Children's Health Insurance Timeline

Introduction

The health and welfare of children has been a longstanding social concern for policymakers in America. With the establishment of Medicaid in 1965, public health insurance coverage for poor children became part of the country's safety net infrastructure. This timeline of key policy developments tracks the evolution of children's health coverage.

Pre-1965

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1912

The Federal government establishes the Children's Bureau to investigate and report upon "all matters pertaining to the welfare of children and child life among all classes of our people." In 1913, the Children's Bureau is located in the Department of Labor.

1935

The program of Grants to States for Maternal and Child Welfare is enacted Title V of the Social Security Act of 1935. This formula grant program, administered by the Children's Bureau, had two health components: Maternal and Child Health (MCH) ("services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress"); and Crippled Children's Services (CCS) ("for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling").

The Aid to Dependent Children (ADC) program is enacted as Title IV of the Social Security Act of 1935 to make grants to states for cash assistance to "needy dependent children."

1965-1969

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Medicaid and Medicare, two individual entitlement health coverage programs, were enacted as part of the Social Security Amendments of 1965. Medicaid, Title XIX of the Social Security Act, was a federal-state program in which voluntarily participating states would receive federal matching funds for the costs of providing a defined set of medical and long-term care benefits to certain categories of individuals. Among the categories required to be covered were children in families receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program under Title IV-A of the Social Security Act. Federal matching funds were not available for the costs of health care for children not receiving cash assistance.

Presidential Remarks During the Signing Ceremony

1967

The Social Security Amendments of 1967 allow states to extend Medicaid coverage to "optional" populations not receiving cash assistance. These included “Ribicoff children,” (persons under 21 who did not receive AFDC cash assistance but were determined to be in equal need of medical assistance) and "medically needy" children (ineligible for cash assistance but with high medical expenses).

1967: The Social Security Amendments of 1967 requires states to cover EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services for all eligible children up to age 21, whether “mandatory” or “optional” populations (except “medically needy” children).

EPSDT Fact Sheet

1970-1974

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1972

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

1975-1979

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1977

The Health Care Financing Administration (HCFA) is established within the Department of Health, Education and Welfare to combine the federal administration of the Medicare and Medicaid programs into a single agency.

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 is not passed by Congress. This failure partially inspired later incremental steps to expand coverage to children in the 1980s.

1980–1984

A Reagan Administration proposal to convert Medicaid from an individual entitlement into a block grant to states fails.

1981

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The Omnibus Budget Reconciliation Act of 1981 (OBRA 81) converts the Title V Maternal and Child Health formula grant program into a block grant to states. The program is administered by the Health Services and Resources Administration in the Public Health Service.

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.

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. Children under 21 are exempt from all cost-sharing on any services.

TEFRA allowed states to extend Medicaid coverage to"Katie Beckett" children under age 18 with disabilities who require institutional care but are able to live at home, regardless of the family's income or resources.

Profiles of Medicaid's High Cost Populations

1984

The Deficit Reduction Act of 1984 (DEFRA) mandates Medicaid coverage of children born after September 30, 1983, up to age 5, in AFDC-eligible families, even if the families are not receiving cash assistance. DEFRA also requires states to extend Medicaid to first-time pregnant women and pregnant women in two-parent unemployed families who meet AFDC eligibility standards but do not qualify for cash assistance.

1985–1989

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1986

The Omnibus Budget Reconciliation Act of 1986 (OBRA) gives states the option of extending Medicaid coverage to pregnant women and infants (up to 1 year of age) with incomes up to 100 percent of federal poverty level (FPL), regardless of whether they receive cash assistance. This first established the connection between Medicaid eligibility and the national, annually indexed FPL rather than state-set AFDC levels.

1987

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

1988

The Medicare Catastrophic Coverage Act of 1988 (MCCA) requires states to phase in Medicaid coverage for pregnant women and infants in families with income up to 100 percent of FPL, whether or not they are receiving AFDC cash assistance.

