State Health Watch

Vol. 10 No. 1 *The Newsletter on State Health Care Reform* January 2003

In This Issue

New political makeup of Congress raises different questions for states

With the political balance of power changing in the nation's capital — Republicans will control the White House, the House of Representatives, and the Senate — an important question for state officials is the impact the change will have on Medicaid and efforts to reform what has become a very expensive program. (**See related story on state budgets, p. 4.**)

While no one can say with any guarantee how things will play out, *State Health Watch* asked a number of observers for their opinions and predictions. Their responses varied from a sense that little would change to an expectation for significant changes in how Medicaid works.

Ray Hanley, Arkansas Medicaid director, who is president of the National Association of State Medicaid Directors, tells *SHW* he doesn't foresee much change.

"The Bush administration has been very flexible on waivers over past years, seemingly trusting states to a much appreciated extent to make Medicaid work better. Hanging over this, however, has been a sense of concern on the federal level about the impact of

*See **Political makeup** on page 2*

Study finds rate of return on tobacco dollars is best when directed to other health programs

Although some states have seen dramatic returns on their investment in tobacco control programs, many are using their tobacco-settlement dollars for purposes other than tobacco control.

Fiscal Fitness: How States Cope

Representatives of Cancer Care Inc. and the CHEST Foundation recently released data showing that some states with among the highest rates of lung cancer are spending the least amount per capita on tobacco-control programs.

Information provided to *State Health Watch* by Spectrum Science Public Relations and the Campaign for Tobacco-Free Kids indicates, based on activities in California, Massachusetts, Oregon, Florida, and other states, that:

- Comprehensive state tobacco-prevention programs that are adequately funded can quickly and substantially reduce tobacco use.
- State tobacco-prevention programs can be insulated against attempts by the tobacco industry to reduce program funding and

*See **Fiscal Fitness** on page 5*

State Health Watch
The Newsletter on State Health Care Reform

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Cover story

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waivers on the federal budget. It's been an interesting balancing act. What may change in the new Congress is movement on a Medicare drug benefit. To the extent of the benefit it may well free up some financial obligations states now incur to provide drugs to low income seniors and the states very much need this relief."

Arizona Sen. Susan Gerard, who chairs the Health Committee in the Arizona Senate, says she expects to see more waivers and opportunities for states to come up with innovative ideas that can be approved. "Arizona already has some of the most innovative waivers, so there shouldn't be much change for us," she says.

Sen. Gerard said that a National Conference of State Legislatures meeting at the end of 2002 included discussion of a prescription drug benefit for the elderly and concern that there would not be much federal financial aid for states. "The feds aren't in that great shape, either," she explains.

Sen. Gerard says states will be most concerned about protecting programs they already have and dealing with their financial crises, rather than thinking about new opportunities. "The big fear is that there will be more federal mandates," she relates. "We're not hearing there will be more money coming, but maybe more flexibility."

Bob Seiffert, Nebraska Medicaid director, foresees little change to Medicaid in the next few years. "Nebraska is projecting that revenue will fall short of traditional spending by more than 10%," he tells *SHW*.

"In my 30 years here, we've never faced anything like this. Except for a handful of states, all of us have the same serious problem."

Mr. Seiffert says he expects that the pattern of expansion and waivers "is likely to come to a screeching halt no matter who controls Congress." He says he suspects that those predicting federal expenditures will find they have overestimated what will be required because states won't be able to meet their matching requirements.

"We hope that as devastating as state budgets have been, the feds may respond," Mr. Seiffert says. "We still don't know how serious the problem really is. We'll have a much better sense in the early months of 2003. That may be the time for discussions about the federal match rate and disproportionate share payments."

Michael Deily, Utah Health Department director of health care financing, was reluctant to predict what might happen in Congress. "I don't know where the Republican majority is coming from," he adds. "States are looking for help with their budget troubles. We're looking for federal relief to help us stay afloat. Congress looks at the deficits as a philosophical/fiscal problem with the states. About the best we can do is sit and wait and watch."

Nikki Highsmith, policy director at the Center for Health Care Strategies in Lawrenceville, NJ, says her organization tries to be of assistance to states without getting caught up in the changing political currents.

"The main cost drivers for Medicaid have been enrollment growth, long-term care, medical inflation, and the cost of prescription drugs," she says. "We've been working with states to develop short-term strategies to cope with these problems. States are struggling with what they can do in the short term

and with how to prepare for some longer-term issues down the road. I think the tension between state flexibility and federal oversight will continue. I particularly expect to see additional flexibility through waivers or demonstration programs in long-term care and dual eligibles."

At the Washington, DC-based Center for Health Services Research and Policy, Colleen Sonosky, assistant director, hears a lot of talk about trying to move Medicaid to more of a block grant approach. "Congress has been looking at the National Governors Association reform proposal and ideas from the Medicaid Commission and various groups in Congress but nothing has happened. However, now that Republicans control both the Senate and the House, there will be discussion of true Medicaid reforms," she says.

Gearing up for a fight

"I think we'll hear a lot about block grants, even if they call it something different. Republicans think that Democrats are gearing up for a fight over block grants, so that's why they may want to call it something different. A lot of people who were involved in the 1995-96 block grant battles are pulling out their old files. The Republicans are trying to learn how the Democrats fought it back then so they can counter the fight now," Ms. Sonosky explains.

