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Changing the Game: How Medicare and Medicaid Re-invented America's Safety Net for Communities of Color

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This year marked the 50th anniversary of Medicare and Medicaid, an unprecedented federal effort to ensure that key vulnerable populations – the elderly and the poor – have access to essential and life-saving health care services. 2015 also marked the 30th anniversary of the Department of Health and Human Services' release of the landmark 1985 Heckler Report, the first comprehensive federal assessment of the health status of African Americans and other minority groups. In recognition of these two major milestones in the health equity movement, the Health Policy Research Consortium has released "Changing the Game: How Medicare and Medicaid Re-invented America's Safety Net for Communities of Color."

Overview

There have been important milestones in the years since Medicare and Medicaid was established in 1965. Significantly, the Heckler Report[1] was released 20 years later, in 1985. The landmark report found that health disparities resulted in 60,000 "excess deaths" each year. A major outcome of the report was the creation of the HHS Office of Minority Health in 1986. Today, the nation continues to face the persistent challenge of health disparities. The 2015 Kelly Report: Health Disparities in America[2] reviewed the progress we have made in addressing health disparities since the Heckler Report, noting the heavier burden that today's minority communities bear for HIV/AIDS, breast cancer, lupus, diabetes, and end-stage renal disease.

The report concluded: "Health disparities in communities of color continue to be intractable hurdles in the quest to achieve health equity in America."

In addition to "excess deaths," disparities exact an onerous economic burden on society. LaVeist and colleagues found that between 2003 and 2006 the combined costs of health inequalities and premature death in the United States were about $1.24 trillion. Eliminating these disparities would have reduced direct medical expenditures by $229.4 billion for those years[3].

While acknowledging that the social determinants of health play an important role in health disparities, the Kelly Report highlighted the critical importance of continuing national efforts to strengthen access to the health care system for minorities and other vulnerable populations. Since its passage in 2010, the Affordable Care Act (ACA) has been one important tool in that effort, increasing the number of insured by 16 million, including 2.3 million African American adults and 4.2 Hispanic adults. The federal initiative also doubled the size of National Health Services Corps, which provides a stronger supply of diverse healthcare providers for vulnerable populations and strengthens diversity and cultural competence in healthcare delivery[4].

Of course, long preceding the ACA are the Medicare and Medicaid programs, which today provide health insurance for 1 out of every 3 Americans. Medicare ensures health coverage for 50 million seniors, while Medicaid provides coverage for 9 million disabled persons and 11 million non-elderly low-income parents, other caretaker relatives, pregnant women, and other non-disabled adults. Approximately 31 million children receive their health coverage through Medicaid and the Children's Health Insurance Program (CHIP).[5] Additionally, Medicaid is the nation's leading provider of long term care, such as nursing homes.[6]

Medicare and Medicaid play a critical role as a safety net for communities of color and other highly vulnerable populations. In 2015, the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare and Medicaid, launched the first-ever health equity plan for Medicare.[7] The historic evolution of both programs offers important lessons about what has been achieved on the health equity front – and what new work remains to be done. The evolution of Medicare, beginning with its early roots in the era of Jim Crow, can inform our understanding of the evolving role of Medicare and Medicaid in the health equity movement.

The Role of Medicare in Hospital Desegregation

On July 2, 1964, with Rev. Martin Luther King, Jr. and others looking over his shoulder, President Lyndon B. Johnson signed the landmark Civil Rights Act of 1964 into law. The most sweeping legislation since Reconstruction, the new law widely banned racial discrimination and segregation in schools, the workplace, and public facilities. The bill held enormous implications for improving key social determinants of health for African Americans, including employment, education, and housing. The bill also held great promise for improving health care access.

Indeed, one year later, on July 30, 1965, LBJ would sign into law a second momentous piece of legislation – amendments to the Social Security Act – creating Medicare and Medicaid, pillars of health care for the elderly and the poor. President Harry Truman, who had been a long supporter of the idea, stood by LBJ at the bill-signing and received the first Medicare card in U.S. history[8].

