Sawbones 599: Medicare and Medicaid

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["Medicines" by The Taxpayers plays]

Justin: Hello, everybody! Welcome to Sawbones, a marital tour for misguided medicine. I'm your co-host, Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: Started your timer.

Sydnee: You did. You never do that.

Justin: Is that okay?

Sydnee: Yeah, just…

Justin: Was that like out of pocket?

Sydnee: It was unexpected.

Justin: It was just that we had started talking, and I pushed it. I'm sorry, I don't know what I was thinking. I'm really sorry.

Sydnee: I mean you threw up my rhythm, so I don't know that—this whole show now, I can't predict.

Justin: Can you just pretend to push it? Just so it's like… *boop*!

Sydnee: *Boop*! Well, it doesn't make that noise. It doesn't—I don't know why we both made that noise. It doesn't make any noise, it's just like a little click.

Justin: Hello, happy…

Sydnee: Happy? [chuckles]

Justin: Happy election day to you.

Sydnee: It is. I don't think it's a happy, I think it's—it is—

Justin: It is election day in America—

Sydnee: It's just a statement. It is election day.

Justin: As this is being released. And we…

Sydnee: It's the midterms!

Justin: The midterms!

Sydnee: The most exciting…

Justin: Yeah.

Sydnee: Election season.

Justin: You know, it's not that… The thing is, it can be tough. It could be a slog. We've all been through the wringer. But if you're thinking about getting out to vote today, if you haven't already… I hope you—I hope you do. I hope you get out there and make your voice heard.

Sydnee: Yes.

Justin: We wanted to give you sort of an appropriate topic for the day.

Sydnee: Well, I think—okay, so this isn't about elections or voting, because I don't know what that has to do with medical history per se. But I do think it's important to realize that when it comes to healthcare and elections, like politics and healthcare, I think sometimes it gets boiled down to very like binary issues.

Justin: Mm-hm.

Sydnee: Are you for this or against this? And I don't think we look at the broader policy aspect, because it's kind of—I think it gets kind of like…

Justin: Boring.

Sydnee: Boring! Yes. Right? No, it does. It does. If you start thinking about policy and how we could actually make changes to make our lives better, you really can get in the weeds with some of this stuff. And I think because of that, it doesn't always get platformed in election season. And so—and it's also not necessarily—

Justin: It's not sexy.

Sydnee: No, it's not sexy. It's not a soundbite. It's not an easy catchphrase. It's not something that you can necessarily like rally the troops to support. And so I think it gets lost. But I think that the result of that sometimes is that huge, important programs are greatly impacted by elections. And by the time we realize that has happened, it's too late. And I think specifically when it comes to healthcare, and you look at programs like Medicare and Medicaid, we don't—we kind of know what they are—do you know—okay. I get this—I get asked this question all the time. What's Medicare versus Medicaid? And you can boil it down to the simple terms, the terms in which people ask me. Which one is for…

Justin: Man, okay, so let—I—medic—

Sydnee: You can say it the way people say it.

Justin: Is Medicaid for senior citizens and Medicare is for people that can't afford it? No, Medicare is for senior citizens, Medicaid is for people that can't afford it.

Sydnee: Yes.

Justin: Okay.

Sydnee: So, that is the—I get asked this question a lot. Which one is for old people? I'm not saying that… this is not ageism. I'm saying I—this is the way that I'm asked the question. Which one is for old people? Which one is for poor people?

Justin: Medic—Medicare—

Sydnee: This is the question that people ask me constantly. Medicare is a benefit that kicks in after you're 65.

Justin: Their hair is gray.

Sydnee: Yes.

Justin: Medicare.

Sydnee: When you're 65, you get Medicare. Or certain other medical conditions, they're like, if you have end stage renal disease, for instance. But generally speaking, Medicare is for the elderly, Medicaid is for people who live at a certain percentage of the poverty line. And then again, there are always exceptions, but those are generally what these two programs do. They're different. Medicare kicks in as soon as you turn 65. Medicaid, there's means testing.

Justin: Okay.

Sydnee: You have to qualify for it.

Justin: Check this out. You need Medicare if you have gray hair. You need Medicaid if you don't get paid. Pretty good, right?

Sydnee: Okay, that's pretty good.

Justin: All right. There you go. You'll remember that forever now.

Sydnee: I think that it's—I think Medicaid would be an important thing to talk about right now, because even though Medicaid is not on the ballot today, as you're listening, Medicaid was on the ballot two years ago. I don't know that people thought about it that way. But it was.

Justin: In what sense?

Sydnee: In the sense that the changes to Medicaid that will result from the so-called One Big Beautiful Bill, come January of 2027, will transform, I would say, in a very negative way, healthcare in this country. And that change was on the ballot two years ago.

Justin: Yeah, for sure.

