

## **Medicaid – The Need for Reform<sup>\*</sup>**

**John Holahan  
Allan Weil**

Making substantial changes to the Medicaid program in the name of reform has been a major focus of the Bush administration and the Congress. Some major changes to Medicaid occurred in the Deficit Reduction Act, and the Bush administration has also approved several Section 1115 waivers that make significant changes to the program. Secretary of Health and Human Services Michael Leavitt also established a commission to consider fundamental reforms.

The primary diagnosis of the problem with Medicaid is the program's high and rising costs. Thus, most of the recent reform initiatives attempt to deal with containing program spending. In this paper, we argue that these recent policy initiatives (increased cost sharing, flexibility in benefit/design and premium assistance) will not have significant effects on program spending and are not real reform. But while we do not believe that these initiatives will accomplish much, we do believe Medicaid does need reform for several reasons. We discuss these reasons and then present four alternative options as well as cost estimates for each. We then discuss a number of remaining issues that are outside of these options and cost estimates.

It is important at the outset to note that the Medicaid program has provided great benefits to low income Americans. The program provides insurance coverage to over 40 million Americans and to some 50+ million at any point during the year. Most of these would not have had coverage without Medicaid. As a result, the number of uninsured would have been much higher than the 45 million reported for 2005. Medicaid has been a major source of health care

---

<sup>\*</sup> This paper is a shortened version of a paper that appeared in the journal *Health Affairs*. John Holahan and Alan Weil "Towards Real Medicaid Reform" *Health Affairs*, February 23, 2007.

coverage for low income pregnant women and children, and for the disabled. The program pays for about half of all births in United States. It helps low income elderly and disabled people pay for Medicare premiums and cost sharing. It is a major source of support for safety net hospitals and clinics. Finally, it is the backbone for the nation's long-term care system.

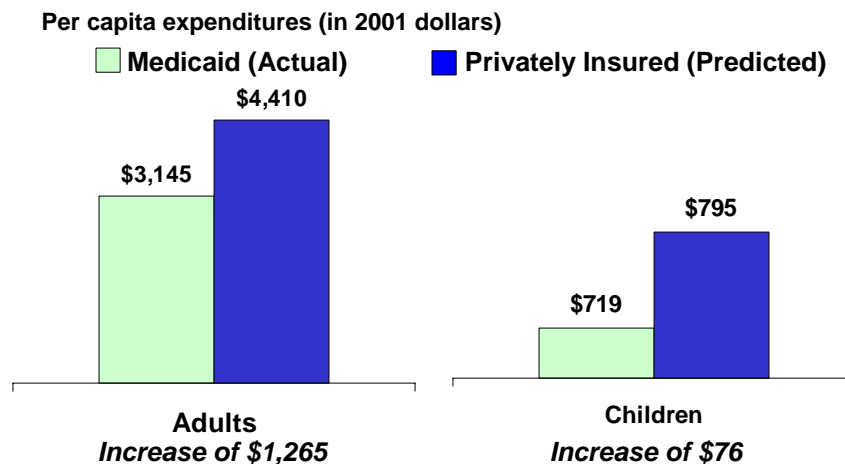
The proposals adopted by the Bush administration and the Congress in recent years are not likely to have significant effects on program costs. The problem with Medicaid is often identified as one of moral hazard.<sup>1</sup> People face costs at the point of service which are too low and thus tend to overuse services. In addition, the program is accused of having a “Cadillac” benefit package, i.e., benefits far in excess to those available to low income working Americans.<sup>2</sup> The solution to these problems is to provide states with greater flexibility to impose more cost sharing and to limit benefit packages. These policies may reduce utilization but could also do great harm by reducing use of services that are vitally needed by low income populations. They also ignore the fact that Medicaid in essence solves the rationing problem that cost sharing is designed to serve by keeping provider payment rates low and thus reducing access to providers.