Historically, many presidents had advocated for government-funded health insurance coverage for every man, woman, and child in the United States, dating back to President Theodore Roosevelt's attempts[9] in the early 20th century. Other presidents would make the case in the succeeding half century, but the movement did not gain appreciable momentum until after President Truman's unsuccessful attempts in mid-century. Opponents had derisively referred to universal health care coverage as 'socialized medicine'. The American Medical Association (AMA), the nation's largest membership group for physicians, was a key opponent of LBJ's Medicare idea. In contrast, leaders at the National Medical Association (NMA), formed in 1895 by African American physicians, dentists, and pharmacists, saw Medicare as opportunity to expand health care access for vulnerable populations.

NMA leaders and their colleagues at the National Association for the Advancement of Colored People (NAACP) fully understood that the passage of the Medicare bill in 1965 could do more than improve health care access for the elderly and the poor. It could also – in concert with the Civil Rights Act of 1964 – take on Jim Crow in hospitals across the country.

Indeed, it is a seldom told story that the hard-fought Medicare bill was key to desegregating the nation's hospitals and to paving the road toward diversity and cultural competency in the health care workforce. The Civil Rights Act alone was hardly enough to remove "white only" signs from hospital doors. Prior to the passage of Medicare (and for a few years after its passage), segregated hospitals were the norm throughout much of the South and even in parts of the North. As late as 1959, only 83% of general hospitals in the North – and a mere 6% of hospitals in the South – admitted African American patients without any restrictions. Of the remaining 94% of Southern hospitals, 33% refused to admit any black patient, 50% had "colored only" wards, and the remainder had some artful mix of Jim Crow policy[10].

Racial segregation also posed a roadblock for African American healthcare providers. In the North, a paltry 10% of hospitals allowed African American interns and residents, and only 20% permitted African American physicians to serve as medical faculty staff. In the South, where the African American population comprised an even larger proportion of the overall U.S. population, only 6% of hospitals allowed African American interns and residents, and only 25% granted medical staff privileges to black doctors.

At the promising new dawn of Medicare, hospital segregation policies in the South and North still posed formidable access barriers for African American patients and providers. Hospitals were indeed one of the last strongholds of racial segregation (see Table 1). As noted by Dr. Sandra Gadson, past president of the NMA: "From obstetrics to cardiology to emergency care, Negro hospitals clearly did not have the same state-of-the-art equipment, the same medical supplies, or the same building infrastructure as White-only hospitals."[11]

Table 1: Civil Rights Milestones 1940s - 1960s	
Desegregation of major league baseball	1947

Desegregation of the Armed Services	1948
School desegregation	1954
City bus desegregation	1956
Desegregation of Interstate transportation	1961
Desegregation of public accommodations	1964
Hospital desegregation	**1965-66**

Source: The role of Black physicians and the National Medical Association[12].

However, with the auspicious arrival of the Civil Rights Act of 1964, the nation's 7,000 hospitals – as places of public accommodation – were now subject to the new law's antidiscrimination measures. In the face of obstinate resistance to hospital integration, LBJ leveraged the power of Title VI of the Civil Rights Act to secure compliance from recalcitrant southern hospital administrators. Under his direction, the Department of Health, Education and Welfare (HEW) used a carrot-and-stick approach to carry out the bold federal mandate for hospital integration. That is, HEW dangled a treasure chest of Medicare reimbursement dollars as the "carrot," while threatening to withhold those same dollars as the "stick."[13]

To be sure, resistance to hospital integration was no small challenge in the 1960s. Indeed, prior to Medicare and the Civil Rights Act of 1964, desegregation advocates had already won judicial backing to integrate the nation's hospitals. In the 1963 case of *Simkins vs. Moses H. Cone Memorial Hospital*, a federal appellate court had already upheld hospital integration, overturning the "separate but equal" segregation provision embedded on the 1946 Hill-Burton Act.[14] But the landmark *Simkins* ruling was merely on the books; it could not actually *enforce* hospital integration in local hospital admissions departments – or even in local emergency departments. Enforcement would need to come from the Executive branch. Taken together, the 1963 *Simkins* ruling, the Civil Rights Act of 1964, and the 1965 arrival of Medicare's purse strings brought the triple policy play needed to release Jim Crow's deadly grip on the U.S. healthcare system.