Sydnee: But I don't know that we thought about it that way. And so I think it's important that we understand some of these big, unwieldy, bureaucratic programs, so that we know… what we want to do about them when we go to the voting booth. Right?

Justin: Makes sense to me, Syd.

Sydnee: Okay. So, where did Medicaid come from? Why is it controversial? It's healthcare for people who can't afford it. Why is that so controversial?

Justin: Because people don't like to help pay for other people. They want to keep all their money for themselves.

Sydnee: Well, that's… I mean, that's a very sad—[chuckles] I guess that could be the answer.

Justin: A lot of people are kind of mean, and they don't want—and sometimes there's more mean people than nice people. And sometimes the meeople will keep all their money. Basically.

Sydnee: The meeople?

Justin: The mean people. Pardon me.

Sydnee: So, when we look at the history of healthcare in the US, it's very different, obviously. There are many developed countries that have realized that some sort of taxpayer, like subsidized, single-payer universal healthcare system is beneficial to the—to si—like society in general.

Justin: Mm-hm.

Sydnee: And to the country's well-being, and improves quality of life and controls costs in many ways. Obviously, America hasn't realized that, or at least not widespread enough—

Justin: Not enough—

Sydnee: That we could pass it. But did we try? So, do you know that Harry S Truman actually was the first American president to really push for universal healthcare? Do you have a thing? I know you and the girls are memorizing all the presidents. Do you have a thing for Harry S Truman?

Justin: Harry S Truman, we… Harry S Truman had really, really terrible eyesight. I mean like really, truly bad. He was… I think these days he probably would have been legally blind? I believe that's right. We have a mnemonic device that's the best I got for Harry S Truman.

Sydnee: That's interesting. You know, I—that I ps—I empathize.

Justin: Yeah, yeah, yeah.

Sydnee: Without my contacts—

Justin: It's rough.

Sydnee: I'm blind as well. So according, historically, according to Truman, he noticed when he enlisted for service, military service during World War I, how many young men were deemed unfit for service. And this got him

thinking that perhaps the healthcare system in the United States was inadequate, and maybe a change needed to be made. And this was an idea that he carried all the way to the White House, eventually.

Justin: Hm. He was actually a… he was prevented from going to West Point because he was 20/50 in his right eye and 20/400 in his left eye.

Sydnee: Hm? He's still better off than me, I'm 20/400 in both.

Justin: There you go.

Sydnee: There you go. And certainly, as I say this, I'm sure there are people who understand American history better than I do. I know medical history quite a bit, but when it comes to the broader American history, I recognize I'm not an expert. Obviously, I think it is fair to say that when you look at FDR's New Deal and the programs that were being enacted, that if we carry on an FDR presidency for another four, eight, 12, 16, I don't know, as long as we would have elected him, right?

Justin: Mm-hm.

Sydnee: Years—would we have gotten to socialized medicine, universal healthcare? Probably, right? I think that's a—I think it's fair to say that Truman wasn't the first one to think of it or to talk about it, but he was the first one to actually propose this idea in the form of introduce legislation in Congress. So in 1945, we see a bill introduced called the Wagner-Murray-Dingell Bill, which was—

Justin: Sorry… one more time.

Sydnee: Wagner-Murray-Dingell.

Justin: Thank you.

Sydnee: Yes. And basically, I mean, the idea is really straightforward. We use a tax, like a payroll tax, on everybody.

Justin: Okay.

Sydnee: And it pays for healthcare.

Justin: Nice!

Sydnee: And then you get healthcare.

Justin: Good idea.

Sydnee: Really straightforward!

Justin: Very straightforward, we love that.

Sydnee: Yes! Lots of places figured this out. [titters]

Justin: You might—you might say we're the only industrialized nation that hasn't.

Sydnee: Yes. You might.

Justin: You might say—make that argument.

Sydnee: You could, because you'd be correct. So, you could indeed say that. It was met with a lot of resistance, most notably by the American Medical Association. I will say that throughout this episode, the AMA plays the role of the villain, for most of medical history.

Justin: Yeah.

Sydnee: Yeah. I don't—

Justin: They've certainly played it plenty on this here podcast, I know. [chuckles]

Sydnee: It's interesting, because if you look at like broad, national propaganda campaigns, like lobbying campaigns, this is probably one of the earliest—and I'm certainly not the only one. Obviously, the American government and the military, as we engaged in conflicts, propaganda has

always been part of that. So, certainly not—this is not the only example. But this is a really solid example of a propaganda campaign on behalf of the American Medical Association to combat a universal health care program. Basically, they tied it to socialism. So they would put out cartoons of, you know, people waiting in extremely long lines to get in to see a doctor, or you finally get in to see the doctor and it's a robot.

Justin: You mean like in… like a real robot?

Sydnee: Mm-hm. Like we're not—I mean, the idea that it's—it's that, I think at the time, the fear of like automation, the fear that individualism would be lost.

