THE ECONOMICS OF MEDICAID
Assessing the Costs and Consequences
EDITED BY JASON J. FICHTNER

MERCATUS CENTER
George Mason University
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Medicaid is the primary source of health care funding for America’s low-income population. The program is now very large by most any standard. In 2012, 68 million people were enrolled in Medicaid at some point during the year.¹ The program now serves a larger population than Medicare. Medicaid is state based and administered, but is jointly funded by the general revenues of the federal government and the states. In fiscal year (FY) 2011, total Medicaid expenditures were $432 billion, 64 percent of which was funded by the federal government and 36 percent by the states. Each of the 50 states administers its own Medicaid program subject to federal requirements concerning such matters as program eligibility and the treatment of beneficiaries and medical providers. But the states have little incentive to reduce costs because under the federal matching program they lose federal dollars for every program dollar saved. Given the complex federal-state funding structure and conflicting state incentives, the federal government faces a daunting problem.

Rapid growth has characterized both Medicaid expenditures and Medicaid beneficiaries (figures 1 and 2). Medicaid is an important contributor to the rise of total spending on health care in the United

CHAPTER 2: MEDICAID’S COST DRIVERS
JUNE O’NEILL
States, which now consumes 17.7 percent of gross domestic product (GDP). National health expenditures (NHE), a global measure covering all health spending, both privately and publicly funded, rose from 12.5 percent of GDP in 1990 to 17.7 percent in 2011. Over the
same period, spending on Medicaid increased as a share of NHE, from 10 percent of NHE to 15 percent. Measured as a percent of GDP, Medicaid rose from 1.0 percent of GDP in 1985 to 2.9 percent in 2011.

The growth in Medicaid expenditures over time has been spurred by increases in the size of the population groups eligible for program participation as well as by increases in the cost of delivering medical care to those groups. Program costs are also affected by changes in the broader economy, such as economic fluctuations and changes in provider prices. Additionally, program costs are affected by programmatic changes such as those in the federal share of total expenditures and in federal guidelines setting terms of eligibility, as well as changes in state policies concerning covered services. Fraud and abuse have also plagued both Medicare and Medicaid. A recent study estimated that fraud and abuse in the two programs cost the federal government as much as $98 billion in 2011. Efforts by states to enlarge federal Medicaid payments have also been legally questionable at times.

The Patient Protection and Affordable Care Act (ACA) is likely to have a significant effect on the Medicaid program. As originally passed, the ACA mandated that state Medicaid programs cover all individuals with incomes below 133 percent of the federal poverty level (FPL). This provision would extend Medicaid to those who were not previously eligible for the program because their incomes were too high. (The previous income limit had been set at the FPL.) In addition, the expansion would extend coverage to single adults without children, a group that had been excluded from Medicaid. The expansion was scheduled to start in 2014 and was estimated to add 17 million nonelderly adults to the Medicaid rolls by 2022. In 2012, however, the Supreme Court held that the mandate requiring the state expansion of Medicaid was unconstitutionally coercive.

As a result of the Supreme Court decision, it is now optional for states to decide whether or not to proceed with the expansion. To induce states to sign on to the expansion, the federal government agreed to pay 100 percent of hospital and other medical bills of the
Medicaid’s cost drivers

newly covered beneficiaries for a period of three years. After that, the federal payment is scheduled to drop to 90 percent. (For a detailed description of how the ACA will affect Medicaid in the states, see chapter 5, page 65.)

It is difficult to predict the long-run impact of the expansion on Medicaid costs. For example, if those who enter the program initially are adults who turn out to have expensive chronic conditions, cost pressure might very well rise. The states appear to be conflicted. As of July 1, 2013, 24 states indicated that they are moving forward with the expansion, 21 indicated that they are not moving forward, and 6 said that debate in their state was ongoing.7

Program History and Details

Medicaid became law in 1965 under Title XIX of the Social Security Act. The program was created to provide funds for medical services to low-income groups. In addition to income and asset limitations, eligibility for federal funds was tied primarily to receipt of public welfare assistance in what was then Aid to Families with Dependent Children (AFDC), and to the low-income elderly, blind, and disabled groups who receive Supplemental Security Income (SSI). Although AFDC in 1996 was replaced by Temporary Assistance for Needy Families (TANF), eligibility for Medicaid is still automatic for low-income families with children who meet the requirements for AFDC as specified in 1996. Medicaid eligibility is also extended to those low-income elderly and disabled who qualify for SSI.

