

## Medicaid: A Timeline of Key Developments

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### 1965-2009

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#### **Presidential remarks during signing ceremony.**

**1965:** If states elected to participate, then they would receive federal matching payments based on a formula related to state per capita income with a 50 percent matching floor and 83% matching ceiling for service expenditures. Participating states must cover "mandatory" populations (Aid to Families with Dependent Children (AFDC) and other cash assistance recipients) and services (physician, inpatient and outpatient hospital, laboratory and x-ray, skilled nursing facility). Additionally, participating states must provide supplemental coverage to low-income Medicare beneficiaries for services not covered by Medicare.

**1989:** OBRA 89 also required states to cover services provided by federally-qualified health centers (FQHCs).

**1990:** The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) mandated coverage of children ages 6 through 18 in families with incomes at or below 100 percent of FPL (whether or not they were receiving AFDC cash assistance) with coverage phased in one year at a time and completed by 2002.

#### **Health Coverage for Low-Income Children.**

**1990:** OBRA 90 required states to pay Medicare premiums for Medicare beneficiaries with incomes between 100 and 120 percent of the federal poverty level, also known as special low-income Medicare beneficiaries (SLMBs).

**1990:** OBRA 90 established the Medicaid prescription drug rebate program requiring pharmaceutical manufacturers to give "best price" rebates to states and federal government.

**1965:** Beyond federal requirements, states could cover "optional" populations such as the "medically needy" (ineligible for cash assistance but high medical expenses) and services (e.g., prescription drugs, clinic services, home health care, dental, physical therapy, other diagnostic, screening, preventive, and rehabilitative services). One "optional" population category, Ribicoff children, allowed persons under 21 who didn't qualify for cash assistance, but were determined to be in equal need of medical assistance, to gain Medicaid coverage. In later years, other poverty-related expansions would cover many of these children, but the provision was instrumental in covering many children.

**1965:** Medicaid is placed under the jurisdiction of the Social Rehabilitation Administration, an agency focusing on poverty and welfare programs.

**1967:** The Social Security Amendments of 1967 mandate EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services for eligible children up to age 21.

**1967:** Concern about the growing federal costs of the Medicaid program led Congress to include a provision in the legislation to limit Medicaid eligibility to the "medically needy" whose income was at most 133 1/3 percent of the AFDC income eligibility level in a state.

**1971:** States are given the option to cover services in intermediate care facilities (ICFs) for the elderly and individuals with disabilities with lower level of care needs than those available in skilled nursing facilities. They are also given the option of covering services in facilities for individuals with mental retardation (ICFs/MR).

**1972:** The Social Security Amendments of 1972 established the Supplemental Security Income (SSI) program of cash assistance for the elderly and individuals with disabilities. States must either cover SSI recipients or use their 1972 Medicaid eligibility standards ("209(b) option") for the elderly and individuals with disabilities.

 **"My Name Is..."**

**1991:** The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 restricted the use of revenues from provider donations and provider taxes as the state share of Medicaid expenditures. It also placed a national ceiling on Medicaid special payments to DSH hospitals. This action was prompted by 27 percent annual spending growth in the program from 1990-92. Budget deficits and increased Medicaid enrollment led states to use DSH payments combined with provider donations/taxes to account for the state share of Medicaid spending. These actions were viewed as states attempting to shift costs to the federal government.

**1993:** The Clinton Administration begins approving section 1115 waivers to states allowing more statewide expansion demonstrations. Many states began greater use of Medicaid managed care for delivery of care and expanded coverage to previously uninsured populations like childless adults. Two states' waivers received particular attention for new developments. Oregon's waiver (the first statewide waiver approved in over 10 years), the Oregon Health Plan, expanded coverage to all uninsured residents up to 100 percent FPL, moved almost all non-disabled enrollees into managed care, and set up a prioritized list of services to define the program's benefit package. The priority list ranked medical conditions and treatments by medical necessity. The level of covered services was determined based on the state's budgetary resources. Tennessee's waiver, TennCare, made all uninsured residents eligible for the waiver program moving everyone into managed care delivery, but only residents below 100 percent of FPL paid no premiums and at 400 percent of FPL the enrollee paid the full premium. Enrollment in the program was originally capped at 500,000 for new eligibles.

#### **Section 1115 Waivers: Current Issues**

**1993:** The Omnibus Budget Reconciliation Act of 1993 placed facility-specific ceilings on special payments to DSH hospitals, established national standards for state use of formularies to manage their prescription drug benefit and tightened prohibitions against the transfer of assets in order to qualify for Medicaid nursing home coverage.

**1995:** The U.S. Congress passes as part of the budget process and President Bill Clinton vetoes legislation converting Medicaid to a block grant to

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**1972:** The 1972 Amendments also repealed the "maintenance of effort" requirement on states. States could now reduce expenditures on Medicaid from one year to the next.