Justin: Yeah.

Sydnee: I mean, that was the whole thing, right? With like if you look at individualism versus socialism, the idea that we will be all just this collective of humanity and no longer unique people. And that really… is a—that chafes—

Justin: We don't like that—yeah—

Sydnee: The American spirit, right? Like that's our—

Justin: Unique.

Sydnee: That's kind of one of our core problems. [chuckles]

Justin: You think about the DMV, our big problem with the DMV is that everybody has to go there.

Sydnee: Yes.

Justin: It just doesn't seem right or fair. [chuckles]

Sydnee: And to be fair—

Justin: We're being treated like everyone else. [chuckles]

Sydnee: The Congress was conservative at the time, and so they were not particularly amenable to the idea. And then when this campaign started, which, you know, equated it with socialism, it failed pretty quickly. Truman was able to get a bill passed called the Hill-Burton Act, which gave federal dollars to build more hospitals, to expand access to health care. But that didn't necessarily do anything to increase affordability to the middle class.

And it's really interesting because if you look at the—like a letter that Truman wrote about this early days, he was specifically trying to help people who didn't make enough money to afford health care on their own, but didn't make so little money that they fell into any sort of charitable giving type of program.

He was talking about the middle class. And he could not rally the American public to support the middle class. But this definitely laid the framework for a discussion of Medicaid, because more and more people were going without insurance, health care costs were already rising at this point. And we know that—and we've done this before, we've done a whole episode on the history of health insurance in the US. Why do we tie health insurance to an employer? It's weird on its surface.

Justin: It's fairly convoluted. We did do an episode about it.

Sydnee: Yeah, we have an episode, so you can listen to why we did that. The short answer is that it was a way to attract workers. When we couldn't necessarily increase wages, we could offer benefits. And so fringe benefits, like we made a deal with a local hospital where if we all pay in this certain amount, we all get treated at this hospital. And so that was sort of the, you know, impetus. But there were a lot of people who got left out of this, and then certainly for the elderly. And this was really rising to a level of societal concern by the '50s, when we had people who were aging out of sort of the working world—

Justin: Right.

Sydnee: Needed medical care.

Justin: Right, because we had tied it to employment, if you're not employed, you need a plan.

Sydnee: Yes. And we're talking about like this is Social Security is still young. You know, we are—this is—the idea that we should take care of our elderly after they retire was still sort of a relatively new idea. And it wasn't necessarily tied to medical benefits, those were kind of two separate social programs at this point. So, in the '50s, we start to see these incremental provisions. So like we'll do this deal where the federal government can provide some funds to pay a health care vendor for somebody who is blind, or somebody who has a disability, or somebody who is above a certain age. But they're all very targeted.

Justin: Kind of like Band-Aid-y—

Sydnee: Yes.

Justin: Stopgap measures.

Sydnee: Yes. And the—all of this is easing us into this place where maybe the government should pay for health care. And there were certainly a lot of people working in health policy who were trying to push us. People who saw what FDR started, saw what was happening maybe overseas, you know, with the National Health Service, and said, this is the direction we should go. And so, this is where we see William J Cohen enter the picture. And William J Cohen has been called the father of Medicaid, the father of Medicare. He really was the one that was able to maneuver these—his ideas of what an ideal health care system would be, into a policy that was palatable to Congress and the American public at large.

Justin: Right.

Sydnee: And a lot of what I'm referencing to is from an article he wrote, actually, all the way back in the '80s, about his time working in government. First with Eisenhower, he wasn't part of the Eisenhower administration, he worked on the outside. And then he was part of Kennedy and the Johnson administration, actually working on these programs from inside and developing this policy. But basically, he saw the Truman defeat. And it was

what he wanted. What Turman—Truman's national health care plan is what he thought would work. But it wasn't something that he was necessarily going to be able to do. So he started working—he was—he was key to these little things that I mentioned, like these vendor payments, the idea that the federal government could start doing something. And then he started in the late '50s and into 1960, making some moves to say, well, now, what if—what if it wasn't all the federal government? Would you be more amenable to it? If maybe the state had to match that money?

Justin: We, in this case, being who?

Sydnee: The Congress, the American people, the American medical assoshe… Basically, he is coming definitely from a… Democrat perspective. I would say not what we would think of as left wing by today's standards, but a liberal. Definitely a more, dare I say, socialist perspective.

Justin: Yeah.

Sydnee: But he is trying to sell it to a more conservative Congress, and a more conservative American public. What if we ask the states to also put into this pot?

Justin: Hm.

Sydnee: What if—

Justin: We share the—share the load—

Sydnee: Yes! What if we shared the load? Instead of just the federal government taxing you, taking your tax dollars and throwing it back at you in the form of health care, which is like the purest form of this, what if we say, well, we will give the state of West Virginia X dollars, as long as West Virginia matches those dollars. Does that make sense?

