Surveying the Landscape: Mountains & Valleys

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The economic crisis of the past several years has placed unprecedented stress on state Medicaid programs as governors and legislators struggle to balance their budgets. In most states, Medicaid represents at least the second largest expenditure of state general fund dollars, and, therefore, inevitably is required to produce cost-savings during economic downturns. Recent enrollment growth, prompted by the recession, has fueled a corresponding growth in expenditures and the program now serves approximately sixty million low-income Americans with total expenditures reaching an estimated $427 billion.

States are always looking for ways to make Medicaid as efficient and cost-effective as possible. During the past several years, these efforts intensified as Medicaid officials had to enact numerous programmatic and administrative changes to reduce costs. Among the most common strategies employed by the states are provider rate reductions or freezes, benefit limits, managed care expansions, delayed program initiatives, and prescription drug limits. Unfortunately, limiting adult dental coverage or eliminating it altogether has been among the budget-balancing actions taken by a number of states, leaving more adults without comprehensive oral health services.

The recent expiration of enhanced federal Medicaid funding states received through the American Recovery and Reinvestment Act (ARRA), lagging state revenues, and continuing enrollment growth are placing even greater fiscal strain on the states. In response, the dialogue of possible actions to further curtail Medicaid spending has changed such that states are now looking at more systemic and fundamental reform strategies.

Despite the stormy waters that Medicaid currently is navigating, there is great energy across the nation toward improving access to oral health services for underserved persons and the role that Medicaid and CHIP can play. There is an unprecedented emphasis on the importance of oral health as a critical component of overall health. Even in the face of severely limited resources, the federal government and many states are pushing forward with new initiatives to increase dental provider availability, utilization of services, and improved quality of care Perhaps even more encouraging is the involvement and partnerships among providers, advocates, payers, philanthropy and policymakers to make oral health a national priority. To ensure ongoing progress in providing optimal oral health to the underserved, it is critical that the current momentum and priority being given to oral health be continued, championed and celebrated.

ECONOMIC WOES & MEDICAID PROGRAM GROWTH

Medicaid is the nation's largest public health insurance program providing coverage in 2010 to more than sixty million low-income persons at an estimated total cost of $427 billion (including enrollment and expenditure of the Children's Health Insurance Program). As enrollment and costs continue to climb, the national debate of how to control Medicaid expenditures is entrenched as a key health policy issue. As one of the costlier federal entitlement programs and the second largest expenditure of state general fund revenues, federal and state government officials remain vigilant in identifying cost containment strategies. While controlling costs is vital to the program's long-term survival, it is important to understand the core reason why the program is so expensive. That core reason relates to the population that Medicaid serves.

Enrollees currently must meet both categorical as well as financial eligibility criteria. Figure 1 illustrates the composition of the Medicaid enrollee population and the corresponding percentage of Medicaid spending that each category of enrollees incurs. As seen below, while the elderly and disabled make up twenty eight percent of the enrollee population, they incur nearly seventy percent of the costs. These individuals, who cannot obtain and/or

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afford coverage in the private market, are the most costly to insure due to their significant health issues. Thus, while every effort must be made to control Medicaid spending, as long as Medicaid is relied upon to do the "heavy lifting" for the health insurance industry (i.e., covering the most frail and costly populations), it will always be an expensive and vitally important enterprise.

