Medicare & Medicaid

MILESTONES
1937-2015

July 2015

PRE-1965

1937

U.S. Surgeon General Thomas Parran proposed that National Health Insurance first cover Social Security beneficiaries.

1939

The Federal Security Agency was created to administer federal organizations dealing with health, education and social insurance, including the Social Security Board, Public Health Service, and Office of Education.

1945

After the Social Security Board called for beneficiary health insurance, President Harry Truman publicly lent his support to National Health Insurance.

1960's

1965

Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act, providing hospital, post-hospital extended care, and home health coverage to almost all Americans aged 65 or older (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board), and providing states with the option of receiving federal funding for providing health care services to low-income children, their caretaker relatives, the blind, and individuals with disabilities. At the time, seniors were the population group most likely to be living in poverty; about half had health insurance coverage.

To implement the Health Insurance for the Aged (Medicare) Act, the Social Security Administration (SSA) was reorganized and the Bureau of Health Insurance was established on July 30, 1965. This bureau was responsible for the development of health insurance policy. Medicaid was part of the Social Rehabilitation Service (SRS) at this time.

1966

Medicare was implemented and more than 19 million individuals enrolled by July 1.

1967

An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) comprehensive health services benefit was established for all children getting Medicaid. Medicare was also given authority to conduct demonstration projects.

1970's

1972

Medicare eligibility was extended to individuals under age 65 with long-term disabilities and to individuals with end-stage renal disease (ESRD). Medicare was given additional authority to conduct demonstration programs.

Medicaid eligibility for elderly, blind and disabled residents of a state was linked to eligibility for the newly enacted Federal Supplemental Security Income (SSI) program.

1973

The HMO Act provided start-up grants and loans for the development of health maintenance organizations (HMOs). HMOs meeting federal standards relating to comprehensive benefits and quality were established and under certain circumstances had the right to require an employer to offer coverage to employees. The Medicare statute was also amended to provide for HMOs to contract to provide Medicare benefits to beneficiaries who choose to enroll.

1977

The Health Care Financing Administration (HCFA) was established to administer the Medicare and Medicaid programs.

1980's

1980

Coverage of Medicare home health services was broadened. Medicare supplemental insurance, also called "Medigap," was brought under federal oversight.

1981

Freedom of choice waivers and home and community-based care waivers were established in Medicaid. States were required to provide additional payments to hospitals treating a disproportionate share of low-income patients (called "disproportionate share hospitals," or DSH).

1982

The Tax Equity and Fiscal Responsibility Act made it easier and more attractive for health maintenance organizations to contract with the Medicare program providing for Medicare payments on a full risk basis. In addition, the Act expanded the Agency's quality oversight efforts through Peer Review Organizations (PROs).

1983

An inpatient acute care hospital prospective payment system for the Medicare program, based on patients' diagnoses, was adopted to replace cost-based payments.

The Medicare hospice benefit was established as an option for beneficiaries to receive all-inclusive care to relieve pain and manage symptoms in a home setting rather than an institutional setting.

1986

The Emergency Medical Treatment and Labor Act (EMTALA) required hospitals participating in Medicare that offer emergency services to provide appropriate medical screenings and stabilizing treatments.

Medicaid coverage for pregnant women and infants (up to 1 year of age) up to 100% of the Federal Poverty Level (FPL) was established as a state option.

1987

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) strengthened the protections for residents of nursing homes.

1988

The Medicare Catastrophic Coverage Act of 1988 was enacted, which included the most significant changes since enactment of the Medicare program, improved hospital and skilled nursing facility benefits, covered mammography, and included an outpatient prescription drug benefit and a cap on patient liability.

The Medicare Catastrophic Coverage Act also provided for Medicaid coverage for pregnant women and infants up to 100% of the FPL was mandated; special eligibility rules were established for institutionalized persons whose spouses remained in the community to prevent "spousal impoverishment." The Qualified Medicare Beneficiary (QMB) program was established to pay Medicare premiums and cost-sharing charges for beneficiaries with incomes and resources below established thresholds.

The Clinical Laboratory Improvement Amendments (CLIA) of 1988 strengthened quality performance requirements for clinical laboratories to ensure accurate and reliable laboratory tests and procedures.