Justin: Mm-hm.

Sydnee: And maybe we need to start adjusting it state by state. Maybe this state needs more dollars. Maybe this state needs less dollars. Maybe we should figure out formulas for each state.

Justin: We're integrating the states into the—into the whole calculation.

Sydnee: Yes. But this was a—this process was long and arduous. It wasn't going to be as easy as we think people who are living at or below or just barely above the poverty line still deserve health care. We think the elderly who are no longer working deserve health care. It can't be that simple. We're going to have to sell it in a series of incremental changes. And so, I want to talk about how we got to the Medicaid we have today and why it is about to change drastically.

Justin: Yeah.

Sydnee: But first, we have to go to the billing department.

Justin: Let's go.

[theme music plays]

[ad read]

Justin: All right, Sydnee, what was next for Medicare and Medicaid?

Sydnee: So, it's interesting, because Medicare and Medicaid would all be sort of adopted simultaneously. And if you had to guess which program would be more controversial, what would you have guessed?

Justin: Medicaid.

Sydnee: Me too.

Justin: Because everybody loves our grandpas and grandpa—and grandmas and gran… grand folks, you know?

Sydnee: That's what you would assume, right?

Justin: We all love those guys! They also vote. So you would think that like from a… a rather craven perspective too, it'd be an easy win.

Sydnee: So, Kennedy definitely supported Medicare. Like the Kennedy administration came in saying, "We want Medicare," and then, you know, the Johnson administration that took over similarly. They wanted Medicare. They liked the idea of some sort of assistance, especially for the working poor, in terms of health insurance. But Medicare was not a popular idea at the time. The fundamental difference you have to understand is that Medicare is just an entitlement. It's a benefit. You just get it, right? You turn 65—

Justin: For becoming old.

Sydnee: You get Medicare.

Justin: Old enough.

Sydnee: Medicaid has means testing. Medicaid, you have to earn in the sense that—

Justin: Reverse earn.

Sydnee: We get to check you.

Justin: Okay.

Sydnee: We get to vet you.

Justin: All right.

Sydnee: The conservative part of the government liked that idea.

Justin: Oh, we like that we have some say in—

Sydnee: Yeah! Like we don't know—like anybody—the eye—I think it's this—I think underneath all this is this idea that health care is still a privilege.

Justin: Mm-hm.

Sydnee: Because what chafed people about Medicare is that even if you didn't really work, we're going to give you health care. Or even if you didn't, I don't know, like we didn't… whatever our standards were in the '60s, you didn't go to church enough? I don't know.

Justin: Right.

Sydnee: [chuckles]

Justin: Didn't love Meatloaf enough—

Sydnee: Yeah. Like you don't like baseball, like you still get health care. There was this—like it bothered people the way that we would just give this thing.

Justin: Mm-hm. It's like free.

Sydnee: It's a handout! It's a handout!

Justin: Yeah.

Sydnee: Medicaid was not quite as controversial, because the thought was, well, we can check people. We can make sure. We can make sure they really need it. Right? And all of it—

Justin: And only people who need it, ostensibly, only people who need it will get the help.

Sydnee: Yes.

Justin: Otherwise, it's easy to tell a story of like, you know, the rich, elderly people getting their Medicare—

Sydnee: So initially, the Cohen strategy was to work with Mills, who was head of the House at the time. And basically, he was very conservative, but

he was still for the idea that some sort of health care program for the elderly is probably okay. But we just have to be really careful with how we did it. So there was a bill passed in '60 called the Care Mills Act. And it was just a really straightforward like, we're going to kind of match payments based on the income of each state, with the federal government. And it's going to help pay for health care in those states, for the people who can't afford it, to a certain degree. But the problem, and I mean, I think you see this—if anybody was really—like if you—if you're one of those people who was really paying attention during the debates on Obamacare or the Affordable Care Act, a lot of people were saying like, well, but this is going to become—like initially as we start this, this could be expensive or it could be unwieldy. Like it's going to have to catch on for it to start to make sense. You need enough people to enroll—

Justin: Yeah.

Sydnee: For some of these programs to—

Justin: Yeah.

Sydnee: To really flourish. And I think that's what you see at this time period, are these sort of like baby steps, that if you stop there, are going to kind of collapse in on themselves.

Justin: Mm-hm.

Sydnee: So you—it leaves Congress with no choice but to either propel them forward—

Justin: The next—yeah.

Sydnee: Or let them die. And as we have seen, once you give people health care, it's really hard to take it away from them.

Justin: Mm-hm.

Sydnee: At least it's hard to run on that platform.

Justin: [chuckles]

Sydnee: And so, initially, the Kerr-Mills Act starts to extend these medical benefits, people over 65. And then they start to like expand them to people who maybe don't make enough money to pay for medical services. So you start—like you see—

Justin: But it's still Medicare?