The real reason for spending growth in Medicaid is primarily due to, first, enrollment growth that can be traced to the erosion of employer-sponsored insurance, particularly for low wage workers, and increases in income inequality—both have meant that more people qualify for Medicaid under existing eligibility standards. Second, there has been an increase in the incidence and recognition of disability resulting in a consistent (approximately) 3 percent increase in the number of disabled enrollees. Finally, the health care inflation that has plagued the entire healthcare system also affects Medicaid.<sup>3</sup>

Recent research has shown that Medicaid costs are not higher than for low income people with private insurance on a risk-adjusted basis, i.e., statistical studies that control for disability

and the presence of chronic illness show that the same population would be more costly if individuals were given private coverage (Figure 1)<sup>4</sup>. We have shown that spending would increase from \$719 to \$795 for children and from \$3,145 to \$4,410 for adults (2001 dollars) if people on Medicaid were given private coverage, not including likely higher administrative costs. Furthermore, Medicaid costs have not been growing faster than private insurance. (Figure 2)

**Figure 1**  
**Medicaid Costs are Not Higher than Private Insurance on a Risk-Adjusted Basis**



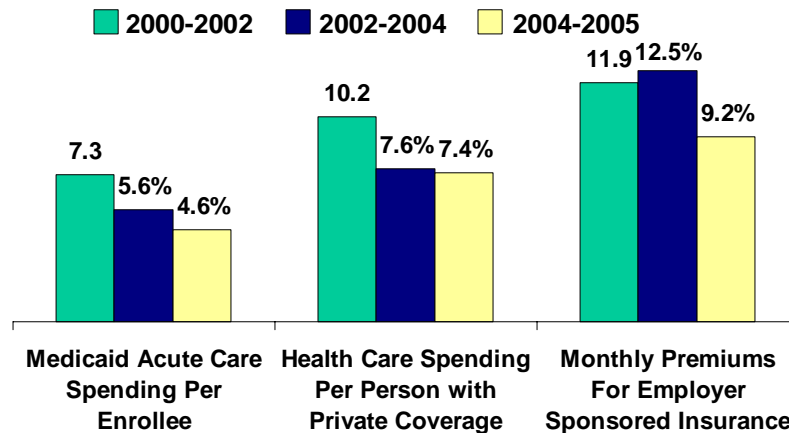
Note: All differences are statistically significant at the 5% level. "Adults" defined as age 19-64. "Children" defined as age 0-18.  
 SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999: Hadley and Holahan, Inquiry, Vol. 40, No. 4 (Winter 2003/2004).

But while recent diagnoses and solutions do seem misguided, we do believe that Medicaid does need reform. We highlight four reasons.

First, Medicaid costs are a growing burden for states. While Medicaid costs per enrollee are not high in comparison to the private market, Medicaid enrollment growth coupled with medical care inflation is clearly forcing healthcare spending to increase at a rate in excess of growth in state revenues.

Figure 2

### Medicaid Costs are Not Growing Faster than Private Acute Care Services, 2000-2005



Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1999-2006; Paul B. Ginsburg, Bradley C. Strunk, Michelle I. Banker, and John P. Cookson, "Tracking Health Care Costs: Continued Stability But At High Rates in 2005", Health Affairs, October 3, 2006.

Second, the variation among states in coverage and provider payment rates are extremely large and difficult to accept given the large national stake in financing the program, i.e., a majority of the money in each state are federal dollars. Thus, we believe there is a national interest in how these funds are used and the variation that we observe is inconsistent with that national interest.<sup>5</sup>

Third, a related issue is that eligibility standards are extremely complicated to understand and are also restrictive, excluding populations, i.e., childless adults, that have very low incomes and are in need of better access to health care.

Finally, the creative financing arrangements that states have employed over the last 15 years, while typically legal, have also led to a considerable amount of mistrust between federal and state governments.<sup>6</sup> They have led to the transfer of funds to state governments with little or

no state matching payments, a practice that is clearly inconsistent with the fundamental nature of the program.