For sure, even with the triple play, the racial transformation of hospital beds did not occur overnight. One year after signing Medicare into law, LBJ cautioned: "Medicare will succeed—if hospitals accept their responsibility under the law not to discriminate against any patient because of race." That was a *big* "if." As late as 1967, the federal government was still dispatching a team of inspectors to enforce the required integration compliance needed for Medicare certification. Nonetheless, when Medicare rolled out on July 1, 1966, the nation's healthcare delivery system had overturned the official reign of Jim Crow in American medicine.

In reflecting on the social gains brought by the Medicare bill, former HEW Secretary Wilbur Cohen would later write:

> *"There is one other important contribution of Medicare and Medicaid which has not yet received public notice – the virtual dismantling of segregation of hospitals, physicians offices, nursing homes, and clinics as of July 1, 1966.... If Medicare and Medicaid had*

not made another single contribution, this result would be sufficient to enshrine it as one of the most significant social reforms of the decade…"[15]

The Continuing Importance of Medicare and Medicaid

While remarkable progress has clearly been made in removing racial barriers to healthcare, much work lies ahead. According to the congressionally-mandated report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care[16], minorities are still more likely to receive a lower quality of care even when they hold the same insurance coverage as their white counterparts. For example, the 2002 report showed that minority patients are less likely to be given the appropriate heart medications and less likely to receive kidney dialysis or transplants. As noted in the more recent National Healthcare Disparities Report[17], despite some gains healthcare disparities among racial and ethnic groups remain "large and persistent." These disparities hold true for both quality of care and health outcomes.

Such disparities also persist among Medicare patients, evidence that although Medicare was able to unlock the door to care, it has not been able to ensure racial equity on the other side. For example, compared to their white counterparts, African American patients under Medicare today receive fewer office visits, mammograms, and colonoscopies[18]. These patients are also less likely to receive beta-blockers after a heart attack or have eye examinations if diabetic[19].

Moreover, according to the Bureau of Health Professions, many racial and ethnic minorities continue to be underrepresented in the health care professions – even though "current evidence supports the notion that greater workforce diversity may lead to improved public health, primarily through greater access to care for underserved populations and better interactions between patients and health professionals."[20] In 2000, African Americans and Hispanic Americans represented 12.3% and 12.5%, respectively, but only 4.5% and 5.1% of physicians/surgeons, 3.4% and 3.6% of dentists, 1.7% and 2.7% of optometrists, and 9.0% and 3.3% of registered nurses[21].

This matters, especially given the huge number of racially and ethnically diverse people who become eligible for Medicare every day. With increased demand for Medicare services because of the aging 'Baby Boomers', and the reduced supply of primary care providers, including physicians[22] along with the continued shortage of minority providers, demographic pressures require that policymakers keep a close eye on the program's viability. Communities with provider shortages also tend to be places with the most acute medical need and the most vulnerable populations, i.e. the places where health disparities are most acute.

Medicare plays a key role in educating the nation's physicians. According to the Association of American Medical Colleges (AAMC), there are about 110,000 residents (people who have graduated medical school and are now ready to specialize) in training in the U.S. every year. AAMC estimates that this training costs teaching hospitals[23] about $16.2 billion a year, of which Medicare picks up $3.3 billion. Put another way – training a medical resident costs an average of $152,000 a year – Medicare pays about $40,000, or about 26.3%, via the Direct Graduate Medical Education (DGME) payment system.

Since Medicare provides coverage for many patients with complex needs (that are more expensive to treat) that other institutions cannot (read Medicare population), Medicare supports about $6.5 billion of these higher patient costs via the Indirect Medical Education (IME) program.

It is safe to say that without Medicare's contribution it would be nearly impossible to train the physicians most responsible for taking care of that population, and without the teaching hospitals that do the training it would be impossible to provide a lot of the more complex and resource-intensive care necessary for treating the nation's seniors. Since many in this population are either among the sickest, people of color, or people of limited means, Medicare's viability matters.

As more of these seniors turn 65 and matriculate into Medicare, amidst the aforementioned provider shortage, it seems rational to expect that policymakers would want to empower Medicare to expand the number of residency slots necessary to meet the demand.