Although federal law requires states to cover certain population groups and sets certain financial eligibility criteria, states can apply for waivers to expand coverage beyond the specified groups. A state can also cover certain groups without federal approval if it is willing to fully pay the costs of the group without federal assistance. Within the federal guidelines, each state establishes its own eligibility standards, determines the amount and duration of services offered, sets the rate of payment for services, and generally administers its own program.
States vary considerably with respect to the relative size of their low-income populations and population characteristics, such as the proportion with chronic problems that would allow classification as disabled. Not surprisingly, program participation and costs per enrollee differ considerably across the states. Thus in FY2009, the average share of a state's population enrolled in Medicaid was 20 percent. In California, however, 30 percent of residents were enrolled; in Utah only 6 percent were enrolled. The average Medicaid payment per beneficiary in the United States in 2009 was $5,527. The highest per capita payment was in Connecticut ($9,577); the lowest in Georgia ($3,979). Connecticut’s high payment is attributable to a relatively large proportion of their beneficiary population qualifying for long-term care.

As Joseph Antos explains in chapter 1, the federal government pays a share of the expenditures in each state’s Medicaid program. That share, known as the federal medical assistance percentage (FMAP), is determined annually by a formula based on the state’s per capita income compared with the national average income. The federal share is larger in states with lower per capita income. The FMAP by law can be no lower than 50 percent or higher than 83 percent. The historical average has been a 57 percent state share. However, the American Recovery and Reinvestment Act (ARRA) of 2009, enacted as part of an effort to stimulate recovery from the 2008 financial crisis, gave states a temporary increase in their FMAPs of up to 14 percentage points, depending on their unemployment rates. The FMAP boost was in place from the first quarter of FY2009 through the first quarter of FY2011. Additional legislation continued the higher rates through the second and third quarters of 2011, but at lower levels. In FY2013, the FMAP ranged from a low of 50 percent (12 states including New York, New Jersey, and California) to a high of 73.4 percent in Mississippi.

The dramatic shifts in Medicaid funding during the recession are displayed in table 1 along with information on changes in annual growth rates in total health spending (NHE) as well as in other major sources of health care funding, public and private. For each spending
Table 1. Growth in National Health Expenditures (NHE) and in Selected Spending Sources, Percentage Change from Previous Year (calendar years 1990–2011)

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>NHE</td>
<td>11.0</td>
<td>6.6</td>
<td>6.2</td>
<td>4.7</td>
<td>3.9</td>
<td>3.9</td>
<td>3.9</td>
</tr>
<tr>
<td>Medicaid</td>
<td>11.0</td>
<td>10.5</td>
<td>6.3</td>
<td>5.8</td>
<td>8.8</td>
<td>5.9</td>
<td>2.5</td>
</tr>
<tr>
<td>Federal</td>
<td>11.4</td>
<td>10.6</td>
<td>6.7</td>
<td>9.6</td>
<td>21.9</td>
<td>7.7</td>
<td>-7.1</td>
</tr>
<tr>
<td>State</td>
<td>10.4</td>
<td>10.4</td>
<td>5.7</td>
<td>0.7</td>
<td>-10.0</td>
<td>2.5</td>
<td>22.2</td>
</tr>
<tr>
<td>Medicare</td>
<td>11.4</td>
<td>7.4</td>
<td>7.4</td>
<td>8.0</td>
<td>6.9</td>
<td>4.3</td>
<td>6.2</td>
</tr>
<tr>
<td>Private Health Insurance</td>
<td>13.0</td>
<td>7.0</td>
<td>5.0</td>
<td>3.9</td>
<td>3.2</td>
<td>3.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Out-of-Pocket</td>
<td>9.0</td>
<td>3.8</td>
<td>5.3</td>
<td>2.4</td>
<td>0.1</td>
<td>2.1</td>
<td>2.8</td>
</tr>
<tr>
<td>GDP</td>
<td>5.8</td>
<td>6.4</td>
<td>4.9</td>
<td>1.9</td>
<td>-2.2</td>
<td>3.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Real GDP*</td>
<td>1.9</td>
<td>4.1</td>
<td>1.9</td>
<td>-0.3</td>
<td>-3.1</td>
<td>2.4</td>
<td>1.9</td>
</tr>
</tbody>
</table>