We propose four options that will address these problems. All have somewhat different objectives. All are designed to cost about the same amount to the federal government and to provide about the same savings to states. They each will increase costs to the federal government more than they provide savings to the states. The net additional cost is overwhelmingly due to the coverage expansions that are a part of each option. The key components of reform are these:

- (1) We would require states to increase coverage to certain income levels for parents and childless adults. States would have the option to go to higher income levels. This would establish a uniform base of coverage across states and reduce the number of uninsured. It would provide a base to build upon with other policies such as tax credits or income related subsidies as, for example, has occurred in Massachusetts.
- (2) We would shift some services or populations wholly to the federal government while shifting other spending obligations wholly back to the states. In general the shifting involves some or all of the care for dual eligibles. This would provide fiscal relief to states and give the federal government a central role in managing the high cost cases. When care is shifted back to states, there is the potential for improving system efficiency but this would also offset the federal costs from the shift of other services to the federal government.

- (3) Federal matching rates for selected populations or services would be increased, e.g., adults, acute or long term care, depending on the option. This would provide fiscal relief to states and an incentive to expand coverage because the cost of expansions is lowered and to avoid cutbacks in times of fiscal stress because the benefits from contractions are less.
- (4) We would end or reform the DSH program. The idea is to end or severely curtail the practices of increasing federal matching payments with no real state contribution. In the paper, we focus on DSH payments but the intent is to include all similar practices.

The four options are as follows:

#### Option I

The primary focus of this option is on expanding coverage for acute care services. It would cover all adults up to 150% FPL with a 30 percent enhanced match. States could expand further with the enhanced matching rate. We would integrate SCHIP with Medicaid; essentially SCHIP would be ended but Medicaid would be altered to have somewhat similar characteristics. There would not be enrollment caps, but there would be premiums and cost sharing for higher income children as in the current SCHIP program. Medicare premiums and cost sharing for acute care services for dual eligibles would be federalized. We would retain the current clawback payments in which states make payments to the federal government for their estimated share of drug payments had there been no Medicare drug benefit. We would increase federal matching payments on acute care services by 30 percent. This would affect acute care services

used by adults, children and non-dual disabled populations. The long-term care matching rates would be unchanged. We would eliminate DSH. The argument is that there is less of a need with a broad coverage expansion for the residual safety net and it could become a state responsibility.

## Option II

Option II also places a strong emphasis on coverage expansion and fiscal relief, but extends the financial help to long term care spending. Option II would mandate that coverage be extended to all adults to 150% FPL with a 15 percent enhanced match. Federal matching payments for all services, both acute care and long term care would be increased by 15 percent; SCHIP would stay a separate program. There would be a 15 percent enhanced match on both Medicaid and SCHIP services. This would end the distinction between SCHIP and Medicaid where higher income children receive higher federal payments. It would federalize acute care services for dual eligibles, including eliminating the clawback payment now made by states. Option II would also eliminate DSH for the reasons given above.

## Option III

Option III would have more of a long term care focus. It assumes that the primary policy concern is the impact of an aging population on states. Option III would mandate coverage of all adults, but only to 100% FPL. There would be no change in current matching rates for acute care services. SCHIP would be unchanged with the current higher federal matching payments. It would federalize acute care services for dual eligibles and eliminate the drug clawback. The major focus here would be an increase in federal matching payments for long term care services

by 30 percent. In this option, we would also restructure DSH. Because there is less of a coverage expansion, we would maintain DSH payments, but we would redistribute them so that the states would get the same amount per low income person. This would deal with the current problem of poor distribution of funds: ten states now get 71 percent of DSH payments, five states get more than \$1000 per uninsured person and 16 states get less than \$100 per uninsured person.

#### Option IV

Option IV would be the largest change in current policy. It would mandate coverage of all adults to 100% FPL but there would be no change in matching rates. SCHIP would be unchanged with the current 30 percent higher matching rate. The major focus would be the shifting of all costs of dual eligibles to the federal government, including long term care. This option would also eliminate the prescription drug clawback payment. Option IV would shift responsibility for long term care services for non-dual eligibles back to the states. Finally, DSH payments would be restructured as described above.