There is reason, however, to be optimistic. Medicare's trustees[24] have reported that the Medicare Trust Fund's solvency has been extended by several years, pursuant to the successes of the Affordable Care Act (ACA). In addition, Medicare expenditures[25] have grown at a slower rate in the few years since the ACA has been the law of the land. There is also evidence that the cost savings have not sacrificed quality[26]. In fact, Medicare is, in many ways, providing better quality care[27] for less money. Medicare beneficiaries report high rates of customer satisfaction[28].

For African American physicians who were trained during the Civil Rights era, including the pre-Medicare days, their medical training involved clinical rotations in different settings. For example, medical students would do some parts of their training in hospitals that cared for predominantly White patient populations, while other rotations would be in segregated hospitals where all the patients were predominantly African American.

The Evolution of Medicaid as Health Disparity Player

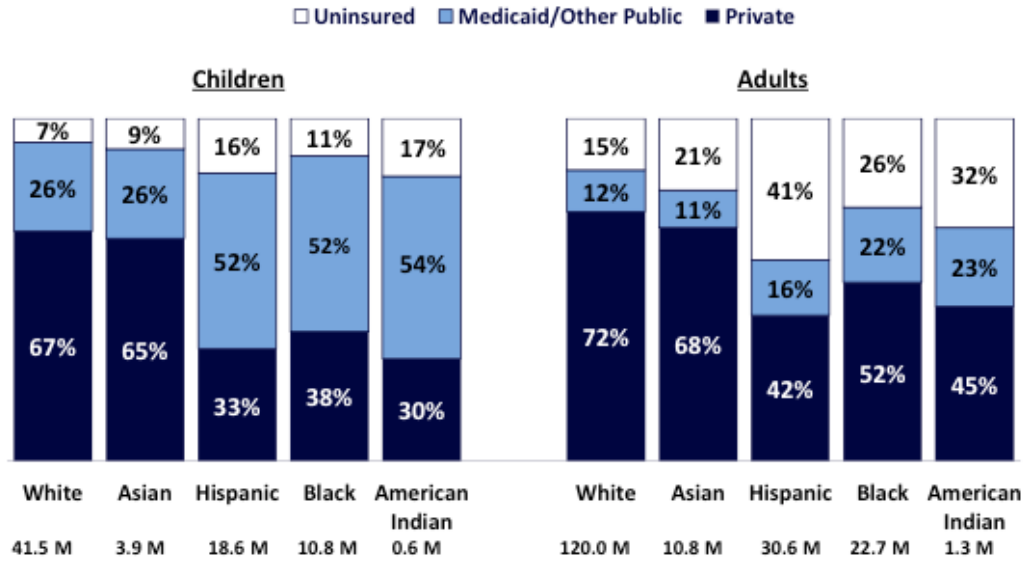
Growth

Medicaid now serves significantly more people than it did in 1966, including millions of children covered under the Children's Health Insurance Program (CHIP)[29], which is managed, in most states, by the same agency that is responsible for Medicaid. CHIP was enacted in 1997. It was intended to provide a safety net for children whose parents could not afford to provide coverage in the private insurance market, but earned too much to qualify for Medicaid. As of May 2015, Medicaid and CHIP enrollment in all states totaled 71,637,63830, an increase of 12.8 million individuals since coverage expansion began on October 1, 2013 under the Affordable Care Act (ACA). In Maryland[31] there were 1,113,338 individuals enrolled in Medicaid and CHIP as of May 2015, a 30.02% increase since October 1, 2013. The fact that CHIP has been reauthorized more than once bears eloquent testimony to its value and utility in the public's mind. The size of the enrollment increases since the ACA also underscores that point. The gap between insured and uninsured children is shrinking. States are gaining control over the overall disparity in coverage for children.

Compared to their White and Asian counterparts, Hispanics, Black and American Indian children are far more likely to be enrolled in Medicaid or other public insurance programs (See Fig. 1).

Figure 1

Health Insurance Coverage by Age and Race/Ethnicity, 2011



Asian group includes Pacific Islanders. American Indian group includes Aleutian Eskimos. Two or more races excluded. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Health Outcomes

The Oregon Health Insurance Experiment[32] was a randomized control trial conducted to gather evidence about the impact of Medicaid coverage on adults. Randomized control trials are the most reliable way to determine causality. The study began in 2008, with the state of Oregon holding a lottery among Oregonians on a Medicaid waiting list. Those who won the lottery were enrolled in Medicaid, those who played the lottery and lost were assigned to the control group. Researchers have since followed the low-income Oregonians in both groups, assessing the use of health care, financial strain, and self-reported health.