Judith Wooldridge, vice president for health research at Mathematica Policy Research in Princeton, NJ, contends the answer to what Congress will do lies in what happens with the nation's economy. "I imagine there will be talk of cutbacks in optional Medicaid services," she says. "I honestly don't know what can be done. The problem affects children even more than adults. I don't expect we'll see much change on the nursing home side; the changes will fall on children and families.

"Philosophically, there may be some interest in making Medicaid simpler. People are uncomfortable with Medicaid being an entitlement. Advocates for Medicaid are not as visible as those for Medicare. But despite the philosophical interest, Medicaid is so complex that not much will happen. And I don't think there is enough of a Republican majority that they can try to do anything really sweeping."

Frank Shafroth, director of federal-state relations for the National Governors Association, says Medicaid "is unsustainable in its current trajectory, but has always faced the competition of standing in line behind Social Security and Medicare. Absent federal action, there are almost certain to be significant cuts in benefits and eligibility by the states. To the extent there is federal action in 2003, it might well be focused on reducing some of the burden on states of the so-called dual eligibles, those 7 million elderly and disabled Americans eligible for both Medicare and Medicaid."

Alwyn Cassil, Center for Studying Health System Change spokeswoman, tells *SHW* that a prescription drug benefit will be a priority for Congress.

"The Republicans campaigned on it and now they have to deliver," she says. "The margin [of political control] is still very narrow, and it's going to take some consensus building just to get a bill. The biggest problem will be finding the money to pay for a plan."

Ms. Cassil says the issue of helping the uninsured also is gaining traction in Congress, with the consensus in the health policy community that the problem of the uninsured is only going to get worse. As far as Medicaid reform is concerned, Ms. Cassil says she wouldn't be surprised at discussions to revisit the idea of block grants, and predicts that Republican governors might push for them. Governors also are likely to seek an enhanced federal match, she predicts, although "you need safeguards because states have shown that they will always try to maximize federal money, for instance through the upper payment level."

Despite a Republican report from a congressional committee in the last Congress making the case for Medicaid reform and outlining possible changes, early reports coming out of congressional offices after the election depict an agenda that doesn't necessarily focus on Medicaid. **(See related story, p. 4.)**

There are indications that the GOP social agenda is likely to include efforts to limit abortions, provide greater support to religious groups, and increase funding for sexual abstinence and fatherhood programs.

Republican Conference chairman Sen. Rick Santorum (R-PA) says the GOP plans to take the country in a "more conservative direction" in the next two years, bringing up a lot of things that conservative groups are interested in seeing considered.

Outgoing Senate Majority Leader Tom Daschle (D-SD) announced at a news conference that Republicans will try to "placate" conservatives, giving Democrats "an opportunity to showcase the difference" between the two parties in preparation for the 2004 elections.

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Big Medicaid cuts may be coming, state officials say

Looking at state budget problems described as worse than the condition of the national economy — worse, in fact, than anything since World War II — representatives of the nation's governors, budget officers, and legislators are predicting significant cuts in Medicaid among other steps to stop the bleeding.

"Any state with a fiscal problem is going to be cutting Medicaid next year," Al Jackson, American Hospital Association vice president for political affairs, told the *Los Angeles Times* in response to the biannual Fiscal Survey of States recently released by the National Governors Association (NGA) in Washington, DC.

That report pointed out that despite significantly curtailing state spending, 37 states still had to reduce their enacted budgets by some $12.8 billion in FY 2002. And nearly midway through the current fiscal year, 23 states told the association they planned to reduce their net enacted budgets by more than $8.3 billion.

No state is immune

Raymond Scheppach, NGA executive director, says no state is immune from the perfect storm-like crisis. "This is a result of a convergence of four major factors that have battered almost every state budget to the point where there just are no easy choices left," he says.

"The combination of long-run deterioration in state tax systems coupled with an explosion of health care costs is creating an imbalance between revenue and spending. To make matters worse, we've had a collapse of capital gains tax revenues added to the overall loss of revenue attributable to economic growth," Mr. Scheppach explains.

Meanwhile, the National Conference of State Legislatures (NCSL) in Washington, DC, weighed in with its own report that said two-thirds of states report declining revenues and more than half face expenditures that exceed levels projected in their current budgets.

> "Spending needs are outpacing projected budget levels, particularly in the area of Medicaid and health care costs."
>
> Bill Pound
> *Executive Director*
> *National Conference of State Legislatures*
> *Washington, DC*

"State legislators face a common problem around the country," says Bill Pound, NCSL executive director. "Spending needs are outpacing projected budget levels, particularly in the area of Medicaid and health care costs. Because most states require a balanced budget each year, these gaps must be resolved by the time state officials close their books; 2003 will certainly be a year of tough policy decisions."

The NCSL State Budget Update found that 33 states reported revenue collections below forecasted levels through October, and 29 states have made revisions to their revenue estimates for FY 2003, with 26 of the 29 lowering their forecast. Thirty-one states reported budget gaps in the early months of the current fiscal year. A $17.5 billion budget gap mostly has developed since the beginning of the fiscal year. Twenty-four states reported that Medicaid or health care programs, which typically account for 15% of the average state's general fund expenditures, are over budget for the early months of FY 2003; 29 states reported that spending is exceeding budgeted levels; and the outlook for the remainder of the fiscal year is bleak, with 38 states concerned or pessimistic about revenue performance and only 10 states (Florida, Hawaii, New Mexico, North Dakota, Rhode Island, Tennessee, Utah, Washington, West Virginia, and Wyoming) reporting a stable or optimistic outlook.