#### **Policy Changes Common to all Options**

There are certain provisions that are common to all options. First, prescription drugs would become a mandatory benefit. All states currently provide prescription drugs, so this is not, in practice, much of a change. Second, there would be increased flexibility in the use of cost sharing above 150% FPL but not below. Third, there would be increased flexibility on mandatory benefits for adults but little or no change in flexibility for children or the disabled. For example, the current EPSDT benefits would remain. Finally, there would be enrollment caps for new optional adult populations, i.e, those above the mandated minimum income levels.

## Coverage Expansions

We estimate the impact of coverage expansion using a detailed spreadsheet model that begins with the baseline of current coverage. The U.S. population is organized by children, parents and childless adults; by income; by current insurance arrangements; and by four geographic regions. We model current eligibility for public programs in great detail for each state. We then apply take up rates to each group based on the current research evidence.<sup>7</sup> We also rely on the extensive literature on the crowd out of private coverage by public expansions.<sup>8</sup> We base our estimates of Medicaid spending on the Medicaid Management Information System for 2002, adjusting forward for inflation using several different sources to obtain 2007 estimates.<sup>9</sup> Because those likely to come into the program through a coverage expansion are likely to be healthier than those in existing programs, we make an adjustment for the better health status of those new enrollees. We also assume a reduced benefit package for adults and make a downward adjustment (7.5 percent) to the cost of care for that population.

Table 1 shows the effect of the coverage expansions on Medicaid enrollment. An expansion to 100% would increase Medicaid roles by 7.1 million and to 150% FPL by 11.1

**Table 1. Estimated Cost of Expanding Coverage to 100% and 150% FPL**

	<b>Percent of federal poverty level</b>	
	<b>100%</b>	<b>150%</b>
<b>Change in coverage (millions)</b>		
Medicaid	7,070	11,117
Employer	-924	-1,861
Nongroup	-967	-1,477
Uninsured	-5,167	-7,779
<b>Cost to government (\$billions, 2006)</b>		
Regular Matching rates		
Federal	\$14.0	\$22.2
State	10.0	15.9
30 percent higher match		
Federal	\$18.2	\$28.9
State	5.9	9.2

million. The majority of these new enrollees would be childless adults. The number of uninsured would fall by 5.2 million with an expansion to 100% FPL and by 7.8 million with an expansion to 150% FPL. The cost to the federal government of an expansion to 100% FPL would be \$24.1 billion and to 150% FPL would be \$38.1 billion.

Each of the four options would increase federal spending by between \$41.1 billion and \$48.5 billion. (Table 2) At the same time, states would save between \$15.1 billion and \$22.6 billion. The net additional cost to the healthcare system would be between \$25.9 billion and \$29.7 billion. Option IV has the largest increase in federal spending and the greatest savings to states. Option I has the greatest net increase in cost to government as a whole.

**Table 2. Changes In Spending, In Billions Of \$ (2006)**

	Federal	State	Net
I	44.8	-15.1	29.0
II	44.6	-15.6	29.0
II	41.1	-15.3	25.9
IV	48.5	-22.6	25.9

The biggest impact on costs is the coverage expansion. For example, in Option I, the expansion to 150 % FPL with a 30 percent enhanced match would increase costs to the federal government by \$28.9 billion and to states by \$9.2 billion. The changes in federal matching payments would shift a substantial amount of money to the federal government and save states a considerable amount as well.

Other than coverage, the biggest single impact is the changes in policies towards dual eligibles. The cost of having the federal government pick up Medicare premiums and cost sharing for acute care services and retaining the current policy on the drug clawback would increase federal costs by \$7.5 billion and reduce state spending by the same amount. Federalizing

acute care for dual eligibles but eliminating the clawback would increase the federal costs by \$14.1 billion and save states the same amount. Shifting all of the costs of dual eligibles to the federal government would shift \$47.7 billion from the states to the federal government.