Sydnee: Medicaid creeping in. None of this is Medicaid or Medicare yet. This was the early—

Justin: Okay, gotcha.

Sydnee: Like evolution—

Justin: Gotcha, okay.

Sydnee: This was the larva of Medicare and Medicaid. But you still, at this point, it is very tied with the Kerr-Mills Act. It is very tied to wha—there is the age thing. But there's also you have to prove that you need it. And I think that this is important to understand, because a lot of the vetting, how do we know if you need it, it was tied to state welfare programs.

Justin: Mm-hm.

Sydnee: So if you qualified for certain state welfare programs, then you may also qualify for this medical assistance. And I believe that's part of why Medicaid is so controversial to this day, because we tied it… We made it this thing that you only get if we also think you qualify for other assistance programs. And I think because we are such an individualistic society, we tie it to… I mean, that's where you get like the handouts kind of mentality.

Justin: There's morality attached to it.

Sydnee: Yeah. Like we're—you didn't work for this, we're just giving it to you.

Justin: Sure.

Sydnee: And the—and the—even the word "welfare," right? Like I think a lot of programs have moved away from the word welfare, which is sad. Like, what is welfare? It's the… well… the faring well of the people. [chuckles]

Justin: It's all good, everybody like was—

Sydnee: Like it's good!

Justin: We love well stuff, we love stuff to be fair, it's a good word!

Sydnee: But we used a lot of these eligibility standards for different welfare programs in those early days to decide whether or not you also qualified for these health programs. And it really tied the idea that Medicaid is welfare. Medicaid is a government handout that we give to people who should be working and getting this, but aren't doing it. This is not me speaking. I think this is what… I think this is why—

Justin: It's too bad, the TikTok actually just ended.

Sydnee: [chuckles]

Justin: So it's too bad.

Sydnee: But I think—I think this is why it gets this bad rap, instead of couching it as a just government provides for the needs of its people, including health care.

Justin: You just, every time that you have these discussions, you have to think about fire trucks. This is what I do. I think about fire trucks, right? Because no one thinks that you're getting a handout when the fire department comes to put the fire out. You know what I mean? It's just like, well, your house is on fire, so that's what we do. [chuckles] You don't think of it as a freebie. You don't think of it as a, well, you didn't work hard enough for the fire department to come. You just put the fire out. You know what I mean? Like in other countries they're like, well, yeah, I mean, there's

a fire! Like, yeah, it's—you're sick, you gotta fix it, and then we'll do something else. [chuckles] But it's like I… you know—

Sydnee: And I thi—but I think—I think that, really, because Medicaid—and I don't—I will say that, for myself, I have no problem with any social welfare programs.

Justin: No kidding?

Sydnee: [chuckles] I do not—

Justin: Last surprising line of Sawbones history.

Sydnee: But when it comes to selling this to especially like in a conservative Congress, if it is tied to social welfare, it's going to be a really difficult sell.

Justin: Sure.

Sydnee: And Medicaid certainly was in those early days. Now, this is all before we're calling it Medicaid. The thing that happened in 1965 is that you have this push to provide care for the elderly. And that is something that they can kind of get people to rally behind. And people are arguing about how to do it, they're arguing about how much the federal government should pay versus the state should pay, and who should bear the burden. And that's where we start to get, I mean, if you—if you're familiar with Medicare, you start to get this like, the initial push was we should just do hospital care. Medicare will cover what happens in a hospital. That's part A, in case you're curious. And then you have this pushback from the AMA saying, well, listen, if you're going to make us do this crap, you better cover what physicians want. And that's part B.

Justin: Mm-hm.

Sydnee: So, you better pay physicians through part B, because we want to get reimbursed for our work. And then eventually part D would come along, which is prescription drugs. But all this argument is happening about Medicare in 1965. Everybody's upset about how we're gonna pay for it and who's gonna—I mean, doctors are fighting it, the AMA is fighting it. The AMA

actually initiated a new campaign that they called Operation Coffee Cup. This started back all the way in 1961, as the beginnings of this program were like being debated in Congress, through the Women's Auxiliary. Where basically doctor's wives would hold like meetings and give people coffee, and then encourage them to write letters to Congress to oppose Medicare.

Justin: Yeah, perfect.

Sydnee: It wasn't Medicare yet, but they're opposing Medicare. Can you imagine if in your community, all the doctor's wives, and then, I mean, hopefully there'd be some husbands now too, but whatever, all the doctors' wives get together and say like, "We've got to stop old people from getting healthcare. It's important to our husbands that old people don't get healthcare."

Justin: "Our husbands tell us that old people shouldn't get healthcare."

Sydnee: And so there's an LP called Ronald—

Justin: Kids that's—kids, that's an album.

Sydnee: That's an album.