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**1972:** All states except Arizona began participating in Medicaid.

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**1977:** Secretary of the Department of Health, Education and Welfare, Joseph Califano, created the Health Care Financing Administration (HCFA) to administer the Medicaid and Medicare programs.

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**1977:** The Carter Administration's Medicaid expansion proposal, Child Health Assessment Program, to expand coverage to 700,000 children of poor families under the age of 6 does not come to a vote in Congress. This failure partially inspired later incremental steps to expand coverage to children in the 1980s.

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**1977:** The Departments of Labor and Health, Education, and Welfare Appropriations Act for FY1977 is passed. It included the Hyde Amendment, which prohibited federal Medicaid payments for medically necessary abortions except when the life of the mother would be endangered.

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**1981:** A Reagan Administration proposal to convert Medicaid into a block grant failed.

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**1981:** The Omnibus Reconciliation Act of 1981 (OBRA 81) reduced federal matching payments to states by specified percentages during period FY 1982-1984 as part of required federal budget savings.

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**1981:** OBRA 81 repealed a requirement that states pay Medicare hospital payment rates, but also allowed states to make additional payments to hospitals serving a disproportionate share of Medicaid and low-income patients. These hospitals become known as disproportionate share hospitals (DSH).

states.

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**1996:** The Personal Responsibility and Work Opportunity Act of 1996 (PRWOA) repealed the AFDC individual entitlement to cash assistance and replaced it with the Temporary Assistance for Needy Families (TANF) block grant to states ending the formal linkage between cash assistance (welfare) and Medicaid eligibility.

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**[Resources on welfare, work, and health care](#)**

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**1996:** PRWOA required states to cover families meeting July 16, 1996 AFDC eligibility standards and allowed to cover families with higher incomes.

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**1996:** PRWOA prohibited extending Medicaid coverage for non-emergency services to otherwise eligible legal immigrants entering U.S. on or after August 22, 1996 for five years. Coverage after the five-year ban is at state option.

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**[Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance](#)**

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**1997:** The Balanced Budget Act of 1997 (BBA 97) established the State Children's Health Insurance Program (SCHIP) allowing states to cover uninsured children in families with incomes below 200 percent of FPL who were ineligible for Medicaid. The federal funds are capped, but the matching rate for costs of SCHIP services is enhanced (30 percent higher than state's Medicaid matching rate), with a federal match of 65 percent as a floor and 85 percent as a ceiling

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**1997:** BBA 97 permitted states to require most Medicaid beneficiaries to enroll in managed care plans without obtaining a section 1915(b) waiver.

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**1997:** BBA 97 required states to pay Medicare premiums for elderly and individuals with disabilities with incomes between 120 and 135 percent of the FPL (QIs), subject to fully federal capped funding.

**1981:** While section 1115 waiver authority predated the Medicaid program, OBRA 81 established two new types of Medicaid waivers. The first, section 1915(b) freedom-of-choice waivers, allowed states to pursue mandatory managed care enrollment of certain Medicaid populations. Prior to this new waiver, less than one percent of the managed care population is enrolled in managed care. The second, section 1915(c) HCBS waiver, allowed states to cover home- and community-based long-term care services for the elderly and individuals with disabilities at risk of institutional care.

### **Recent Growth in Medicaid Home and Community Based Service Waivers**

**1982:** Arizona, the only state without a Medicaid program, opts into Medicaid for acute services only via a section 1115 Medicaid waiver granted by the federal government.

**1982:** The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) revised previous Medicaid cost-sharing policies to expand state options for imposing nominal cost-sharing on certain Medicaid beneficiaries and services.

**1982:** TEFRA allowed states to extend Medicaid coverage to "Katie Beckett" children under age 18 with disabilities requiring institutional care but living at home by waiving requirements to that families fall within SSI income restrictions.

### **Medicaid's Role for People with Disabilities**

**1984:** The Deficit Reduction Act of 1984 mandates coverage of children born after September 30, 1983, up to age 5, of AFDC-eligible families. Coverage for AFDC eligible first-time pregnant women and pregnant women in two-parent unemployed families also becomes mandatory.

**1985:** The Consolidated Omnibus Budget Reconciliation Act of 1985 mandates coverage for all remaining AFDC eligible pregnant women.

**1997:** BBA 97 codifies and reduces state-specific ceilings on payment adjustments to DSH hospitals.

**1999:** The U.S. Supreme Court rules in *Olmstead v. L.C.* that the Americans with Disabilities Act (ADA) can, under certain circumstances, require states to provide community-based services to individuals for whom institutional care is inappropriate.

### **The Olmstead case and its impact on Medicaid.**

**1999:** The Ticket to Work and Work Incentives Improvement Act of 1999 allowed states to cover working disabled individuals with incomes above 250 percent of FPL and impose income-related premiums for such coverage.