The governors' report showed that as a result of weakness in state tax collections and the stalled national economy, the enacted increase in states' FY 2002 general fund spending is only 1.3% and is expected to grow by the same amount in FY 2003, after growing 8.3% in FY 2001. Medicaid spending grew 13.2% in FY 2002, the fastest rate of growth since 1992.

One-time strategies used up

"To address the severe imbalance between revenues and expenditures," the report said, "states relied heavily on specific strategies to reduce or eliminate budget gaps. In fiscal 2002, 26 states reduced the budget gap by enacting across-the-board cuts and using rainy-day funds, 15 states laid off employees, five states used early retirement, 13 states reorganized programs, and 31 states used a variety of other methods. This trend will continue in fiscal 2003. Many of these budget balancing actions are one-time only and cannot be used again."

The governors say the fiscal situation in states can be seen most clearly in their year-end balances. Total balances in FY 2001, FY 2002, and FY 2003 are $37.8 billion, $17.1 billion, and $14.5 billion,

respectively. "FY 2003 total state balances have plummeted by a spectacular 70% since they peaked in fiscal 2000," the report declared.

One of the most significant causes of state budget woes is the growth in Medicaid expenditures, according to the reports. The NGA said the 13.2% growth in Medicaid spending in FY 2002 stands in sharp contrast to the lack of growth in state revenues experienced in the same fiscal year. And in FY 2003, even with extensive cost-saving efforts, Medicaid appropriations are 4.8% above the previous year's level.

"Based on the continued fiscal pressures," the NGA report said, "all states have either taken action in fiscal 2002 or plan to take action in fiscal 2003 to control Medicaid costs. The most prevalent type of cost containment in both fiscal 2002 and fiscal 2003 is controlling pharmaceutical costs, followed by reductions or limits to provider payments." The NGA quoted a report from the Kaiser Commission on Medicaid and the Uninsured, which found that in FY 2003, 40 states plan to implement pharmacy controls, 29 states plan to implement reductions or freezes in provider payments, 15 states plan to reduce Medicaid benefits, and 18 states plan to restrict eligibility.

Another major component of state fiscal problems, and one not heard about nearly as much as Medicaid, is spending for state employee health coverage. The NGA said that an analysis by the Center for Studying Health System Change found that insurance premiums nationally increased by 11% in 2001 and are estimated to go up by 13% in 2002.

Looking to Washington for relief

Mr. Scheppach said the governors are supporting legislation in Congress that could help relieve the budget pressure on states. In particular, a bill proposed in the last session by Sens. Ben Nelson (D-NE), Susan Collins (R-ME), and John Rockefeller (D-WV), and passed by the Senate in July, would have provided $9 billion in fiscal relief to states through a combination of social services block grants and increased federal Medicaid funds.

A $5 billion version was included in a Medicare-giveback bill that was negotiated by Sens. Charles Grassley (R-IA) and Max Baucus (D-MT) but never made it out of the Senate Finance Committee. Any legislation would have to be reintroduced in the new session of Congress this year and would be affected by the shift in the political balance of power in Congress. "The fiscal relief package is an effective means of minimizing Medicaid cuts and would help offset the negative impacts of state budget cuts in the overall economy," Mr. Scheppach says. He also called on Congress to appropriate $3.5 billion for first responders for homeland security and to fund implementation of election reform legislation early in the new session.

But many independent analysts are expressing doubt that much help will be coming from Washington. According to the *Los Angeles Times*, Kenneth Finegold, Urban Institute senior research associate, said, "The general picture is, don't count on anything from the feds, because the federal government now has a deficit, and it also has other priorities besides health care. National security and tax cuts are priorities of this administration, and balancing state budgets is not."

[Get information from the NGA at (202) 624-5300 or on-line at www.nga.org and information from the NCSL at (202) 624-8667 or on-line at www.ncsl.org.] ■

Fiscal Fitness

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otherwise interfere with their successful operation.

- Program funding must be sustained over time to protect initial tobacco-use reductions and achieve further cuts.

A report from California, which in 1988 enacted Proposition 99 to increase cigarette taxes by 25 cents per pack, showed 20% of the new revenues earmarked for health education against tobacco use. Analysts say that despite increased levels of tobacco marketing and promotion, a major cigarette price cut in 1993, tobacco-company interference with the program, and periodic cuts in funding, the program still has reduced tobacco use substantially.

Since passage of Proposition 99, cigarette consumption in California has declined by more than 58%, compared to 33% in the country as a whole. In the 10 years following voter approval of Proposition 99, adult smoking in the state declined at twice the rate it declined in the previous decade. And from 1994 to 2000, smoking among those ages 12 to 17 declined by 35%.