To date, their health outcomes findings[33] include the following:

- Medicaid increased the probability that people self-report 'good or excellent' health (as opposed to 'fair or poor' health).
- Medicaid has no significant effect on measured blood pressure, cholesterol or glycated hemoglobin (helps track blood sugar).
- Medicaid significantly increased the probability of being diagnosed with diabetes after the lottery, and likewise increased the probability of the use of diabetes medication.
- Medicaid reduced observed rates of depression by 30%.

- Medicaid increased the use of preventive care, including a 50% increase in cholesterol monitoring and a doubling of mammograms.

Their other findings, including the reduction of financial hardship and the increased use of emergency rooms (which leads to higher costs) by those who won the lottery, generated copious commentary on both sides of the policy debate.

The experiment will continue to enjoy intense scrutiny however, because it is still 'the only game in town'. The bottom line conclusion from this study - for proponents nationwide - has been that Medicaid makes beneficiaries more proactive and thus less anxious about their health, leading to more prevention and primary care. The nation would be well-served if more states were to conduct a similar experiment, especially in states with large Medicaid-eligible populations.

One key challenge for the program remains - increasing the number of physicians willing to see Medicaid patients, given the low reimbursement[34] rates relative to private insurance. Improving the number of primary care appointment slots would likely reduce the number of Medicaid beneficiaries who use emergency rooms for their care, which would bode well for controlling costs.

These challenges are not unique to Oregon. Improved health outcomes goes to the heart of why society would want low-income populations enrolled in Medicaid. In many parts of the country these populations are people of color, but the lessons of Oregon would still apply, given that the chronic disease challenge is common to all 50 states.

Customer Satisfaction

According to a nationally representative survey conducted by the Kaiser Family Foundation (KFF)[35], the Medicaid program is generally well-liked, and about two-thirds of all respondents reported some family connection to the program. About eight in ten said they would enroll themselves or a child in the program, and most Medicaid beneficiaries feel financially well-protected by the program.

Challenges Ahead

The picture is not all rosy, however. There are currently 17 states[36] that have not yet expanded Medicaid under the ACA, although 4 are considering expansion. This means that roughly 6,537,000 of the most vulnerable Americans will remain uninsured, according to a Families USA[37] estimate. This would include populations who would most benefit, such as uninsured adults, parents with dependent kids, uninsured veterans and their spouses, and working adults who earn too much to qualify for their state's Medicaid but cannot afford to buy coverage on the health insurance marketplaces created by the ACA. These individuals are characterized as falling into "the coverage gap", a modern day version of the "doughnut hole" created in the mid-2000s by the Medicare Part D Drug benefit (which the ACA has since closed)[38].

A significant percentage of these unfortunate (mostly hardworking[39]) citizens also happen to be people of color, and they reside, predominantly, in the Deep South and the Midwest. States like Florida, Texas, and Virginia have hundreds of thousands of uninsured people of color.

They also live in regions of the country where chronic diseases are rife – obesity, hypertension, cardiovascular diseases[40], asthma, HIV/AIDS and cancer all run rampant. It is well-established that uninsured people postpone[41] care because of the bills (which can quickly turn into debt), and often seek care in an emergency situation when the condition has become more complex, and much more expensive to treat. That cost is passed along to those who are insured, resulting in higher premiums in those markets. The costs are not limited to direct medical costs. There is also indirect cost in the form of lost productivity due to wages not earned and taxes not paid. Then there are the costs associated with disability (or death), compounded by forfeited economic activity occasioned by the foregone Medicaid revenue.

The latter is not insignificant. Medicaid is an economic multiplier[42], given that it helps to keep safety net hospitals viable. Many such hospitals[43] have been forced out of business in states that refused to expand Medicaid. These hospitals are often major employers in their communities, and several other small businesses depend on them for their own viability. Their survival matters, not just to the health of the people, but to the health of local economies, especially in rural areas. The problem is even more acute in places where emergency rooms are few and far between.