* Chained 2005 dollars (Department of Commerce, BEA).
Source: NHE and the component health expenditures are from Centers for Medicare and Medicaid Services, Office of the National Health Statistics Group.

source, the table shows the percentage change in expenditures from the previous year. As shown, growth rates in health care spending had generally been high in 1990 when Medicaid expenditures increased at an annual rate of 11 percent—the same as the growth rate in NHE. By 2000, Medicaid growth was still at the high level of 1990 although spending was reduced in most other sources of health care funding. But during the following decade, the slowdown in GDP growth was reflected in lower spending on health care expenditures generally, including Medicaid expenditures. Thus, Medicaid spending, federal and state combined, increased by 5.8 percent in 2008 from the previous year. With the advent of the recession, federal spending accounted for most of that increase as the state share barely increased at all (a rise of 0.3 percent).

Once the full impact of the recession hit in 2009, the annual percentage increase in total Medicaid expenditures rose to 8.8 percent, more than double the rate of increase in NHE. High unemployment
led to additional enrollments and higher Medicaid costs. At the same time, states were financially stressed by plunging revenues related to the high unemployment. As a consequence, state Medicaid spending actually fell by 10 percent. But as part of the recession stimulus effort, the federal government came to the rescue with close to a 22 percent increase in federal funds, which more than offset the collapse in state funding.

The funding of Medicaid differs considerably from that of Medicare in that it is almost entirely drawn from general revenues—both state and federal—whereas Medicare is substantially funded by dedicated revenue sources: payroll taxes and beneficiary premiums. Medicaid is therefore highly important in state budgets. According to the National Association of State Budget Officers (NASBO), in FY2012, Medicaid accounted for 23.9 percent of all state government spending. That percentage exceeded the spending share of all other programs, including elementary and secondary school spending, which accounted for 19.8 percent.10 (For further details on the impact of Medicaid on federal and state budgets, see chapters 3 and 4, pages 49 and 65.)

**SOURCES OF RISING COSTS**

Since its inception in 1966, the spending trajectory of the Medicaid program has been upward, although the rate of increase has varied, sometimes considerably (see figure 1). Medicaid expenditures are driven by growth both in enrollments of beneficiaries (figure 2) and in the medical costs incurred by the beneficiaries.

Costs per beneficiary vary considerably with the characteristics of beneficiaries. Those who are elderly or disabled incur much higher medical costs than children or nonelderly adults; thus, changes in the composition of beneficiaries have a significant effect on costs. The economy influences the flow of beneficiaries, particularly those in the child and nonelderly adult category because increases and decreases in employment affect income eligibility for the program (e.g., family income for children; own income for nonelderly single adults).
Table 2. Distribution of Medicaid Recipients and Medicaid Payments by Eligibility Group and Medicaid Payments per Person Served by Eligibility Group, 1990, 2000, 2010

<table>
<thead>
<tr>
<th></th>
<th>Share of Beneficiaries (%)</th>
<th>Share of Payments (%)</th>
<th>Per Person Served* ($)</th>
</tr>
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<tbody>
<tr>
<td>Children</td>
<td>44.7</td>
<td>46.1</td>
<td>48.4</td>
</tr>
<tr>
<td>Adult</td>
<td>23.8</td>
<td>20.5</td>
<td>23.9</td>
</tr>
<tr>
<td>Aged</td>
<td>13.7</td>
<td>8.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Disabled</td>
<td>14.7</td>
<td>16.1</td>
<td>14.3</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>3.1</td>
<td>8.6</td>
<td>6.8</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

* Constant 2010 dollars.
Source: Data are from the Medicare and Medicaid Research Review, 2012, Statistical Supplement.