Justin: A vinyl long play album.

Sydnee: That the AMA had Ronald Reagan record.

Justin: Kids, Ronald Reagan was the president of the United States of America after Jimmy Carter and before George Herbert Walker Bush.

Sydnee: He was also an actor first—

Justin: Yeah, that's true!

Sydnee: Ronald Reagan speaks out against socialized medicine, and they would play this record while they drank coffee, and then they would write letters to Congress and say, "Please stop old people from—" They didn't say it this way. The whole idea, I mean, the really, this demon of socialized

medicine that gets like… like we're all taunted with every election cycle, this is an old trope. And this is, I mean, you see this at this moment.

Justin: Mm-hm.

Sydnee: If doctors were told, if we allow this to pass, we will then be at the mercy of the government. The government will tell us how to practice medicine. And god forbid that anybody tell us what to do. I'm sorry, we're all like this. You know we're like this, doctors. You know we're like this. But I mean, it's a real fear. I don't like the idea of people telling me how to practice.

I do like the idea of my patients being able to pay for healthcare. Or you know, me paying for it for them, that's fine too. But anyway, so while all of this fight over Medicare is going on, and they're going back and forth over who should pay for, you know, elderly people to access healthcare, Medicaid is kind of being crept into the bill. Because the Kerr-Mills Act is not sustainable, the states were kind of allowed to do their own thing, like we want you to provide—we're gonna match funds to provide care for people who can't afford it. But there were very little like regulations on exactly how and who.

And it was—a lot was left up to state, so it was not working very well. It was only serving a really small—like only certain states, like California and New York, and eventually Michigan. There were only certain states that were really benefiting from it. And so they wanted to expand it, they needed to fix it, and Medicare was kind of the perfect thing to slide it in underneath. So while everybody's freaking out and arguing and Ronald Reagan is talking about Medicare, Cohen is secretly adding into the bill—

Justin: All this Medicaid stuff. [chuckles]

Sydnee: All this Medicaid stuff underneath. And you see, and I should say, like I'm talking about all the opposition, at this same moment, you have a **lot** of groups, like especially if you look at like the unions, are standing up and saying, we have to do something. Like we have to take better care, especially of our elderly. The Medicare part, there was a lot of social

pressure. We cannot let—once you get to a certain age and you can't work anymore, you can't just get sick and die.

Justin: Right.

Sydnee: That's not the America we want. And so, while everybody's paying attention to Medicare, Cohen is having these conversations with people about how the Kerr-Mills Act isn't working well enough. And he actually, he referred to Medicaid as the sleeper in the legislation. Nobody was paying attention. He stuck something in there called the Improvement and Extension of Kerr-Mills Program.

Justin: [laughs]

Sydnee: Title 19. It wasn't… this wasn't like a trick. It was just in there. Everybody could read about it. But everybody was so busy fighting over Medicare that they didn't notice that, in the meantime, they introduced the idea of Medicaid, which would be the federal government is gonna provide each state with matching funds. The state does get the power to vet who qualifies for Medicaid.

Justin: Okay.

Sydnee: That is still true. We're utilizing state formulas to see, you know, who lives at the right percentage of the poverty line or who has what medical conditions and who qualifies for Medicaid is up to the states. And exactly what services Medicaid delivers was also up to the states. But there were regulations.

Justin: Okay.

Sydnee: Like within reason. You can't just say like, okay, well, we're only going to pay for Tylenol. [chuckles]

Justin: Right.

Sydnee: You know what I mean.

Justin: Sure.

Sydnee: So, Medicaid gets snuck in—

Justin: Tylenol and Band-Aids! Good luck.

Sydnee: Yeah, Tylenol and Band-Aids, that's it. So Medicaid gets snuck in, in 1965, under the umbrella of Medicare. And all of a sudden, we have a way for—and again, the goal when Truman started this idea, even as Cohen was expanding it, yes, certainly, they're looking for people who are living below the poverty line, who are not employed, who are not able to work. Certainly, they want to provide for those individuals. But they're also recognizing, and this is true to this day, that the majority of people who receive Medicaid work. We just don't pay them enough to be able to afford insurance, or they make too much for other program—I mean the—we—it was a recognition that there is this gap that our society has never filled.

Justin: Right.

Sydnee: Where you can't work hard enough to afford healthcare in the US, typically. Some can, many can't. And so that stuck for a long time. And there were, of course, there were changes made. There was a section in Medicaid, in the original provision, back in 1965, it was section 1903, and this was actually later repealed because people got so mad about it. Again, stuff that Cohen just snuck in.

And it said basically that… the states need to make a satisfactory showing of efforts in the direction of broadening the scope of the care and services that are made available under the plan and the—in the direction of liberalizing the eligibility requirements, with a view toward furnishing by July 1st of 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards. Basically, the idea is there's this secret passage in original Medicaid that says—

Justin: By '75, this needs to be—

Sydnee: Universal healthcare!