**1999:** The Emergency Supplemental Appropriations for FY 1999 transferred the federal share of \$240 billion, 25-year master settlement between states and tobacco manufacturers to states.

**2000:** The Breast and Cervical Cancer Treatment and Prevention Act of 2000 allowed states to cover uninsured women with breast or cervical cancer regardless of income or resources at enhanced SCHIP federal matching rate.

**2000:** The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act directs Secretary of HHS to issue regulations tightening upper payment limits (UPLs). This continued a trend of the federal government clamping down on state financing practices.

### **Medicaid Financing and Intergovernmental Transfers**

**2001:** The Bush Administration announces the section 1115 waiver initiative, Health Insurance Flexibility and Accountability (HIFA), allowing states

to demonstrate comprehensive state approaches that will increase the number of individuals with health insurance coverage using current-level Medicaid and SCHIP resources.

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**1986:** The Omnibus Reconciliation Act of 1986 (OBRA 86) required states to cover treatment of emergency medical conditions for illegal immigrants otherwise eligible for Medicaid.

☰ **[Background Report on HIFA Initiative](#)**

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**1986:** OBRA 86 also gave states the option of covering pregnant women and infants (up to 1 year of age) up to 100 percent of federal poverty level (FPL) and allowed states to pay for Medicare premiums and cost-sharing for low-income qualified Medicare beneficiaries (QMBs) with income at or below 100 percent of FPL.

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**2003:** The Jobs and Growth Tax Relief Reconciliation Act of 2003 raises all state Medicaid matching rates by 2.95 percentage points for the period April 2003 through June 2004 as temporary federal fiscal relief for the states due to the downturn in the economy. Congress recognized that state revenue collection had declined just when Medicaid programs were facing increased enrollment by low-income families.

☰ **[The Impact of Federal Fiscal Relief fact sheet](#)**

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**1987:** The Omnibus Reconciliation Act of 1987 (OBRA 87) gave states the option of covering pregnant women and children under age 1 in families with income up to 185 percent of FPL.

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**2003:** The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 establishes a new Medicare Part D prescription drug program enacted with full premium subsidies for individuals with incomes below 135 percent of FPL. Medicaid drug coverage for dual eligibles, those who qualify for both Medicaid and Medicare, is transferred to Medicare effective January 1, 2006. States are required to make a monthly "clawback" payment to the Medicare program reflecting state savings from enrollment of dual eligibles in Medicare Part D drug coverage beginning January 2006. (A video, Transitions, explores the issues and challenges dual eligibles face as their drug coverage transitions from Medicaid to Medicare)

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**1987:** OBRA 87 also enacted nursing home reforms that upgraded quality of care requirements and revised monitoring and enforcement of facilities participating in Medicaid.

📺 **[Transitions](#)**

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**1988:** The Medicare Catastrophic Coverage Act of 1988 (MCCA) required states to pay the Medicare premiums and cost-sharing for low-income Medicaid beneficiaries with incomes below 100 percent of FPL (QMBs).

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**1988:** MCCA also required states to phase in coverage for pregnant women and infants in families with income up to 100 percent of FPL.

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**2003:** Congress raises state-specific DSH allotments by 16% for FY 2004 for all states, through FY 2009 for low-DSH (states that historically had not been large users of DSH) states.

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**1988:** MCCA established new eligibility rules for institutionalized individuals whose spouses remain in the community to prevent spousal impoverishment.

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**2005:** The U.S. Congress passes a budget resolution requiring \$10 billion in cost savings from the Medicaid program.

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**1988:** The Family Support Act of 1988 required states to extend 12 months transitional medical assistance (TMA) to families losing AFDC cash assistance due to earnings from work. (fact sheet, Transitional Medical Assistance)

### **Transitional Medical Assistance**

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**1989:** The Medicare Catastrophic Coverage Act of 1988 was repealed, including both the Medicare outpatient drug benefit and the cap on out-of-pocket expenses. The Medicaid provisions of the bill, QMB coverage, remained.

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**1989:** The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandated coverage for pregnant women and children under age 6 in families with incomes at or below 133 percent of FPL (whether or not they were receiving AFDC cash assistance).

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**1989:** OBRA 89 expanded the EPSDT benefit for children under 21 to include needed diagnostic and treatment services even if the services were not covered under for adult beneficiaries.

**2005:** Secretary Michael Leavitt of the Department of Health and Human Services established an advisory Medicaid Commission. The Commission will submit two reports. The first, due September 1, 2005 will outline recommendations for Medicaid to achieve \$10 billion in savings during the next five years as well as ways to begin meaningful long-term enhancements that can better serve beneficiaries. The second, due Dec. 31, 2006, will provide recommendations to help ensure the long-term sustainability of Medicaid.

### **HHS Press Release**

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