These policies would have different effects across regions. The coverage expansions would have the biggest impacts on the south because coverage levels are currently lower there. The increases in federal matching rates would help the northeast the most because Medicaid programs in that region tend to have broader coverage and richer benefits than elsewhere in the country. Federalizing spending for dual eligibles also benefits the northeast the most, again because of broad coverage and richer benefits, particularly in long term care. Cuts in DSH payments would hurt the northeast and the south the most. DSH restructuring would have an adverse effect on the northeast but would benefit all other regions, although not all states within those regions.

Table 3 shows these effects. For the northeast, the greatest increase in federal spending and greatest savings to the states is in Option IV. This is because of the shifting of dual eligibles

**Table 3. Impacts Of Proposed Medicaid Reform Options, By Region, 2006**

Option	Percentage Change in Medicaid Spending							
	Northeast		Midwest		South		West	
	Federal	State	Federal	State	Federal	State	Federal	State
1	21.1	-16.8	28.4	-12.6	35.8	-11.7	34.0	-8.8
2	22.5	-18.0	29.5	-14.7	33.7	-6.6	35.9	-12.8
3	23.4	-19.8	28.4	-13.9	29.4	-7.3	29.3	-7.9
4	33.8	-30.7	34.8	-22.3	27.1	-3.3	36.3	-16.7

**SOURCE:** Author's calculations based on population information from the March 2005 Current Population Survey and spending data from the 2002 Medicaid Management Information System (MMIS).

**NOTE:** Spending data were adjusted to 2006 using the CMS-64 and Congressional Budget Office (CBO) projections (March 2006 CBO baseline).

to the federal government; since the northeast spends proportionately more on dual eligibles than other regions, it benefits the most from this policy. In contrast, the south is better off under

Option I because the increase in federal payments because of the broad coverage expansion. It gains less from the increased matching rates because it spends less on those services currently.

### **Other Issues**

There are a number of other issues that are important for Medicaid reform.

1. Cost containment efforts historically have relied on controls over provider payment rates and increased use of managed care. Recent initiatives are attempting to introduce more cost sharing and benefit flexibility. As noted, these latter initiatives are likely to have relatively small effects. Rather, we believe that cost containment should be focused on the highest cost beneficiaries. At present, 7.5 percent of Medicaid beneficiaries account for two-thirds of Medicaid spending.<sup>10</sup> There is a need for a large federal investment in both Medicaid and Medicare case management and care coordination programs.<sup>11</sup> There is a need for changes in payment approaches to provide incentives for physicians to coordinate and manage the care of patients with multiple chronic conditions and to expand Medicaid managed care (with beneficiary protections) to more of the disabled.<sup>12</sup> This is new territory to be sure, but clearly this is where the money is and where the focus of cost containment for spending on particularly low-income populations should be focused.
2. We believe the provider payment rates should be improved. This would improve the image of the program among providers as well as increase physician participation rates. Setting minimum standards and rates could become the responsibility of the Medicare

Payment Advisory Commission. Medicaid payment rates could gradually be increased over time, i.e., to a minimum of 90 percent of Medicare rates.

3. Creative financing, including all practices that bring in federal monies without real state or local matching rates, should be eliminated. We have focused on DSH in the discussion above, but there are a number of other similar arrangements such as upper payment limit programs, school based clinic programs and targeted case management.<sup>13</sup> These programs added at least \$13 billion to federal outlays in 2005 with unknown state matching contributions. The federal government should enforce current rules designed to reduce or eliminate all such practices.<sup>14</sup>
4. There should be an effort to increase participation rates in Medicaid. In general, participation rates of those eligible for Medicaid are slightly above 50 percent. Some states have much higher participation rates.<sup>15</sup> There should be a combination of federal promotion and advertising as well as federal standards for outreach, income verification and re-certification. Higher participation rates would increase Medicaid enrollment and spending but also lower the number of uninsured, reducing the need for many government programs that support safety net providers.
5. Long term care has generally not been discussed in the options presented above. Two areas, however, are important. While it is important to limit large transfers of assets to obtain Medicaid eligibility, these are not likely to result in large budgetary savings.<sup>16</sup> However, the current spend down requirements require people to spend large amounts of

money before becoming Medicaid eligible. There is a need to permit people to retain somewhat higher levels of assets and income. The second issue is the extreme unevenness in the coverage of home and community based services for impaired elderly and disabled people. Efforts should be made to permit states to expand coverage of home and community based services in general and to people with higher income levels.

