionate medical care that preserves their dignity at

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[80] Social Security Amendments of 1965, 79 Stat. 291 § 1801-1803 (July 30, 1965) (https://www.congress.gov/89/statute/STATUTE-79/STATUTE-79-Pg286.pdf#page=6).

[81] Karen Davis and Sara R. Collins, Health Care Financing Review, *Medicare at Forty*, Table 1, page 55 (Winter 2005-2006) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/05-06Winpg53.pdf#page=3).

[82] Amy Finkelstein and Robin McKnight, National Bureau of Economic Research, *What Did Medicare Do (And Was It Worth It)?,* Table 5, page 37 (September 2005) (https://www.nber.org/system/files/working_papers/w11609/w11609.pdf#page=39).

[83] Sanders Korenman, Dahlia K. Rehmler, Rosemary T. Hyson, The Journal of the Economics of Ageing, *Health Insurance and Poverty of the Older Population in the United States: The Importance of a Health Inclusive Poverty Measure* (February 2021) (https://www.sciencedirect.com/science/article/abs/pii/S2212828X20300621) (the impact of Medicare and Social Security on the poverty rate among seniors); U.S. Census Bureau, Current Population Survey, *Historical Poverty Tables: People and Families – 1959 to 2023,* Table 3 (updated September 10, 2024) (https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html) (poverty rate data).

[84] Mamta Bhatnagar, Lauren A. Kempfer, and Keith R. Lagnese, StatPearls, Hospice Care (updated March 13, 2023) (https://www.ncbi.nlm.nih.gov/books/NBK537296/).

[85] Sarah E. Pajka, Manuscripts and Archives Prize for Yale History, *Doctors, Death, and Denial: The Origins of Hospice Care in 20th Century America*, pages 23-24 (2017) (https://elischolar.library.yale.edu/cgi/viewcontent.cgi?article=1045&context=mssa_yale_history#page=25).

the end of their lives.[86] By 2020, there were 5,200 hospice providers in the United States, and nearly half of Medicare beneficiaries received hospice care in the last year of their life in 2022.[87]

Medicare was also a driving force for racial equality. Before the passage of Medicare, Black Americans and other racial minorities received care in racially segregated hospitals and faced outright exclusion from some facilities.[88] Even after the Civil Rights Act of 1964 required hospitals to integrate, noncompliance was the norm.[89] Medicare and Medicaid, however, became powerful catalysts for integration because hospitals had to become racially integrated to participate in the programs. According to one analysis, "In less than four months, private hospitals in the United States went from the nation's most segregated private institutions to its most integrated."[90] By July 1966, over 92% of American hospitals were in compliance with the Civil Rights Act.[91]

By improving access to care, enhancing protection from devastating medical expenses, providing comprehensive end-of-life care, and reducing racial and economic inequities, Medicare has expanded, not contracted, the freedoms of its beneficiaries. The most extreme claim about Medicare – that it would end freedom in the United States – has proven to be just as inaccurate as the other predictions made by Medicare's opponents.

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[86] Marilyn Moon and Cristina Boccuti, The Urban Institute, *Medicare and End-of-Life Care,* page 4 (September 2002) (https://www.urban.org/sites/default/files/publication/59836/1000442-Medicare-and-End-of-Life-Care.PDF#page=6) (1983 palliative care benefit); Medicare Payment Advisory Commission, *Hospice Payment System,* page 1 (November 2021) (https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospice_final_sec.pdf).

[87] Centers for Disease Control and Prevention, *National Center for Health Statistics: Hospice Care* (November 5, 2023) (https://www.cdc.gov/nchs/fastats/hospice-care.htm) (number of hospice providers); Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program*, Chart 11-9, page 183 (July 2024) (https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf#page=194) (proportion of beneficiaries receiving hospice care in the last year of their life).

[88] D. Mark Anderson, Kerwin Kofi Charles, and Daniel I. Rees, National Bureau of Economic Research, *Imposing Policy on Reluctant Actors: The Hospital Desegregation Campaign and Black Postneonatal Mortality in the Deep South,* page 1 (revised April 2023) (https://www.nber.org/system/files/working_papers/w27970/w27970.pdf#page=3) (segregated facilities); David Barton Smith, Health-Matrix: The Journal of Law-Medicine, *The "Golden Rules" for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act,* page 35 (2015) (https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1017&context=healthmatrix#page=4) (exclusion from facilities).

[89] Emily A. Largent, Public Health Reports, *Public Health, Racism, and the Lasting Impact of Segregation* (September 17, 2018) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6225869/).

[90] David Barton Smith, Health-Matrix: The Journal of Law-Medicine, *The "Golden Rules" for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act,* page 52 (2015) (https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1017&context=healthmatrix#page=21).

[91] Carole Bennett, Online Journal of Issues in Nursing, *Healthcare Justice, Medicare, and the Racial Desegregation of Hospitals in the South* (September 27, 2023) (https://ojin.nursingworld.org/table-of-contents/volume-28-2023/number-3-september-2023/articles-on-previously-published-topics/healthcare-justice-medicare/).