The Family Support Act of 1988 requires states to extend 12 months transitional medical assistance (TMA) to families with children losing AFDC cash assistance due to earnings from work.

1989

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

OBRA 89 expands the EPSDT benefit for Medicaid-eligible children under 21 to include needed diagnostic and treatment services even if the services are not covered under the state's Medicaid program for adult beneficiaries.

1990–1994

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) mandates coverage of children ages 6 through 18 in families with incomes at or below 100 percent of FPL.

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

Health Coverage for Low-Income Children

In the case Sullivan v. Zebley, the Supreme Court mandated an individualized functional assessment process for children to help determine eligibility for SSI benefits (this was already allowed for adults). Prior to the decision, children could qualify for SSI benefits if they had a disability that was on a "listing of impairments". This ruling contributed to a growth in the number of disabled children on the SSI and Medicaid programs.

1995–1999

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The Personal Responsibility and Work Opportunity Act of 1996 (PRWOA) repeals the AFDC individual entitlement to cash assistance and replaces it with the Temporary Assistance for Needy Families (TANF) block grant to states. This marks the end of the linkage between receipt of cash assistance (welfare) and children's eligibility for Medicaid, a process begun in 1967 with the enactment of the "Ribicoff child" and "medically needy" options. PRWOA requires states to extend Medicaid coverage to all parents and children in families meeting July 16, 1996 AFDC eligibility standards and allows states to cover families with higher incomes. PRWOA also discontinued the use of the individualized functional assessment for determining SSI eligibility for children.

Resources on Welfare, Work and Health Care

PRWOA prohibits extending Medicaid coverage for non-emergency services to otherwise eligible legal immigrants, including children and pregnant women, entering the U.S. on or after August 22, 1996 for five years. Coverage after the five-year ban is at state option.

Medicaid and SCHIP Eligibility for Immigrants

1997

The Balanced Budget Act of 1997 (BBA 97) establishes the State Children's Health Insurance Program (SCHIP), a block grant to states that allows them to cover uninsured children who are not eligible for Medicaid but whose family incomes are generally below 200 percent of the federal poverty level (FPL). Right before SCHIP was enacted, only three states covered children with family incomes up to 200 percent of the FPL. Unlike Medicaid, SCHIP coverage is not an individual entitlement, but federal matching payments are an entitlement to the states up to a cap for each state. The SCHIP program expires September 30, 2007 unless it is reauthorized.

SCHIP at a Glance

1998

Health Care Financing Administration (HCFA) released a letter to state Health Officials in January outlining ways that states could streamline their eligibility processes and increase participation for children eligible but not enrolled in public programs. This marked the beginning of a period of intense outreach and eligibility simplification efforts that states used to enroll more children in Medicaid and SCHIP.

View the HCFA Letter to State Health Officials

1999

In October, President Clinton announced a series of federal efforts to identify and enroll the millions of uninsured children who are eligible for Medicaid and SCHIP such as directing cabinet secretaries to develop strategies to integrate children's health insurance outreach into schools; sending new guidance to states and schools on funding options for school-based outreach; and dedicating more than $9 million over three years in research funds through a public-private partnership to identify effective children's health insurance strategies. To help state and local outreach efforts, HHS, along with the National Governors' Association, launched the Insure Kids Now Hotline, 1-877-KIDS-NOW, and the Insure Kids Now Web site at www.insurekidsnow.gov.

See Frequently Asked Questions from Insure Kids Now

2000–2004

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Beginning in 2000 there were nationwide outreach and education efforts to help inform parents of uninsured children about public health coverage options. States developed and executed major media campaigns and public service announcements (PSAs) to increase public awareness of public coverage programs. States also focused on simplifying enrollment procedures such as eliminating asset tests, eliminating face-to-face interviews, adopting self-declaration of income and 12-month continuous eligibility to help kids enroll and stay enrolled in Medicaid and SCHIP.

View Selected PSAs for Medicaid and SCHIP Coverage

Medicaid Matters (Video)
Medicaid and Children: Overcoming Barriers to Enrollment

2001

The Department of Health and Human Services (HHS) changed the name of the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS) effective as of June 14.