6. The federal matching formula should be reformed.<sup>17</sup> The current system now recognizes differences in incomes. It needs to be restructured to recognize differences in income distribution as well. For example, two states with the same income level could have very different proportions of their population in poverty and thus different needs for federal assistance. Centering the matching rate on income per person in poverty would end up shifting dollars to states with a more skewed distribution of income. If some of the other changes in matching rates and shifts in responsibility to the federal government that have been discussed in this paper were adopted, then all states would come out as winners, but some more than others. There is a need to increase matching rates with rising unemployment on a timely basis.

To sum up, we have identified the problems with Medicaid as the large interstate variation in coverage, the fact that Medicaid costs are increasingly a burden to states, the complexity of eligibility rules, and the issue of creative state financing. To address these problems, we propose to expand and provide a more uniform base of coverage and reduce the number of uninsured. These uniform standards would be easier for the states and federal government to build upon, with further reforms designed to reduce the number of uninsured

Americans. We would also shift more of the financial responsibility for Medicaid to the federal government and provide fiscal relief to states. We would give the federal government greater responsibility for managing the care of high cost patients. There would be a strong incentive for the federal government to invest in learning how to manage these high cost cases. Finally, our proposals would severely restrain the financial manipulations that are now too great a part of the Medicaid program.

The nation is now undertaking a new discussion over universal coverage. We believe the Medicaid reform has to be part of that discussion.

---

<sup>1</sup> Although not specific to Medicaid, the general case for overuse as a concern is set forth in President's Council of Economic Advisors, *Economic Report of the President* (Washington: U.S. Government Printing Office, February 2006); and M.F. Cannon, "Medicaid's Unseen Costs," Cato Institute Policy Analysis no. 548 (Washington: Cato Institute, 18 August 2005).

<sup>2</sup> References by political leaders to Medicaid as a Cadillac program are legion. For example, see radio address by Tennessee Gov. Phil Bredesen, 11 June 2005, <http://democraticgovernors.org/news/280> (accessed 9 February 2007)

<sup>3</sup> J. Holahan and A. Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs* 24 (2005): w52-w62 (published online 26 January 2005; 10.1377/hlthaff.w5.52); and J. Holahan and M. Cohen, *Understanding the Recent Changes in Medicaid Spending and Enrollment Growth between 2000-2004*, Pub. No. 7499 (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2006).

<sup>4</sup> J. Hadley and J. Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40, no. 4 (2003): 323-342.

<sup>5</sup> J. Holahan, "Variation in Health Insurance Coverage and Medicaid Expenditures: How Much is Too Much?" in *Federalism and Health Policy*, ed. J. Holahan, A. Weil, and J. M. Weiner (Washington: Urban Institute, 2003), 111-143; and B.C. Spillman, "Adult without Health Insurance: Do State Policies Matter?" *Health Affairs* 19, no.4 (2000): 178-187

<sup>6</sup> T.A. Coughlin and S. Zuckerman, "States' Strategies for Tapping Federal Revenues: Implications and Consequences of Medicaid Maximization," in *Federalism and Health Policy*, ed. Holahan et al., 145-178; and D. Rousseau and A. Schneider, *Current Issues in Medicaid Financing – An Overview of IGT's, UPL's and DSH*, Pub. No. 7071 (Washington: Kaiser Commission, April 2004).