1989

The Medicare drug benefit and other enhancements of Medicare coverage in the Medicare Catastrophic Coverage Act of 1988 were repealed after higher-income seniors protested new premiums. A new Medicare fee schedule for physician and other professional services, a resource-based relative value scale, replaced charge-based payments.

Medicaid coverage of pregnant women and children under age 6 up to 133% of the FPL was mandated; expanded Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements were established.

1990's

1990

Phased-in Medicaid coverage of children ages 6 through 18 under 100% of the FPL was established, and a Medicaid prescription drug rebate program was created. A specified low-income Medicare beneficiary eligibility group (SLMBs) was also established for Medicaid programs to pay Medicare premiums for beneficiaries with incomes at least 100% but not more than 120% of the FPL and limited financial resources.

Additional federal standards for Medicare supplemental insurance were enacted.

1991

Medicaid Disproportionate Share Hospital (DSH) spending controls were established, and provider-specific taxes and donations to states were capped.

1995

SSA became independent of the Department of Health and Human Services (HHS). After occupying office space on the SSA campus and in other nearby buildings in Baltimore, HCFA consolidated into its own 960,000 square foot national headquarters down the road from SSA on Security Boulevard.

1996

Welfare Reform: The Aid to Families with Dependent Children (AFDC) entitlement program was replaced by the Temporary Assistance for Needy Families (TANF) block grant; the welfare link to Medicaid was severed; a new mandatory low-income group not linked to welfare was added to Medicaid; and enrollment in/termination of Medicaid was no longer automatic with receipt of welfare cash assistance.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed. It had several provisions. First, it amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 to provide for new federal rules improving continuity or "portability" of coverage in the large group, small group and individual health insurance markets. HCFA implemented HIPAA provisions affecting the small group and individual markets.

Second, it created the Medicare Integrity Program which dedicated funding to program integrity activities and allowed HCFA to competitively contract for program integrity work. Third, it created national administrative simplification standards for electronic health care transactions. Fourth, it required HHS to issue privacy regulations if Congress failed to enact substantive privacy legislation.

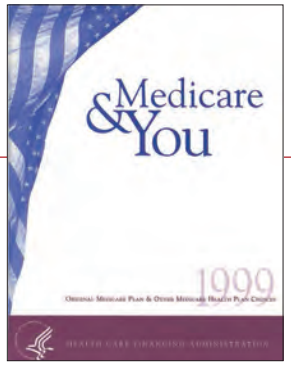
1997

The Balanced Budget Act of 1997 (BBA): The Children's Health Insurance Program (CHIP) was created; limits on Medicaid payments to disproportionate share hospitals were revised; new Medicaid managed care options and requirements for states were established. BBA also made changes to Medicare including:

- Establishing an array of new Medicare managed care and other private health plan choices for beneficiaries, offered through a coordinated open enrollment process.
- Expanding education and information to help beneficiaries make informed choices about their health care.
- Requiring HCFA to develop and implement five new prospective payment systems for Medicare services (for inpatient rehabilitation hospital or unit services, skilled nursing facility services, home health services, hospital outpatient department services, and outpatient rehabilitation services).
- Slowing the rate of growth in Medicare spending and extending the life of the trust fund for 10 years.
- Providing a broad range of beneficiary protections.
- Expanding preventive benefits.
- Testing other innovative approaches to payment and service delivery through research and demonstrations.

1998

The Internet site Medicare.gov was launched to provide updated information about Medicare.



1999

The first annual Medicare & You handbook was mailed to all Medicare beneficiary households.

The toll-free number, 1-800-MEDICARE (1-800-633-4227), became available nationwide.

The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work. The law established optional Medicaid eligibility groups and allowed states to offer a buy-in to Medicaid for working-age individuals with disabilities.

The Balanced Budget Refinement Act of 1999 (BBRA) increased payments for some Medicare providers and increased the amount of Medicaid DSH funds available to hospitals in certain States and the District of Columbia. Other related legislation improved Medicaid coverage of certain women's health services.

2000's

2000

The Benefits Improvement and Protection Act (BIPA) further increased Medicare payments to providers and managed health care organizations, reduced certain Medicare beneficiary co-payments, and improved Medicare coverage of preventive services. BIPA created a new Medicaid prospective payment system for Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs) and modified the amount of Medicaid DSH funds available to hospitals. It also delayed for one year the sunset of transitional medical assistance provided to families eligible for welfare.