2002

2002 marked the height of a severe economic downturn where state revenues plummeted and Medicaid spending and enrollment growth peaked as more individuals (especially children) fell into poverty, lost employer sponsored health coverage and qualified for Medicaid coverage. States began to aggressively implement efforts to control Medicaid costs focused on controlling provider payments and prescription drug spending. Many states suspended outreach activities or implemented enrollment barriers to limit Medicaid and SCHIP caseload growth during this time.

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, provided that the state maintains its Medicaid eligibility levels. 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

2004

$1.3 billion in unspent federal SCHIP matching funds initially allocated for fiscal years 1998, 1999, and 2000 revert to the federal Treasury on September 30, 2004. These funds are no longer available to states with insufficient allocations of federal SCHIP matching funds to cover all eligible children.

2005–2009

40 states and the District of Columbia cover children in Medicaid or SCHIP with family incomes at or above 200 percent of FPL compared to only three states in 1997

2006

The Deficit Reduction Act of 2005 (DRA), signed into law in February 2006, allows states to impose cost-sharing for most services on children eligible for Medicaid on an "optional" basis (generally those with family incomes above 100% of FPL). The DRA requires all children and parents who apply for Medicaid or seek to continue their coverage and who claim to be U.S. citizens to document their citizenship and identity. Medicare beneficiaries and most individuals with disabilities are exempt from this requirement. The DRA allows states to offer disabled children under 19 with family incomes below 300 percent of FPL to purchase Medicaid coverage by paying income-related premiums.

Deficit Reduction Act of 2005: Implications for Medicaid Issue Brief

40 states and the District of Columbia cover children in Medicaid or SCHIP with family incomes at or above 200 percent of FPL compared to only three states in 1997, right before SCHIP was enacted.

2007

With a good economy and the prospects for robust reauthorization legislation, states took action to expand coverage in an effort to reduce the number of uninsured children in their state. With SCHIP set to expire on September 30, 2007, the House and Senate passed separate SCHIP reauthorization bills that would have significantly expanded funding and coverage for children in the summer of 2007. In the midst of the reauthorization debate, CMS issued guidance on August 17, 2007, which limited states' ability to expand SCHIP to children with family incomes above 250% of poverty. In the fall, Congress passed two versions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) with strong bi-partisan support. The President vetoed both bills. While census numbers showed a slight decline in the number of uninsured children during 2007 due in part to increases in eligibility for public coverage programs, state progress was hindered by the failure to fully reauthorize SCHIP reauthorization, the August 17th Directive and enrollment barriers as a result of the new federal mandate including in the DRA that required US citizens to provide proof of citizenship and identity when applying for or renewing Medicaid coverage.

State Health Insurance Program (SCHIP): Reauthorization History

Resuming the Path to Health Coverage for Children and Parents

2008

States continued to make progress on expanding health coverage to uninsured low-income children and families. Several states were able to implement significant coverage expansions for children and others implemented eligibility simplifications and outreach. In 2008, the largest barriers to moving forward were related to the temporary reauthorization of SCHIP and the August 17th Directive. During the course of 2008, states were also starting to feel budget pressures with the onset of another economic downtown. As states worked to adopt budgets for state fiscal year 2009 (which starts in July for most states) most were able to hold onto their current eligibility levels and streamlined procedures, but the recession creates mounting pressure to cut spending as the need for coverage expands. States are hopeful that reauthorization of SCHIP and federal fiscal relief for Medicaid spending are first orders of business in the Obama Administration.

State Fiscal Conditions and Medicaid

2009

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 was one of the first pieces of legislation passed by the 111th Congress and signed into law by President Obama in early February. The law expands CHIP to an additional 4 million children who would otherwise be uninsured and also gives states the option to eliminate a five-year waiting period for legal immigrant children and pregnant women to be eligible for Medicaid and CHIP. President Obama also rescinded the August 17th Directive which had restricted states' ability to cover children in families with income above 250% of the federal poverty level.