Social Determinants of Health

Increased access to care, however, is only one part of the efforts needed to reduce or eliminate disparities in health and health care. More fundamentally, many structural barriers impede good health for vulnerable populations. Some problems begin long before a patient shows up at the doctor's office, and these problems are often compounded when people suffer from more than one chronic disease.

Medicare and Medicaid have been successful in addressing a few of those barriers. In addition to increased access to affordable care, providing health coverage for these vulnerable populations has helped keep multiplied millions out of poverty[44]. In fact, Medicaid[45] kept 2.6 million Americans out of poverty in 2010, making it the third largest anti-poverty program in the U.S. Those poverty-reduction effects were most pronounced among disabled adults, the elderly, children, and racial/ethnic minorities, according to the authors of a recent report cataloguing these gains. There are two main drivers – reduction in mean or out-of-pocket spending, and traditional insurance, which protects beneficiaries from the vagaries of unexpected or serious illness. The results are striking. The per capita medical out of pocket spending for individuals enrolled in Medicaid was estimated at $376, compared to $871 for those who are not enrolled.

These gains have, in turn, helped increase quality of life and productivity among beneficiaries, evidence of which are the high satisfaction rates among those who benefit from these programs.

Today's CMS Strategy for Achieving Health Equity

The CMS Equity Plan for Improving Quality in Medicare was launched in September of 2015, in order to "outline the agency's path to sustained progress in advancing health equity for Medicare beneficiaries." The plan will focus on 6 priorities – standardized data collection; evaluating disparities impact and solutions across CMS programs; develop and disseminate promising approaches to reduce health disparities; increase the capacity of the health care workforce;

improve communication and language access among limited English proficiency (LEP) populations; and increasing physical accessibility of health care facilities.

This plan, however, should be considered within the wider context of the national effort to eliminate health disparities, such as the National Partnership for Action (NPA) to End Health Disparities, created as a result of the ACA. The NPA includes several components, including a Federal Interagency Health Equity Team[46] (FIHET), created to "support the integration of health equity in programs, policies, and practices" across the federal government.

The ACA also created the Center for Medicare and Medicaid Innovation (CMMI), charged with supporting the development and testing of innovative health care payment and service delivery models. For example, CMMI is now running demonstration projects[47] that: evaluate how well Federally Qualified Health Centers (FQHC) deliver advanced primary care; how hospitalizations can be avoided among nursing home residents; and how much care can be delivered at home to encourage independence for Medicare beneficiaries who suffer from multiple chronic conditions.

A full accounting of the effectiveness of these efforts is not yet possible however, given that the CMS Equity Plan is too new to have generated any data regarding success or failure. The NPA Plan is older, but the data regarding its effectiveness can only be found as aggregate national numbers that do not specifically isolate CMS' role in reducing or eliminating health disparities.

Strengthening the Safety Net

There is no question, however, that the nation needs a social safety net. There is also no disputing the fact that Medicare and Medicaid constitute a robust safety net that should be protected. Both programs are now more robust[48] as a result of the ACA, and more gains are probable under current statute. The question is – how long before we achieve health equity?

Achieving health equity would mean slightly different things for both programs. For Medicaid, it could mean re-evaluating eligibility rules across various states. Some states are so restrictive with their benefits that someone has to be literally destitute to qualify[49]. If that state happens to be one that has also refused to expand Medicaid under the ACA and has large vulnerable populations, then disparities will be exacerbated, not eliminated. Achieving equity could also mean increasing provider reimbursements to incent providers to see Medicaid patients, or resisting the urge during election cycles to propose turning Medicaid into a 'block grant'. (A block grant would be a fixed budget for Medicaid for each budget cycle. If the money runs out because of increased demand before it is time for the next budget allocation, then the state has to come up with the money, with no federal provisions).

For Medicare it could mean continuing the demonstration projects implemented by CMMI, especially those that show the most promise. It may also mean revisiting the incentives in the ACA to keep driving those payments for 30-day readmissions downward. Recent evidence[50] has shown that the hospitals that see the sickest patients are seeing the most readmissions and are forced to pay the most penalties. These patients are invariably people of color, and/or those suffering from complex conditions or multiple chronic illnesses.

