
Key Milestones in Medicare and Medicaid History, Selected Years: 1965-2003

1965—Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act, extending health coverage to almost all Americans age 65 or over (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board), and providing health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. Seniors were the population group most likely to be living in poverty; about one-half had health insurance coverage.

1966—Medicare was implemented on July 1, serving more than 19 million individuals. Medicaid funding was available to States starting January 1, 1966; the program was phased-in by States over a several year period.

1967—An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under age 21 was established.

1972—Medicare eligibility was extended to 2 million individuals under age 65 with long-term disabilities and to individuals with end-stage renal disease (ESRD). Medicare was given the authority to conduct demonstration programs.

Medicaid eligibility for elderly, blind, and disabled residents of a State could be linked to eligibility for the newly enacted Federal Supplemental Security Income Program (SSI). Eighteen million individuals were covered by Medicaid.

1977—The Health Care Financing Administration was established by Secretary Califano to administer the Medicare and Medicaid Programs.

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 (1915b) and home and community-based care waivers (1915c) were established in Medicaid; States were required to provide additional payments to hospitals treating a disproportionate share of low-income patients (i.e., disproportionate share hospitals [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. In addition, the act expanded the agency's quality oversight efforts through peer review organizations.

1983—An inpatient acute hospital prospective payment system (PPS) for the Medicare Program, based on patients' diagnoses, was adopted to replace cost-based payments.

1985—The Emergency Medical Treatment and Labor Act required hospitals participating in Medicare that operated active emergency rooms to provide appropriate medical screenings and stabilizing treatments.

1986—Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of the Federal poverty level (FPL) was established as a State option.

1987—The Omnibus Budget Reconciliation Act of 1987 strengthened the protections for residents of nursing homes.

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

Medicaid coverage for pregnant women and infants to 100 percent FPL was mandated; special eligibility rules were established for institutionalized persons whose spouses remained in the community to prevent “spousal impoverishment,” qualified Medicare beneficiary program was established to pay Medicare premiums and cost-sharing charges for beneficiaries with incomes and resources below established thresholds.

1989—The 1988 MCCA was repealed after higher-income elderly protested new premiums. A new Medicare fee schedule for physician and other professional services, a resource-based relative value scale, replaced charge-based payments. Limits were placed on physician balance billing above the new fee schedule. Physicians were prohibited from referring Medicare patients to clinical laboratories in which their physicians, or physicians’ family members, have a financial interest.

Medicaid coverage of pregnant women and children under age 6 to 133 percent FPL was mandated; expanded EPSDT requirements were established.

1990—Phased-in Medicaid coverage of children age 6-18 under 100 percent FPL was established; Medicaid Prescription Drug Rebate program was established; specified low-income Medicare beneficiary eligibility group was established for Medicaid Programs to pay Medicare

premiums for beneficiaries with incomes at least 100 percent, but not more than 120 percent of the FPL and limited financial resources. Additional Federal standards for Medicare supplemental insurance were enacted.

1991—Medicaid DSH spending controls were established and provider-specific taxes and donations to States were capped.

1996—Welfare Reform: The Aid to Families with Dependent Children entitlement program was replaced by the Temporary Assistance for Needy Families block grant; the welfare link to Medicaid was severed; a new mandatory low income group not linked to welfare was added; and enrollment/termination of Medicaid was no longer automatic with receipt/loss of welfare cash assistance.

1997—Balanced Budget Act of 1997: State Children’s Health Insurance Program (SCHIP) was created to provide health insurance to working families without such coverage; limits on Medicaid payments to DSHs were revised; new Medicaid managed care options and requirements for States were established.

Medicare changes included: an array of new Medicare managed care and other private health plan choices for beneficiaries, offered through a coordinated open enrollment process; expanded education and information to help beneficiaries make informed choices about their health care; five new PPSs for Medicare services (for inpatient rehabilitation hospital or unit services, SNF 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; and expanding preventive benefits.

1998—The Internet site www.medicare.gov was launched to provide updated information about Medicare.

1999—The toll-free number, 1-800-MEDICARE (1-800-633-4227), was available nationwide. The first annual *Medicare & You* handbook was mailed to all Medicare beneficiary households.

The Ticket to Work and Work Incentives Improvements Act of 1999 expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work. 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 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—The Benefits Improvement and Protection Act (BIPA) further increased Medicare payments to providers and managed health care organizations, reduced certain Medicare beneficiary copayments, and improved Medicare's coverage of preventive services.

BIPA created a new Medicaid PPS for federally qualified health centers and rural health clinics and it modified the amount of Medicaid DSH funds available to hospitals, while it provided a one-year extension on the sunset of transitional medical assistance provided to families eligible for welfare.

2001—The Health Care Financing Administration was renamed the Centers for Medicare & Medicaid Services (CMS) by Secretary Thompson.

2003—The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) made the most significant changes to Medicare since the program began. MMA creates a prescription drug discount card until 2006, allows for competition among health plans to foster innovation and flexibility in coverage, covers new preventive benefits, and makes numerous other changes. In 2006, the new voluntary Part D outpatient prescription drug benefit will be available to an estimated 43 million Medicare beneficiaries from private drug plans, as well as, Medicare Advantage plans. Medicare beneficiaries also receiving Medicaid will receive their drug benefit through the Medicare Program. Employers who provide retiree drug coverage comparable to Medicare's will be eligible for a Federal subsidy.

Medicare will consider beneficiary income for the first time: beneficiaries with incomes less than 150 percent of the FPL with limited assets will be eligible for additional subsidies for the new Part D prescription drug program; beneficiaries with higher incomes will pay a greater share of the Part B premium starting in 2007.

ADDITIONAL RESOURCES

CMS has a trove of materials (including oral history interviews with former Secretaries, Administrators, Members of Congress, and others; Presidential speeches; *Health Care Financing Review* issues from the 30th and 35th anniversaries; and other materials) on Medicare and Medicaid history available on the Web at: <http://www.cms.hhs.gov/about/history>.