In a similar program in Massachusetts, cigarette consumption declined by 32% between 1992 and 1999. Florida used tobacco-settlement funds for a program targeted to young people that in three years has seen smoking among middle-school students decline 47% and among high-school students by 30%, resulting in almost 75,000 fewer youth smokers. However, the governor and Legislature have cut funding for the program in every year since its inception, and for the first time, no statistically significant decline in smoking was observed between 2000 and 2001. Even more of a concern is the fact that

increases in smoking between sixth and seventh grades and between seventh and eighth grades reached record high levels in 2001.

But despite this evidence that tobacco prevention efforts are successful in reducing tobacco use, and despite the assumption that reduced tobacco use will have a positive impact on health care costs down the road, many states simply are not taking advantage of the money coming to them from the multibillion dollar tobacco Master Settlement Agreement to implement and maintain programs in their states.

Agreement's promise unfulfilled

"The states are missing a tremendous opportunity to save lives," says Peter Bach, MD, a pulmonologist and epidemiologist associated with New York City's Memorial Sloan-Kettering Hospital, who was lead investigator on a study of state expenditures of settlement funds for tobacco control programs published in the Oct. 3, 2002, *New England Journal of Medicine*. "The agreement is not living up to its promise and most states are spending far less money on tobacco control than was recommended by the CDC [Centers for Disease Control and Prevention]." **(See chart, pp. 7-8.)**

Cancer Care Inc. and the CHEST Foundation analyzed the findings in Mr. Bach's study and reported that the 10 states with the highest rates of lung cancer from 1994 to 1998 among men and women averaged $1.93 per capita and $2.67 per capita in spending on tobacco-control programs, respectively. The CDC's recommendations to states range from $5 to $15 per capita per year for smoking-control programs, with a mean of $7.47.

His article noted that the agreement specifically states that one of its goals was to support "tobacco-related public health measures." As a result, he says, it had been hoped that states would invest a considerable proportion of their settlement revenue in comprehensive tobacco-control programs.

Because previous reports failed to take into account the fact that some states fund tobacco-control efforts from other sources, Mr. Bach and colleagues used a cross-sectional analysis to assess overall state expenditures for tobacco-control programs in the context of other state economic and health data. The results were disappointing for those hoping the settlement would be used to reduce smoking.

Mr. Bach found a mean expenditure on tobacco control of $3.49 per capita in 2001, with most states investing far less than the CDC recommended. Only six states exceeded the CDC recommendations. "State governments in aggregate distributed roughly $6.5 billion in settlement funds in 2001," he reports. "Approximately 6% of these funds were devoted to tobacco-control programs. In aggregate, health care expenditures made up approximately 41% of the total state settlement allocations; long-term care and medical research received 3% and 4% respectively; tobacco-growing communities received about 5%; and more than one-third of the funds were distributed to other non-health-related programs such as education, child and adolescent services, budget reserves, and miscellaneous programs. States with higher smoking rates had significantly lower expenditures for tobacco-control programs.

"This finding persisted even after tobacco-producing states were excluded from the analysis. Funding for tobacco-control programs also showed a trend toward an inverse correlation with the rate of smoking-related deaths." Mr. Bach says that in trying to identify state characteristics associated with use of settlement funds for tobacco control, they found that legislatures in tobacco-producing states tended to devote a lower proportion of settlement revenue to tobacco-control programs than did legislatures in other states. There was no relation between the proportion of settlement funds allocated to tobacco-control programs and various measures of tobacco-related health burden such as smoking rate, smoking-related mortality or morbidity from lung cancer, or smoking-attributable Medicaid expenditures.

The inverse correlation between state smoking rates and funding of tobacco-control programs is of serious concern, according to Mr. Bach. "A possible explanation for this finding is variability in the local tobacco culture among states," he says. "We found that tobacco-producing states were investing less than half as much in their tobacco-control programs as other states. Political and economic concerns may make it less attractive for lawmakers to support tobacco-control programs in these states."

Even when tobacco-producing states were excluded from the analysis, the inverse relation between smoking rates and funding of tobacco control programs persisted, suggesting that state tobacco production is not the sole explanation for the finding. Another possible explanation is that states with higher funding levels now have lower smoking rates as a result of their programs, but Mr. Bach says this explanation is unlikely given that most state tobacco-control programs are relatively new and that their effect is thought to be incremental, increasing over several years.

While some may argue that investment of settlement funds in nonhealth-related programs is

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Listing of Lung Cancer Rates and Spending on Tobacco-Control Programs