Justin: Right. And that did—but they noticed that.

Sydnee: They noticed that right before '75. New York noticed it first and said, "No, no, no, no, no, no, no! We need to take this out of there. We're not gonna do this crap." [chuckles] So, there've always been changes made to Medicaid. The most substantial in a positive way is in 2010, when what many refer to as Obamacare or the Affordable Care Act was accepted into law, which expanded Medicaid, if the state wished, to individuals who make 138% of the poverty line. This included pretty much all children. It streamlined the process. If you are someone who practiced medicine prior to 2010 and after 2010, you can attest to the impact of this in the states that accepted it, which most did.

Justin: Right.

Sydnee: There were some states that refused the Medicaid expansion, which data has proven was… was not to the benefit of their citizens. We see decreased costs and increased quality of life and increased positive health outcomes in states that accepted the Medicaid expansion.

Justin: They were wrong. They made the wrong choice.

Sydnee: Yes, they made the wrong choice. But what we saw is a lot more individuals able to access healthcare. And I mean, I can attest in our own community, I used to work at a free clinic that had to convert to a clinic that could accept Medicaid, because so few individuals were left uninsured.

Justin: Mm-hm.

Sydnee: So, this is a positive thing. So few people didn't have insurance that they could not sustain on those few individuals, and they had to also accept Medicaid in order to continue to exist.

Justin: Yeah.

Sydnee: So, it was really transformative, this expansion of Medicaid. And I think this incrementalism, this is the history of healthcare in the US,

incremental changes trying to get us to where every other industrialized nation already got, which is universal healthcare.

Justin: Right.

Sydnee: The problem is the One Big Beautiful Bill. So, even as I think Barack Obama moved us closer to Cohen's goal of universal healthcare, Donald Trump has moved us significantly further away, starting January 1, 2027. So, it changes Medicaid in a variety of ways. First, it's going to add work or volunteer requirements of about 80 hours a month to all, whatever you qualify as, able-bodied individuals between the ages of 19 and 64. So, if you do not meet these work or volunteer requirements, you will no longer be eligible for Medicaid.

Justin: Okay.

Sydnee: It forces you to apply more frequently. This is just—this is one of those where they hope you don't notice. It's kind of like when they sign you up for those like services online, like the free trials, and then they hope you never notice enough to cancel it.

Justin: Yeah.

Sydnee: It's kind of like that in reverse. They're going to keep making you re—like be reassessed, re-evaluated, and sign up again, in hopes that you'll miss a deadline, and it will just lapse and you won't realize it.

Justin: Right. So they're basically limiting access, trying to make it harder to get.

Sydnee: They're trying to make it—yes. They're trying to make Medicaid harder to get. They're going to restrict access further based on immigration status because, of course, that's the biggest target. They're restricting some uses of like provider taxes to fund Medicaid. So some of the ways that states pay for Medicaid, they're changing, they're limiting—they're doing a lot of damage to medical students. They're going to limit the kinds of loans that medical students are eligible to receive, to pay for their medical education, and they're going to cap the amount that they can receive.

Justin: Why?

Sydnee: I mean, the functional result of this, I mean, I'm sure that they would say to save money, but the result of this will be that fewer people from low-income backgrounds or… I mean, fewer people are going to seek medical education. It's going to restrict it to access for only those who come from wealth, or have the ability to take on certain other kinds of loans. So they're restricting access to medical school with this. It doesn't provide fixes for long-term inflation-based Medicare reimbursement.

That's been a push from the AMA for a long time, like you should reimburse us at a level that equates to inflation. They are not. There's no fix for that. This is the part that made the AMA really mad. And it's going to be more expensive, this is outside of Medicaid, but it's going to be more expensive to participate in like the ACA marketplace insurance programs. They already ended the tax credits for that. So they're basically pricing people out of that market, they're kicking people off Medicaid. The idea is it's going to save the government money. Except does it?

Justin: It doesn't.

Sydnee: Because we'd still have universal healthcare in this country in one form…

Justin: Emergency rooms!

Sydnee: The emergency room. They cannot turn you away from an emergency room. It is the least efficient and most expensive way that we could provide healthcare, but we will do it that way. So it doesn't save money.

Justin: No. It's financially ruinous for the people that can't afford it. They get deeper in debt to a point where they'll never get out. Like it hurts them and it hurts the system because that money is gone. The people who do the care, that money also doesn't. So it's just like a huge, sucking wound. But they—and they know, it's not like it's a surprise, like…

Sydnee: And it's used to justify, in part, some of these exorbitant healthcare costs. Why does the hospital charge you $20 for a Tylenol? Well, they have to, because they've got to eat all these costs from these ER visits that they never get reimbursed for. Now, I'm not saying that that's true, but it continues that sort of narrative.