Prevention and primary care are equally vital for both programs. As mentioned earlier, if the structural inequalities and social determinants of health are better addressed, then the illnesses presented to the health care system will be less complex, and therefore less expensive to treat. Most importantly, these efforts could potentially reduce pain and suffering, increase quality of life, and eliminate the "excess deaths" experienced by these vulnerable populations.

Conclusion

The important hard-won gains notwithstanding, the challenge of addressing health disparities for communities of color continues a full half century after the passage of both the Civil Rights Act and Medicare. Still, the passage of the landmark Medicare law in 1965 was no small achievement in the history of the U.S. healthcare system. Medicare and Medicaid created access to vital healthcare resources for the elderly, the poor, and the disabled – groups in which communities of color face serious health inequities. These publicly-funded health coverage programs have demonstrated – in a measurable and unprecedented way – the indispensable role of federal policy and leadership in addressing health equity yesterday and today. And they will likely continue to serve as vital health equity resources in the days ahead.

Appendix A: MEDICAID MILESTONES

- **1965** – President Lyndon Baines Johnsons signs Medicare and Medicaid legislation into law.
- **1967** – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) introduced. EPSDT designed to ensure comprehensive preventive care for Medicaid beneficiaries under 21.
- **1972** – Supplemental Security Income (SSI) enacted under Social Security, allowing states to link Medicaid to SSI for elderly, blind, and disabled residents who meet the criteria.
- **1977** – Health Care Financing Administration (HCFA) established to administer Medicare and Medicaid, transferring the responsibility from the Social Security Administration.
- **1981** – States required to subsidize hospitals (known as Disproportionate Share Hospitals) that see a disproportionate share of low-income patients who are unable to pay their hospital bills. Subsidy would become known as the DSH (pronounced 'dish') payment.
- **1982** – Arizona becomes the last state in the union to opt into Medicaid.
- **1986** – States granted the option to allow Medicaid coverage for pregnant women and infants (up to 1 year of age), up to 100% of the federal poverty level (FPL). This would become a mandate in 1988. The next year the mandate was extended to include children from birth to 6 years of age, and from 100 to 133% FPL.
- **1990** – Medicaid Prescription Drug Rebate program established. The program is an agreement between CMS and drug manufacturers (about 600 now participate), wherein the manufacturer gives the state a rebate on drug purchases. In exchange the state's Medicaid program would cover most of that manufacturer's drugs.
- **1995** – President Clinton[1] vetoes a bill passed by the U.S. Congress that would turn Medicaid into a 'block grant' program. A block grant is a fixed amount of money allocated at the start of a budget cycle. A state would get no supplemental funds if the block grant runs out before the next budget cycle, which would happen when demand spikes, such as during economic recessions. The block grant idea resurfaces cyclically, usually during election campaigns.
- **1997** – Children's Health Insurance Program (CHIP) established. Known as SCHIP at the time, it was intended to wrap around traditional Medicaid coverage for children whose parents earned too much to qualify for Medicaid, but not enough to afford private health insurance.
- **2000** – Uninsured women are granted Medicaid coverage for breast or cervical cancer regardless of income or resources, a state option made possible by the Breast and Cervical Cancer Treatment Act of 2000.
- **2001** – HCFA renamed Centers for Medicare and Medicaid Services (CMS).
- **2009** – CHIP reauthorized. American Recovery and Reinvestment Act of 2009 (aka "the stimulus") also enacted, providing a temporary increase in federal matching funds for Medicaid in response to the most severe economic recession since the Great Depression.
- **2010** – The Patient Protection and Affordable Care Act (aka the ACA) is enacted after rancorous debate, creating the nation's most significant health care overhaul since Medicare and Medicaid were established. It provides for Medicaid expansion up to 138% FPL. Significant opposition leads to legal battles that culminate in landmark Supreme Court cases.
- **2012** – The Supreme Court rules that the ACA passes Constitutional muster, but allows each state to decide whether or not they would like to participate in the Medicaid expansion.
- **2013** – Open Enrollment (including Medicaid expansion) under the ACA begins. Rocky start for many states, including Maryland. Medicaid coverage begins 1/1/2014.

Source: Key Milestones in Medicare and Medicaid History, Selected years: 1965-2003. Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/05-06Winpg1.pdf Retrieved from the Internet. July 28, 2015.

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