State	Lung Cancer Rates Among Men*	Lung Cancer Rates Among Women*	CDC Lung Cancer Rates Among Men**	CDC Lung Cancer Rates Among Women**	Tobacco Control Programs			
					Expenditures Per Capita***	CDC Recommended Amount**	Revenue Per Capita***	Total Revenue Amount***
Alabama	84.5	35.8	n/a	n/a	$0.30	$6.19	$21.81	$97,000,000.00
Alaska	74.9	52.6	43	42.5	$4.01	$13.27	$33.82	$21,200,000.00
Arizona	66.8	41.8	69.5	52	$7.32	$6.10	$17.09	$87,700,000.00
Arkansas	n/a	n/a	n/a	n/a	$0.58	$7.10	$19.23	$51,400,000.00
California	65.8	43	54.3	47.2	$3.44	$5.12	$22.41	$759,200,000.00
Colorado	56.9	35	47.3	38.4	$3.32	$6.31	$19.76	$85,000,000.00
Connecticut	75.4	48.5	81.1	63.9	$0.30	$6.50	$32.42	$110,400,000.00
Delaware	95.4	57.4	100.4	70.8	$4.61	$11.80	$29.99	$23,500,000.00
District of Columbia	98.1	45.5	105.7	60.6	n/a	n/a	n/a	n/a
Florida	91	53	120.7	87	$2.49	$5.35	$45.76	$731,300,000.00
Georgia	72.8	33.5	n/a	n/a	$2.19	$5.69	$18.69	$152,200,000.00
Hawaii	59.5	30.6	67.3	44.9	$10.82	$9.08	$29.65	$35,800,000.00
Idaho	60.8	36.4	57.7	41.5	$1.75	$9.13	$17.39	$22,500,000.00
Illinois	85.3	46.2	81.7	58.8	$2.26	$5.46	$23.25	$288,700,000.00
Indiana	85.8	44.1	n/a	n/a	$6.05	$5.93	$17.52	$106,500,000.00
Iowa	80.8	40.3	88.1	56.1	$3.52	$6.78	$18.42	$53,900,000.00
Kansas	n/a	n/a	82.6	58.4	$0.83	$6.96	$19.23	$51,700,000.00
Kentucky	121.7	58.5	120.7	77.6	$0.84	$6.42	$25.98	$105,000,000.00
Louisiana	101.3	45.3	96.3	53.9	$0.37	$6.23	$31.33	$140,000,000.00
Maine	n/a	n/a	n/a	n/a	$15.47	$9.01	$37.10	$47,300,000.00
Maryland	88.7	51.2	75.7	58	$4.05	$5.95	$26.47	$140,200,000.00
Massachusetts	76.4	47.9	81.9	68.4	$10.25	$5.76	$37.83	$240,200,000.00
Michigan	86.4	48.6	82.7	61.2	$0.66	$5.61	$26.05	$258,900,000.00
Minnesota	62.8	37	64.3	47.4	$4.92	$6.11	$68.50	$337,000,000.00
Mississippi	84.1	33.5	n/a	n/a	$12.82	$6.88	$74.21	$211,100,000.00
Missouri	95.6	51.6	98.5	67.2	$0.43	$6.07	$25.40	$142,100,000.00
Montana	71.3	45.5	74.4	55.7	$4.85	$10.65	$29.04	$26,200,000.00
Nebraska	73.9	36.8	73.1	51.3	$4.83	$8.03	$21.56	$36,900,000.00
Nevada	80.1	58.3	n/a	n/a	$0.59	$8.04	$18.92	$37,800,000.00
New Hampshire	77	49.5	70.9	61.6	$3.29	$9.28	$35.04	$43,300,000.00
New Jersey	78.7	46.4	80.1	64.5	$3.80	$5.60	$28.50	$239,800,000.00
New Mexico	52.8	31.4	50.8	36.2	$1.89	$7.93	$20.34	$37,000,000.00
New York	75.7	44.9	73.9	59.2	$1.74	$5.28	$39.75	$754,300,000.00
North Carolina	93.9	41	89.8	56.1	$0.32	$5.74	$17.73	$142,700,000.00
North Dakota	64.1	35.2	68.6	43.1	$1.71	$12.73	$35.35	$22,700,000.00
Ohio	83.8	47.1	94.3	63.9	$0.13	$5.52	$27.52	$312,400,000.00
Oklahoma	n/a	n/a	n/a	n/a	$0.59	$6.58	$18.63	$64,300,000.00
Oregon	72.7	49.7	80.5	68.2	$2.71	$6.51	$19.96	$68,300,000.00
Pennsylvania	82.6	43.1	98.3	66.7	$0.10	$5.46	$27.83	$341,800,000.00
Rhode Island	91.4	53.3	103.4	78.9	$3.03	$10.01	$42.54	$44,600,000.00
South Carolina	87	40.4	97.1	49.9	$0.78	$6.36	$18.20	$73,000,000.00

State	Lung Cancer Rates Among Men*	Lung Cancer Rates Among Women*	CDC Lung Cancer Rates Among Men**	CDC Lung Cancer Rates Among Women**	Tobacco Control Programs			
					Expenditures Per Capita***	CDC Recommended Amount**	Revenue Per Capita***	Total Revenue Amount***
South Dakota	n/a	n/a	n/a	n/a	$5.15	$11.77	$28.62	$21,600,000.00
Tennessee	n/a	n/a	n/a	n/a	$0.24	$6.00	$26.61	$151,400,000.00
Texas	87.1	43.4	n/a	n/a	$0.59	$5.31	$46.72	$974,200,000.00
Utah	35.6	19	28.8	17.2	$2.46	$7.40	$12.36	$27,600,000.00
Vermont	n/a	n/a	n/a	n/a	$12.58	$13.42	$40.24	$24,500,000.00
Virginia	75.9	38.6	n/a	n/a	$2.82	$5.77	$17.91	$126,800,000.00
Washington	73.5	50.3	72	58.5	$3.08	$5.94	$21.61	$127,400,000.00
West Virginia	104.4	54.6	133.6	87.3	$4.31	$7.80	$30.41	$55,000,000.00
Wisconsin	74.3	42.9	75.5	51.2	$4.09	$6.03	$22.97	$123,200,000.00
Wyoming	61.3	39.5	59.7	48.6	$5.62	$15.39	$29.97	$14,800,000.00