Justin: Mm-hm.

Sydnee: The net effect of this is that around 11.8 million people are going to lose healthcare coverage. There are 446 hospitals across the US that are at risk of closure because of this.

Justin: That's such a problem with access—

Sydnee: The, yes, they rely—

Justin: Especially.

Sydnee: They rely on Medicaid payments to stay open, and these decrease in individuals on Medicaid are gonna, and on the ACA marketplace programs, are gonna decrease their reimbursements, and hospitals are gonna have to close. You already see hospitals cutting services that are low margin, like delivering babies. There are parts of West Virginia where you have to drive two hours to deliver a baby.

Two hours from a hospital where you can safely deliver a baby. And we are not the only state that suffers from that currently, and this is only gonna get worse under the One Big Beautiful Bill. And then of course, services like behavioral health get cut, because those a—lower reimbursement as well. The effect of all this is that people are going to be sicker, the system will be slower, the costs will be higher. Inequality will increase, the disparities between the haves and the have-nots will get wider.

And if you start to hear, because there's always—there's always rhetoric about like, "Well, but then instead we're gonna do this." So if we're gonna take something away, what are we gonna give? So for instance, there's the Rural Health Transformation Program. When they realized how many of these 446 hospitals were rural hospitals, meaning that maybe this was the

only hospital for a large mile radius, and that it might close because of the One Big Beautiful Bill, that's bad if you're running for office.

That's bad if your constituents realize that. So, the Rural Health Transformation Program was a way to inject money into rural communities, like the thought being, here we're replacing it. But you need to understand that that is a one-time $50 billion over five years restricted funding source to certain hospitals across the US, that will go away after five years. And that is supposed to soften the blow of around 100… I think it's around 140 billion that is being lost, because of the One Big Beautiful Bill.

So it is not—there is no—there is no fix for this baked in. And I think it's—I think it's really important to understand these—I mean, I know that this is all really complex, and I understand that some of this healthcare policy stuff can get boring. As I was reading about the history of Medicaid and the back and forth, I mean, your eyes glaze over a little bit, but I think that part of that is intentional. If it's convoluted enough, you stop listening, and then they do stuff like this.

Justin: Right.

Sydnee: And that's exactly what happened with Medicaid and the One Big Beautiful Bill. It sounds really nice to say, "I work hard, everybody should work hard. You know, I earn the things I get, other people should work hard." That sounds really nice on the surface, but what they're really saying is, "We are going to take healthcare away from people and close hospitals and make it harder to be healthy."

Justin: People who do work.

Sydnee: Yes, people who already work, make it harder to be healthy in this country unless you are rich already. That is the effect of this. Oh, and by the way, the AMA is against the One Big Beautiful Bill. [titters] There's the—there's the denouement. The AMA is on our side now.

Justin: Yeah. I… I think it bu—it's easy to despair, and obviously you have the right to do that, but I would encourage you, if you're listening to this on Tuesday, and you're someone who can vote in America, you should do that.

You can have an impact on this at a smaller scale. And if enough folks vote that they don't want things to be like this anymore, then you gotta hope that things will get better, things will improve. And the only way that you could do that, or at least the most effective way you can do that right now, today on Tuesday, the 3rd of November, is to go and vote. So go do that.

Sydnee: You should.

Justin: And then despair. Despair *after* that. Vote first.

Sydnee: I think it's important that we, the voters, control the issues that our representatives are talking about. I think for a long time now, it's gone the other direction. They tell us, they give us a binary, are you for this or against this? Do you like this or do you hate this? And instead, it's gotta come from us. We have to be the ones saying, hey, where do you stand on healthcare? Where do you stand on Medicaid? Do you really think that if you can't work or volunteer, you deserve to get sick and die? Is that really where you—is that really how you feel our country should function? And if that is, why would I wanna vote for you? We need to demand answers on these issues…

Justin: You had an inflection like there was gonna be more of the sentence.

Sydnee: I'm just, I don't have anything else. I'm very frustrated. [chuckles]

Justin: [laughs]

Sydnee: I'm very frustrated reading the—health insurance is a scam. It's all a scam! [titters]

Justin: All right, there it is.

Sydnee: We need a single payer healthcare system. Take our tax dollars. Give us all healthcare. It's a human right.

Justin: Yeah.

Sydnee: End health insurance.

Justin: Whoa! Here she goes. Thanks so much for listening to our podcast. A nuanced, thoughtful take on the American healthcare system we call Sawbones. Thank you to The Taxpayers for the use of their song "Medicines" as the intro and outro of our program.

Sydnee: Health insurance is a scam! [chuckles]

Justin: Thanks for listening. Thanks to you for listening. That's gonna do it for us. Until next time, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don't drill a hole in your head.

["Medicines" by The Taxpayers plays]

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