<sup>7</sup> T.M. Selden, J.S. Bantlin, and J.W. Cohen, "Medicaid's Problem Children: Eligible but Not Enrolled," *Health Affairs* 17, no. 3 (1998):192-200; L. Dubay, J. Haley, and G. Kenney, *Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era*, Assessing the New Federalism Pub. No. B-40 (Washington: Urban Institute, 2002), *Health Affairs*, 26, no. 1 (2007):w22-w30 (published online 30 November 2006; 10.1377/hlthaff.26.1.w22); and A. Davidoff, A. Yemane, and E. Adams, *Health Coverage for Low-Income Adults: Eligibility and Enrollment in Medicaid and State Programs* (Washington: Kaiser Commission, February 2005).

---

<sup>8</sup> L. Blumberg, L. Dubay, and S. Norton, "Did the Medicaid Expansion for Children Displace Private Insurance? An Analysis Using the SIPP," *Journal of Health Economics* 19, no. 1 (2000): 33-60; D. Cutler and J. Gruber, "Does Public Insurance Crowd-Out Private Insurance? *Quarterly Journal of Economics* III, no. 2 (1996): 2910340; L. Dubay, "Expanding Public Insurance Coverage and Crowd-Out: A Review of the Evidence," in *Options for Expanding Health Insurance Coverage: What Difference Do Different Approaches Make?*, ed. J. Feder and S. Burke (Washington: Henry J. Kaiser Family Foundation, 1999); and A.T. Lo Sasso and T.C. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics* 23, no. 5 (2004): 1059-1082.

<sup>9</sup> Congressional Budget Office, March 2006 baseline.

<sup>10</sup> A. Sommers and M. Cohen, *Medicaid's High Cost Enrollees: How Much Do they Drive Program Spending?* Pub. no. 7490 (Washington: Kaiser Commission, March 2006).

<sup>11</sup> S.M. Lieberman et al., "Reducing the Growth of Medicare Spending Geographic versus Patient-Based Strategies," *Health Affairs* 22 (2003): w603-w613 (published online 10 December 2003; 10.1377/hlthaff.w3.603); and K.E. Thorpe and D.H. Howard, "The Rise in Spending among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity," *Health Affairs* 25 (2006): w378-w388 (published online 22 August 2006; 10.1377/hlthaff.25.w378).

<sup>12</sup> G.F. Anderson, "Medicare and Chronic Conditions," *New England Journal of Medicine* 353, no. 3 (2005): 305-309; R. Berenson and J. Horvath, "Confronting the Barriers to Chronic Care Management in Medicare," *Health Affairs* 22 (2003): w37-w53 (published online 22 January 2003; 10.1377/hlthaff.w3.37); E.H. Wagner, B.T. Austin, and M. Von Korff, "Organizing Care for Patients with Chronic Illness," *Milbank Quarterly* 74, no. 4 (1996): 511-544; and Medicare Payment Advisory Commission, *Report to the Congress: Increasing the Value of Medicare* (Washington: MedPAC, June 2006), chap. 2.

<sup>13</sup> U.S. Government Accountability Office, "Medicaid States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight," Statement of Kathryn G. Allen before the Senate Finance Committee, 28 June 2005 (Washington: GAO, 2005); and T.A. Coughlin, B.K. Bruen, and J. King, "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs* 23, no. 2 (2004): 245-257.

<sup>14</sup> S. Schwartz et al., "Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity" (Portland, Maine: National Academy for State Health Policy, August 2006).

<sup>15</sup> L. Dubay, J. M. Haley, and G.M. Kenney, *Children's Eligibility for Medicaid and SCHIP: A View from 2000*, New Federalism: National Survey of America's Families, Pub. no. B-41 (Washington: Urban Institute, March 2002).

<sup>16</sup> E. O'Brien, *Medicaid's Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety Net*, Issue Brief (Washington: Georgetown University Long Term Care Project, May 2005). AARP Public Policy Institute, September 2004).

<sup>17</sup> V. Miller and A. Schneider, *The Medicaid Matching Formula: Policy Considerations and Options for Modifications*, Pub. No. 2004-09 (Washington: AARP Public Policy Institute, September 2004).