* Source: "Cancer Facts & Figures 2002," American Cancer Society. *Note: Rates are per 100,000 people from 1994-98.*

**Source: "United States Cancer Statistics: 1999 Incidence," Centers for Disease Control. 2002. *Note: Rates are crude rates per 100,000 from 1999.*

***Source: *New England Journal of Medicine*, Oct. 4, 2002. *Note: All per capita tobacco-control program expenditures are 2001 Tobacco-Settlement Revenue.*

appropriate because the settlement income is meant to replace funds that would have been spent on nonhealth-related programs but had to be diverted to health programs to treat tobacco-related illness; in fact, tobacco-related illnesses represent more than a financial drain on state budgets, because state citizens suffer directly from the effects of tobacco use on their health, economic, and functional status.

CHEST Foundation president Diane Stover, MD, says there will be 170,000 people diagnosed with lung cancer this year and that 92% will die of it. Lung cancer is becoming more of a woman's disease, she says, with more women dying from lung cancer than from breast cancer. Direct medical costs for all lung cancer patients are estimated at $80 billion annually, with an additional $58 billion going to indirect costs.

Ms. Stover explains that with 87% of all lung cancers related to smoking and more than 50% of those now diagnosed with the disease indicating they are former smokers, there is a great need for prevention activities. Prevention should be targeted first, she says, to preventing children and adults from starting to smoke, then to smoking-cessation efforts, and finally to research on drugs that can prevent problems in high-risk people.

"We hope that by presenting our analysis of the *New England Journal of Medicine* data to states, they will see the need to bring more money to the prevention and control programs, where it should be," she adds. "We need to put more money into taking the stigma away from smoking and emphasizing that smoking and nicotine addiction are chronic life-threatening diseases."

Cancer Care executive director Diane Blum reports that Pennsylvania spends the least — 10 cents per capita per year — on control programs, even though its citizens have one of the highest smoking rates. States with the highest spending on control are Hawaii, Maine, Massachusetts, Mississippi, and Vermont. "We're urging the states to make a commitment to use the settlement money for prevention and treatment," she says. "When funds are invested in smoking control, the rate of return far exceeds that received when funds go to other health programs."

[To download information on the study, go to: www.lungcancer.org. Contact Mr. Bach, Ms. Stover, and Ms. Blum through Michelle Tuohey or Amanda Hutchison at Spectrum Science Public Relations. Telephone: (202) 955-6222.] ■

Advocacy group gives U.S. a 'C' in dental care

Oral Health America, a nonprofit advocacy group that develops, implements, and facilitates nationally focused educational, informational, and service programs designed to improve oral health, gave the United States an overall grade of C in oral health for 2001, saying it "signifies new possibilities for the future as well as widespread unmet needs."

The components of the total score break down as follows: B+ for oral health leadership (dental directors and oral health coalition); C+ for oral health status (oral health of children, use of spit tobacco, elderly who have lost all their teeth, and oral cancer mortality rates); C for prevention (fluoridation and sealants), and C- for access to care (availability of dentists, children's Medicaid dental program, visits to dentists, and dental insurance status of adults and elderly).

"As the states and the nation, as a whole, work to improve the health care system, it is important to remember that good oral health is a major contributor to good overall health," Oral Health America stated in its report. "Dental disease can threaten a child's health, well-being, and achievement. (**See related story on children's dental health, p. 10.**) Children with oral health problems can have difficulty eating and sleeping and paying attention in school. In addition, researchers are exploring links between adult oral disease and diabetes, heart disease, stroke, and pre-term, low birth weight babies." (**See related story on dental health of the elderly, below.**)

The report cited statistics that we often don't hear: More than 108 million U.S. adults and children have no dental insurance; for every

Oral health for older Americans is becoming a 'national crisis'

While there may be some bright spots in improving dental care for children (**see related article, p. 10**), Louisiana state dental director Gregory Folse, MD, a clinical assistant professor at the Louisiana State University School of Dentistry in New Orleans, says he currently sees very little opportunity for improvement in what is a national crisis for older Americans.

Not too many years ago, he tells *State Health Watch*, it just was assumed that people would lose all their natural teeth as they grew older. Only 12 years ago, he says, 60% of his nursing home patients had no teeth. Now, however, dentists like Mr. Folse who treat the elderly and disabled in nursing homes are finding that only 40% of patients are without teeth.

"Dentistry has done a good job in helping people keep their teeth," he says. "The dilemma has now become how do we maintain those teeth through the aging process?" As people age and loose function [through arthritis, a stroke, financial concerns, etc.] their daily oral hygiene suffers, resulting in serious and unnecessary oral disease. Many Americans are suffering from poor oral health as we speak, and much of the disease goes untreated for several reasons."

Mr. Folse tells *SHW* that as he talks to groups explaining his concern, they experience the "forehead slap syndrome," slapping their heads in recognition of something they hadn't thought about until he and other advocates bring it to their attention. "Although it's a problem that policy-makers haven't thought about," he explains, "it's huge and getting bigger every year. As bad as the problem is for children, you can quadruple it for the elderly. At least with kids there is a mandated Medicaid system [EPSDT] for oral health, even if it doesn't always work that well. But there's no dental access for the elderly under Medicaid in about 30 states. I see some opportunity for improvement in children's oral health, but I see very little opportunity for aging Americans."