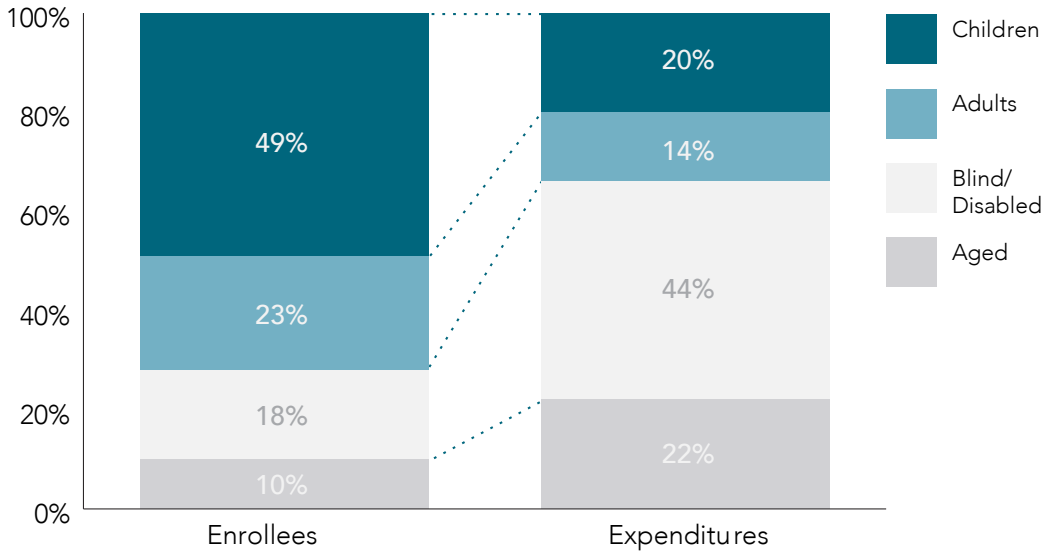
Another driving force that fuels Medicaid costs is enrollment. Due to the countercyclical nature of Medicaid, as the economy worsens, states experience significant enrollment growth and corresponding increases in spending. Between December 2007, and December 2009, an additional 48.7 million persons were enrolled in Medicaid. [Kaiser Commission on Medicaid and the Uninsured. 2011] During recessionary times, states essentially are "double-teamed" by revenue losses and program expenditure increases. A March 2009 article in the *New England Journal of Medicine* reported that for every one percentage point growth in unemployment, there is a corresponding increase of one million persons being enrolled in Medicaid and the Children's Health Insurance Program (CHIP) as well as roughly a $6 million decline in state revenues to support these programs. [Rowland, D. 2009.]

As a result of the recent financial crisis, states experienced a 30.8 percent decline in state revenues between 2008 and 2009; revenues are still below pre-recession levels and growth remains weak in almost all states. The Kaiser Commission on Medicaid and the Uninsured reported in January 2011, that states had to close budget gaps of over $430 billion in fiscal years 2009, 2010, and 2011. For FY 2011, states reported budget gaps of $130 billion. Such startling numbers make it clear why states have struggled mightily in recent years to maintain their Medicaid programs and meet constitutional demands for balanced budgets.

As if the current economic conditions were not enough to challenge even the most creative approaches to maintaining Medicaid viability, states are now having to replace the loss of enhanced funding they had received through the American Recovery and Reinvestment Act (stimulus) to support their Medicaid budgets. Stimulus funding ended on June 30, 2011, and states now must replace a total of $66 billion in federal financing with state revenues. In the face of mounting pressure for cost savings, states have implemented a range of strategies as shown in Figure 2.

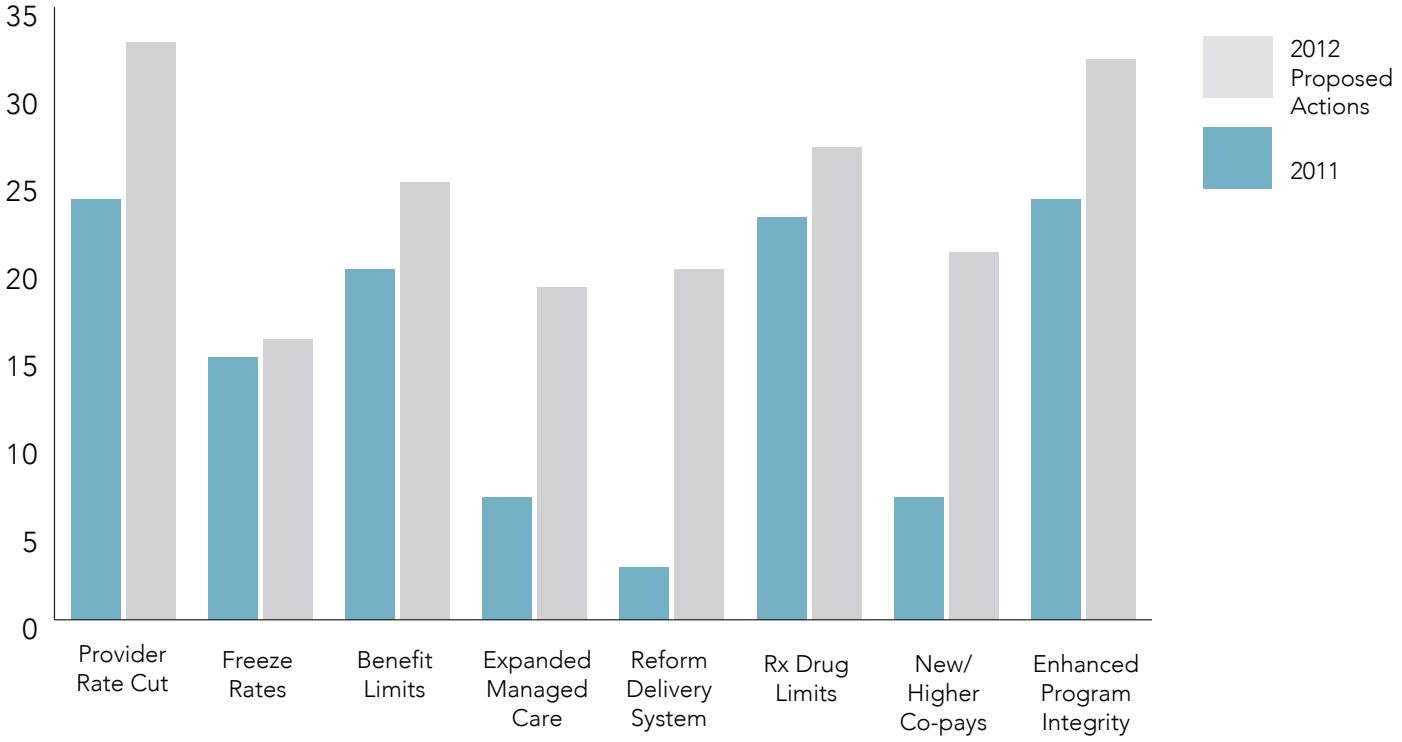
"Maintenance of eligibility" requirements contained in both the ARRA and the Patient Protection and Affordable Care Act (PPACA) have precluded the states from enacting eligibility restrictions to reduce program costs. Instead, states have focused primarily on freezing or reducing provider rates, benefit limits,

Figure 1: Medicaid Enrollment & Expenditures, FFY 2009



Source: Office of the Actuary Centers for Medicare and Medicaid Services. 2010. 2010 Actuarial Report on the Financial Outlook for Medicaid. Baltimore, MD: Centers for Medicare and Medicaid Services.

Figure 2: Medicaid Cost Containment Strategies



Source: Husch B, Cummings L, Mazer S, and Sigritz B. 2011. The Fiscal Survey of States, Spring 2011. Washington, DC: National Governors Association and the National Association of State Budget Officers.

managed care expansions and enhanced program integrity efforts to find savings. Unfortunately, reducing adult dental benefits or eliminating the coverage altogether has been among the benefit cuts that several states, which still offer more than emergency dental services, have put in place. As with most "optional" benefits (i.e., not a federally mandated Medicaid benefit), adult dental services are a frequent target of budget officials in search of savings.

As the weight of continued enrollment growth and depressed revenues have mounted, cost-cutting actions other than those highlighted in Figure 2 have crept into the national dialogue. "Block granting" of federal Medicaid funding has been proposed by the U.S. House of Representatives and a number of Republican governors. Moreover, there have been discussions, albeit preliminary, of potentially eliminating Medicaid altogether.

Despite the concerns over its long-term viability, Medicaid is poised for a significant expansion as the nation moves closer to health care reform. As provided in the PPACA, "categorical" eligibility requirements essentially will be eliminated in 2014 such that anyone with income at or below 133% of the federal poverty level (FPL) will be eligible for Medicaid. As a result, it is estimated that Medicaid enrollment will swell by 16 million persons equaling approximately one-half of the 32 million projected to be newly insured under the PPACA.

Medicaid has played somewhat of a "dual role" during the stressful economic times of the last several years. On the one hand, the burgeoning cost of maintaining Medicaid presents difficult fiscal challenges for federal and state officials. However, the program also has been a lifeline for those persons who lost their jobs (and health coverage) during the recession and became eligible for Medicaid. The program also has provided states a means of insuring and protecting the health and well-being of its citizens hit hardest by the recession.

FINANCIAL STRUGGLES ASIDE, THERE IS GREAT MOMENTUM IN ORAL HEALTH

Despite the deep financial trouble that has enveloped the nation and its health care system, there also has been an unprecedented focus on oral health. Several well-publicized events have clearly identified much needed improvements in our oral health system. The tragic death of Deamonte Driver (a young Medicaid enrollee in Maryland who died from complications of an infected tooth) and Mission of Mercy (MOM) projects (free dental clinics for underserved persons which have shown a bright light on the depth of unmet oral health needs) are constant reminders of how much needs to be done. However, the promising news is that much is happening across the country to respond to these issues.

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There is growing evidence and understanding of the critical relationship between oral health and general health. The impact that oral disease can have on other systems within the body and in exacerbating other health conditions is becoming clearer each day. There is greater awareness of the importance of maintaining good oral hygiene as a means of maintaining an overall healthy body. As a result, initiatives are underway across the nation, including collaborations between medical and dental providers, to provide more holistic and comprehensive care to patients.

In the face of severely limited resources, the federal government and many states are pushing forward with new initiatives to increase dental provider availability, utilization of services, and improved quality of care. The U.S. Department of Health and Human Services launched its Oral Health Initiative in April 2010, to expand oral health services, education and research. Through this initiative, the department is increasing its support of and expanding its emphasis on access to oral health care and the effective delivery of services to underserved populations. In addition, the Centers for Medicare and Medicaid Services (CMS) has developed an Oral Health Strategy aimed at improving oral health access for children enrolled in Medicaid and CHIP. The strategy centers on the establishment of new state and national oral health goals to increase use of preventive services for children. States also are developing new initiatives and strategies for increasing the number of children receiving needed oral health services, some of which are highlighted in other articles in this symposium.

Perhaps even more encouraging is the involvement and partnerships that have developed between providers, payers, policymakers, payers, philanthropy, and advocates to make oral health a national priority. There is a feeling across the country that the time is now for oral health. While there are policy issues about which there is disagreement among various groups, there are a far greater number of issues for which there is agreement and alignment among stakeholders. And, a commitment among stakeholders to address these issues, together, is growing each day. One example is the recent establishment of the U. S. National Oral Health Alliance. Formed in response to the 2009 Access to Dental Care Summit hosted by the American Dental Association, the Alliance provides a new platform for individuals and groups with multiple interests to develop shared solutions that promote optimal oral health through prevention and treatment for underserved children and adults across the country.

Financial and policy challenges in Medicaid and other programs geared toward assisting low-income and underserved persons are perhaps more daunting than ever before. However, in spite of these tough challenges, there is a newfound and growing recognition and enthusiasm for oral health. The energy being directed toward ensuring optimal oral health for all is amping up. To ensure ongoing progress, it is critical that the momentum and priority being given to oral health be continued, championed, and celebrated.

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