Medicaid also at times has been affected by episodes such as the explosion in costs generated by the Medicaid disproportionate share hospital (DSH) program, described below.

The relation between demographic characteristics, per enrollee costs, and total payments is shown in table 2 for the years 1990, 2000, and 2010. Medicaid enrollees are usually identified as belonging to one of four major demographic groups: children, adult, elderly, and disabled. Enrollees classified as adults in the Medicaid program are nondisabled and younger than age 65. As table 2 indicates, Medicaid payments per capita differ considerably by characteristic. In all years shown, children and adults are the lowest cost recipients. In 2010, Medicaid payments per beneficiary were $2,129 for children and $3,102 for the adult category. By contrast, payment per beneficiary was $15,339 for the elderly and $15,752 for the disabled.

The total number of beneficiaries increased from 25 million to 65 million between 1990 and 2010—a rise of 158 percent. Changes in the demographic composition of beneficiaries did not play a major role in the increase in costs over that period. The number of children beneficiaries increased as a percentage of the total and was the only one
of the four groups to do so. The increase, however, was modest. Over the 20-year period, the children’s share of the beneficiary population grew from 45 percent to 48 percent.

But cost pressures did rise for the children group because per person costs increased more for children than the other groups—a 30 percent rise in real dollars between 1990 and 2010. Children remained the lowest per capita payment group in 2010, although the combination of a small gain in beneficiary share and a significant increase in per person payments increased the children’s share of total payments from 14 to 20 percent. The adult group retained their share of about 24 percent of total beneficiaries. They, like children, are a relatively low cost group. In 2010, they accounted for a somewhat smaller share of total payments than was the case in 1990.

Unlike the pattern for the other groups, the Medicaid participation of the elderly declined significantly over the 20-year period, falling from a share of 13.7 percent of total beneficiaries in 1990 to only 6.8 percent in 2010. The elderly are a high-cost group; but as their participation declined, their share of total Medicaid payments fell from 33 percent in 1990 to 19 percent in 2010. Disabled beneficiaries are the other high-cost group. As shown in table 2, the per capita payments of the disabled are quite similar to those of the elderly. But unlike the elderly, the disabled have remained a fairly steady share of total beneficiaries, at about 14 percent. But because their per person payments are high and have been rising—an increase of 18.5 percent in constant dollars between 1990 and 2010—their share of total Medicaid payments has increased from 38 percent in 1990 to 44 percent in 2010, the largest percentage share of any group.

Medicaid is often viewed as an important funding mechanism for long-term medical care in nursing homes. Nursing homes are not exclusively used by low-income people. Middle class individuals may enter nursing homes as paying residents. But nursing home care is expensive and residents who exhaust their financial assets become dependent on Medicaid to pay the bills. In 2010, the average payment per elderly Medicaid recipient for nursing home care was about
$35,000. Only 2.4 percent of the total Medicaid population used nursing home facilities in 2010. But even among elderly recipients, use of nursing facilities has declined significantly. In 1990, 39.5 percent of elderly Medicaid recipients were counted as users of nursing facilities; by 2010, that percentage had fallen to 24.3. Nursing homes are the second most heavily used service by the elderly in Medicaid. Prescribed drugs are the most heavily used: 45 percent of elderly recipients receive drug benefits. But the percentage receiving drug benefits has declined sharply as Medicaid recipients who are also Medicare recipients (so-called dual eligibles) have been shifted into Medicare Part D.

The pattern of nursing home usage in Medicaid is consistent with data released from the Bureau of the Census indicating that the percentage of Americans ages 75 and older living in nursing homes fell from 10.2 percent in 1990 to 5.7 percent in 2010. Among those ages 85 and older, the percentage in nursing homes fell from 21.6 percent in 1985 to 11.6 percent in 2010. Assisted living arrangements and other community services that enable people to stay in the community are replacing nursing homes.