The problem, Mr. Folse says, is that dental care for the elderly hasn't been a priority, even though expectations have changed. People have moved from expecting to lose all their teeth to expecting to retain their teeth and to have access to the care that they need. But services have not kept pace with expectations.

"The majority of the elderly I treat don't like to complain very much," he says. "If you don't have any hope for care, you don't ask for anything."

One bright spot he cites in a generally bleak landscape is the Minnesota Medicaid program's adult dental services. "The system isn't perfect," he says, "but conceptually it puts value on adult oral health. The state agency and politicians recognize a need to invest in good oral health for the elderly and have refused to nickel and dime the situation. An increased awareness of the problem has caused action and allowed reform to take place."

[Contact Mr. Folse at (337) 235-1333.] ■

child without medical insurance, there are 2.6 without dental insurance; poor individuals are less likely to visit a dentist than the nonpoor in any given year; tooth decay is the most common chronic disease, affecting 50% of first-graders and 80% of 17-year-olds; every year more than 30,000 people develop oral and throat cancer; oral/throat cancer is the sixth most common cancer in U.S. males and the fourth most common cancer in black men; and almost 2.5 million days of work are lost each year due to dental problems.

A step forward

A positive step cited by the group is the fact that a number of states have hired dental directors, signifying "an important step toward supplying vital leadership at the state level." Oral Health America said that too many low-income people lack access to care and that too few communities have taken advantage of cost-effective prevention measures. Many children and older Americans have gone too long without adequate dental care. The group says it hopes that opinion leaders, public advocates, policy-makers, and the media will note the shortfalls and work to support existing infrastructure and programs to improve and promote oral health across the country.

Recommended strategies include broadening insurance coverage for children, adults on Medicaid, elderly, and special populations; supporting dental services and education for vulnerable populations; developing accessible oral health services; and using known disease-prevention measures.

(To learn more about the Oral Health America report card and programs to overcome deficiencies, go to: www.oralhealthamerica.org.) ■

Too many children have too much oral disease

While many children in the United States enjoy remarkably good oral health according to Burton Edelstein, founding director of the Children's Dental Health Project of Washington, DC, and director of the Division of Community Health at the Columbia University School of Dental and Oral Surgery, there remains a significant problem in a subset of the nation's children.

"We have a reasonably firm estimate that 4 million to 5 million kids suffer dental disease bad enough that they have functional impairments from dental pain like not sleeping well, not eating well, problems attending to schoolwork, or problems just getting along with other people," Mr. Edelstein tells *State Health Watch*. "Tooth decay is the most prevalent childhood disease — five times more common than asthma, according to the U.S. surgeon general. But 80% of the tooth decay occurs in 20% of the kids. And 25% of that 20% have really extensive disease. What hurts is that we know that this disease is overwhelmingly preventable."

There is a delivery issue, according to Mr. Edelstein, in that the children with the highest levels of disease have the lowest level of treatment, primarily those covered by Medicaid and the State Children's Health Insurance Program or not covered at all. "Medicaid is essentially dysfunctional in a majority of the states in terms of delivery of dental services to children. CMS' [the Centers for Medicare and Medicaid] most recent data show that in 32 states, less than 30% of covered kids received a dental visit in a year's time," he says.

"And that's true even though dental care is required under [Early and Periodic Screening, Detection, and Treatment]," he adds.

A related public health problem, Mr. Edelstein says, is inadequate delivery of prevention services, including an inadequate general availability of fluoride and less than optimal delivery of sealants. "Politically, this issue has traction, There is concern from key policymakers and organizations like the National Governors Association and National Conference of State Legislatures," he says.

At a June 25 hearing of the U.S. Senate's Health, Education, Labor, and Pensions Committee, Arkansas' director of the Office of Dental Health, Lynn Mouden, called for approval of the Children's Dental Health Improvement Act of 2001. Mouden said there is an oral health crisis in this country because to date, oral health has not been a national priority. "Unfortunately, we live in a country where decision makers and insurance companies have decided that health care ends at the neck. For some reason, dental, mental, and vision seem to be in a different category than the rest of the body. We will never achieve optimum oral health until we correct those beliefs," she stated at the hearing.

Ms. Mouden reported that more than 40% of Arkansas children attend school with untreated cavities and one in 12 have emergency dental needs. "Insufficient funding of Medicaid continues to plague Arkansas. Arkansas Medicaid pays approximately 50% of a participating dentist's usual fees. In a profession where overhead typically is 70% of income, it is amazing that dentists are put into the unique position of having to subsidize their services by providing dental care at less than cost. And increased funding for Medicaid is not the whole

answer, because dentistry's commitment to the underserved is well documented. In Arkansas alone, dentists donate more than $8 million each year in free dental care. It is often the bureaucratic barriers that can make participation in Medicaid an administrative nightmare for dentists, most of whom are in solo private practice."