2001

Secretary Tommy Thompson renamed the Health Care Financing Administration (HCFA) the Centers for Medicare & Medicaid Services (CMS).

2003

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) made the most significant changes to Medicare since the program began. MMA created a new optional outpatient prescription drug benefit, effective in 2006, provided through private health plans allowing for competition among health plans to foster innovation and flexibility in coverage, covered new preventive benefits, and made numerous other changes. For the period prior to 2006, MMA created a temporary prescription discount card program.

Beneficiaries with incomes less than 150% of the FPL became eligible for subsidies under the new Part D prescription drug program. MMA also required beneficiaries with higher incomes to pay a greater share of the Part B premium beginning in 2007.

2005

Enrollment started for Medicare Prescription Drug coverage.

2006

Medicare prescription drug coverage (Part D) began Medicare for 39 million beneficiaries. Numerous MMA provisions were implemented, including a number of new preventive services for Medicare beneficiaries.

2009

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This legislation marked a new era in children's coverage by providing states with significant new funding, new programmatic options, and a range of new incentives for covering children through Medicaid and the Children's Health Insurance Program (CHIP).

2010's

2010

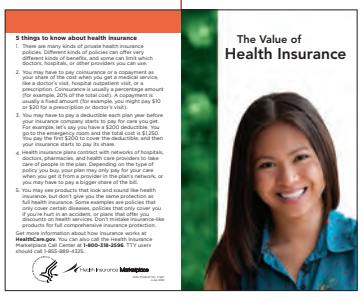
The Patient Protection and Affordable Care Act (ACA), commonly known as the "Affordable Care Act," was signed into law by President Barack Obama on March 23, 2010, for the first time prohibiting health insurance companies from denying or charging more for coverage based on an individual's health status, providing for expansion of the Medicaid program, and subsidies for insurance purchased through State-based Marketplaces to ensure that private insurance is affordable.

The ACA also provided a variety of other insurance reforms, like new preventive benefit requirements and prohibitions on dollar limits, and expanded Medicare drug and preventive services benefits.

2011

3.6 million people with Medicare saved $2.1 billion on their prescription drugs thanks to the Affordable Care Act.

More than 25.7 million beneficiaries in Original Medicare received at least one preventive service following a cost-sharing waiver in the Affordable Care Act.



2012

6.8 million consumers saved an estimated $1.2 billion on health insurance premiums in 2012, due to the "rate review" provision of the Affordable Care Act.

3.5 million beneficiaries saved $2.5 billion on prescription drugs, for an average of $706 per beneficiary.

2013

The Health Insurance Marketplace opened on October 1, 2013. For the first time ever, all Americans were able to shop for affordable quality health coverage, and couldn't be denied or charged more because they had a pre-existing condition.

An estimated 37.2 million Medicare beneficiaries received at least one free preventive service including an estimated 26.5 million people with Original Medicare.

4.3 million seniors and people with disabilities saved $3.9 billion on prescription drugs, or an average of $911 per beneficiary.

2014

During the first open enrollment for the Health Insurance Marketplace, 8 million people signed up for private insurance.

3 million young adults gained coverage thanks to the Affordable Care Act by being able to stay on their parents' plan.

Looking at the additional enrollment since October 2013 when the initial Marketplace open enrollment period began, among the 49 states reporting both May 2015 Medicaid and CHIP enrollment data and data from July-September of 2013, more than 12.8 million additional individuals are enrolled in Medicaid and CHIP as of May 2015.

Up to 129 million Americans with pre-existing conditions, including up to 17 million children, no longer had to worry about being denied health coverage or charged higher premiums because of their health status.

105 million Americans no longer had to worry about having their health benefits cut off after they reach a lifetime limit.

2015

The Medicare Access and CHIP Reauthorization Act (MACRA) changes the way Medicare pays physicians. It replaced the Sustainable Growth Rate (SGR) methodology with a method that's more predictable and speeds up participation in alternative payment models. These models encourage quality and efficiency. MACRA also extended CHIP for two years, through fiscal year 2017.