Such alternatives to nursing homes have become more viable because the income and wealth of the elderly have increased. It is often assumed that the elderly play a significant role in rising health care costs because medical problems increase with age. Although that is true, it is also true that because of gains in medical science and technology, many of the infirmities of old age have been alleviated by such procedures as knee and hip replacements, which enable people to remain more self-sufficient at advanced ages. The older population today has increased its labor force participation and economic status. Successive generations in the United States have become more educated and have attained higher earnings. Recent studies find that the assets of the elderly have increased considerably over time. The increase in resources of the elderly helps explain the declining importance of this demographic in the Medicaid program.

Individuals with disabilities account for 14 percent of Medicaid recipients, and that proportion has been relatively stable for many years.
Many of the disabled who qualify for Medicaid also receive cash benefits from the SSI program. In most states SSI eligibility automatically qualifies an individual for Medicaid. In the other states, applicants must demonstrate that they have an impairment that prevents them from working for at least one year. In addition, applicants must pass a review of assets and income before they qualify for Medicaid. Included in the Medicaid disabled group are individuals with HIV/AIDS, for whom Medicaid is the single largest source of coverage. Although the number of beneficiaries with HIV is growing, coverage for this group still represents less than 3 percent of Medicaid spending. Medicaid data on the services used by the disabled indicate that provision of prescribed drugs and physician services are the most heavily used.

THE DSH EPISODE

It is not surprising that in a program as large as Medicaid, with two major sources of funding, difficulties regarding cost control and instances of fraudulent practices would arise. The most notorious example of the latter involves the Medicaid DSH program, which in the early 1990s was responsible for several years of huge cost increases in federal Medicaid expenditures.

The DSH program involves hospitals that serve a disproportionate number of low-income and uninsured people, and as a consequence have difficulty getting their bills paid. In the early 1980s, Congress attempted to alleviate the problem by mandating that states consider making special payments to disproportionate share hospitals. Few states responded. Congress then added the stipulation that the disproportionate share hospitals could bill the states using the higher reimbursement rates of Medicare.

To help states raise funds to reimburse the hospitals, CMS, at that time called the Health Care Financing Administration, issued a rule that allowed states to receive donations from medical providers. This was an attractive option for states; when they ran out of funds during times of hardship, they were unable to pay providers and therefore
Medicaid’s cost drivers could not apply for any federal matching money. The donations rule enabled hospitals to make a donation to the state. The state then pays the hospital with the donation money and that payment generates an expenditure that qualifies the state to obtain matching payments from the federal government. The state gains the federal money even though little, if any, of the federal payment actually goes to the hospital. The states embellished the idea by adopting provider tax programs that operated similar to the donations. And the payments back to the hospitals were labeled as DSH payments. With the donation and tax schemes, the states were able to leverage the DSH payments into considerable state funds that partly helped the hospitals and partly could be used for other state purposes.

The period of peak DSH activity was 1990–92. In 1992, DSH spending accounted for significant amounts of spending in many states; for example, it accounted for 43 percent of Louisiana’s spending. Medicaid spending in the federal budget escalated, recording annual increases of as much as 30 percent in a single year.

The rapid rise of federal DSH payments did not go unnoticed. Legislation to deal with the problem began in 1991 with the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (the legislation arose from an agreement between the administration of President George H. W. Bush and the National Governor’s Association). The agreement set caps on DSH payments, limiting them to 12 percent of total Medicaid costs. Provider donations were banned and provider taxes were restricted.

But the DSH problem was not fully resolved. States soon developed a new means of raising money for their DSH programs. Money within state budgets is frequently fungible, and many states turned to intergovernmental transfers (IGT) to transfer money from one agency or level of government to another. Thus, some states transferred funds from public institutions such as state psychiatric facilities, state university hospitals, and other public hospitals (city, county) to the state Medicaid agency. The state could then make DSH payments to these public hospitals, once again generating federal share payments. By 1992, DSH accounted
for 15.4 percent of total Medicaid spending. Accounts surfaced that DSH payments were not being used for their stated purpose, but instead were retained by states for general state funding.\textsuperscript{16}

Congress eventually cut back spending on the DSH program through provisions included in the 1993 Omnibus Budget Reconciliation Agreement and the Balanced Budget Act of 1997.

**DUAL ELIGIBLES**
On another front, the federal government and states are facing the escalating costs of covering the group of elderly and disabled individuals who are jointly enrolled in Medicare and Medicaid. Funding and eligibility for the two programs differs, as does the provision of benefits. People who are eligible for the two programs at the same time are called “dual-eligible beneficiaries.” “Full-duals” are eligible for full benefits from both programs. “Partial duals” qualify for Medicare but do not meet the eligibility requirement for all Medicaid benefits. In 2009, dual eligibles made up 13 percent of the combined population of Medicare enrollees and elderly, blind, and disabled Medicaid enrollees. But they accounted for 34 percent of the two programs’ total spending on those enrollees.\textsuperscript{17}

**CONCLUDING COMMENTS**
The provision of health care in the United States is a patchwork. Employer-based coverage started during World War II as wage controls prevented firms from raising workers’ wages. Fringe benefits, most particularly health insurance, were exempt from the controls. It was believed that eventually most workers and their families would gain coverage through their employers. As life expectancy rose, concerns about the retired population led to the development of Medicare. Medicaid was added to fill the gap for people who depended on public assistance and therefore lacked employer-based insurance or Medicare.
Medicaid now covers medical care for one-fifth of the US population. The expansion of Medicaid, spurred by the ACA, would further enlarge the program in those states that sign on to the expansion. It is difficult to control costs and provide incentives for efficiency when jurisdiction and funding are shared. Federal contributions to the states are difficult to direct and control because the payments are fungible. The DSH problem arose for that reason. If the federal payments for the ACA expansion are limited to direct payment of medical bills rather than contributions to the states to pay the bills, the potential for cost escalation may be limited. Medicaid is a unique program. It is state administered, involving 50 states each with different demographic characteristics and income levels. The funding mechanism is complex because it is jointly funded by the federal government and the states, with the federal government paying 57 percent of the total. States have a blunted incentive to reduce spending because they lose federal money for every program dollar saved. Medicaid is clearly a challenge to lawmakers who are responsible for the program.

One alternative that has been periodically considered as a way to provide medical care more efficiently to the low-income population is the mechanism of block grants. The welfare reform of the 1990s essentially converted the old AFDC program into block grants for funding and this has proven to be successful. Presumably, under a block grant, Medicaid still would be required to meet appropriate standards of medical care. The particular mode of administering services would be up to the states, which would likely have different approaches tailored to the characteristics of their populations. But the big difference would be that states would have to deal with a monetary ceiling on federal funds, which presumably would spur cost containment.
1. Some people are enrolled for only part of the year. Taking that fact into account, the Congressional Budget Office (CBO) estimates that enrollment over the course of FY2012 was 55 million expressed as full-year equivalents.


3. See the discussion of the DSH episode below.


5. The effective new income limit is 138 percent of the FPL, since in addition to raising the income level to 133 percent, 5 percent of income is disregarded.


7. These tabulations are from the Henry J. Kaiser Family Foundation, “State Health Facts: Status of State Action on Medicaid Expansion decision as of July 1, 2013.”

8. The data on state enrollment and payment rates are from the Kaiser Commission on Medicaid and the Uninsured.

9. Note that the percentage change for all years shown is the percentage change from the previous year.


11. Data for 2010 are reported in US Census Bureau, 2010 Census Summary File 1. Data for 1990 were reported in a US Census Bureau, Census 2000 Special tabulation and 1990 Census of Population Report, nursing home population: 1990 (CPH-L-1371). A special census report of September 27, 2007, also noted the decline in nursing home use among the elderly that was reported widely in the Wall Street Journal, USA Today, and other news briefs.

12. See for example, Bricker, Kennickell, Moore, and Sabelhaus, “Changing U.S. Family Finances from 2007 to 2010: Evidence from the Survey of Consumer Finances,” *Federal Reserve Bulletin* (2012). They find striking change in the age distribution of net worth. The most recent data show that the age group 75 years of age and older now has the highest median net worth.


14. For further discussion of the DSH program, see Theresa A Coughlin and David Liska, *The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues*, Series A No. A-14 (Urban Institute, October 1997).

15. Ibid.


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