Ms. Mouden said the Children's Dental Health Improvement Act of 2001 (SB 1626 and HR 3659) would provide grants to states to improve Medicaid programs and to address issues of training, public health, and service delivery. It also contains an initiative to support oral health promotion and disease prevention. The bill is gaining bipartisan support in Congress and a House hearing is expected early in the next Congress.

Mr. Edelstein tells *State Health Watch* that in some states, positive actions are being taken. In Washington, for instance, a group of concerned dentists, dental educators, public health agencies, the state dental association, the Washington Dental Foundation, and state Medicaid representatives developed the Access to Baby and Child Dentistry (ABCD) program that focuses on preventive and restorative dental care for Medicaid-eligible children from birth to age 6. Under the program, dentists are able to receive enhanced reimbursement for selected Medicaid preventive service codes for enrolled children by receiving continuing education in early pediatric dental techniques. In addition, dental office staff are trained in communications and culturally appropriate follow-up with client families, and enrolled families are coached in the need for early and preventive dental care and appropriate behavior in dental offices, including the need to keep appointments. Organizers say the education and support encourages dentists in private practice to increase their commitment to expanding dental access in the community.

According to the ABCD web site (www.abcd-dental.org), for such a program to succeed, states need a supportive Medicaid program able to pay the enhanced dental fees and contract with a local government agency to draw down federal match funds for program operations; a local dental society and state dental association that will encourage its members to participate; a dental school pediatric dentistry department willing to develop and deliver the training, certification, and ongoing monitoring of dentists; a local government entity to provide outreach and case management and be eligible for federal matching funds; an oversight task force of representatives from each of the involved entities; and support of a community oral health coalition and other child health advocates who recognize a need for action.

States that are operating successful programs on their own, according to Mr. Edelstein, include Michigan, with a multicounty demonstration contract with a managed care vendor that intends to make the program equal to high quality private care; South Carolina's payment of market rates to dentists; Tennessee, in which TennCare carved children's dental care out of managed care to a single administrative-services-only vendor; and Indiana, which was the first state to pay market rates. he reports that Indiana hasn't been able to continue indexing its rates, however, and thus access has stagnated. Other states making progress are Alabama, Georgia, and Delaware.

On another front, the Reforming States Group, supported by Milbank Memorial Fund, has proposed a public-funded dental insurance program for states that targets children in need and takes full advantage of prevailing dental financing and delivery systems in the context of SCHIP. Backers say the program would promote access to continuous primary dental care; encourage dental provider participation; assure accountability without undue administrative burden; achieve more cost-effective use of resources; target higher-needs children; provide comprehensive dental care; and lead to improved oral health outcomes.

There would be coverage for four levels of dental treatment that children need: diagnostic, preventive, and disease management services; basic restorative care; advanced restorative care; and catastrophic care.

Actuarial studies say estimated costs for the proposed program are approximately $14.50 per enrolled member per month for direct services and $2.50 per member per month for administrative costs.

"The United States public spends 25% to 30% of its child health care dollars on oral health," Mr. Edelstein says. "But Medicaid nationally spends only 5% on dental care, and if nursing home expenditures are included, the figure drops to something like 0.5%."

In one of the last actions of the Clinton administration, then Timothy Westmoreland, Medicaid

director issued a letter to state Medicaid directors on Jan. 18, 2001, quoting a surgeon general's report on children's dental health that said that "Medicaid has not been able to fill the gap in providing dental care to poor children. Fewer than one in five Medicaid-covered children received a single dental visit in a recent year-long study period." Mr. Westmoreland said the agency intended to review state actions in four areas: outreach and administrative case management for children, adequacy of Medicaid reimbursement rates, increasing provider participation, and claims reporting and processing. States also were asked to submit a plan of action for improving children's access to oral health services. Although action on that letter seems to have stalled in the new administration, advocates hope that its intent will be revived.

Mr. Edelstein says that even in a time of state budget problems, there are things states can do to help address the problem:

- simplify Medicaid dental program administrative requirements on dentists;
- ensure that existing "enabling services" such as transportation and follow-up extend to dental care;
- conduct small demonstration projects that can be expanded when the economy improves;
- implement coordinated efforts through active coalitions such as Washington's ABCD program;
- develop plans for a significant reform effort when an opportunity occurs.

[Contact Mr. Edelstein at (202) 833-8288. To download the Milbank Reforming States Group proposal, go to: www.milbank.org/reports/990716mrpd.html. To download the Westmoreland letter, go to: www.cms.gov/states/letters/smd118a1.pdf.] ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Report: Children don't get enough mental health care

BOSTON—Children's mental health services are in crisis, according to a report that found more than one-third of kids are forced to wait more than a year for treatment as often as they need it. "This survey documents how children in Massachusetts are falling through the cracks of mental health services,"' said Rob Restuccia, executive director of Health Care for All, which helped conduct the survey of 300 families who have sought mental health care for their kids. The survey, funded by the Blue Cross/Blue Shield Foundation of Massachusetts, also found that nearly half of the children had showed signs of mental health problems by age 4; almost half of pediatricians rarely or never asked about children's mental health needs; and about one-third of kids' mental health crises occurred at school, where officials were often unprepared to deal with them. Nearly half of respondents said their child's main mental health provider was not at all accessible or only somewhat accessible after regular office hours.

—*Boston Herald*, Nov. 22, 2002

This issue of *State Health Watch* brings you news from these states: