Federal Medicaid Cuts Threaten State Dental Benefits: Lessons from 6 States

72.1 million people rely on Medicaid for their health care. The program is also a critical lifeline to dental care for people with disabilities, children, older adults, and families with low incomes. Whether through work requirements, provider taxes, or other limitations on federal Medicaid spending, Medicaid cuts currently being considered by Congress are likely to back states into a corner, forcing them to reduce or eliminate Medicaid adult dental benefits (MADBs) along with other "optional" services.

In recent years, several states have made changes to their MADBs, offering valuable insight into how the loss of coverage impacts access to dental care, emergency room (ER) use, and overall health systems costs. Looking at examples from six states serves as both a cautionary tale about the consequences of cutting MADBs and offers critical perspective on the importance of dental coverage as well as the health and economic benefits of restoring access to dental care.

Cuts to Medicaid Adult Dental Benefits Restrict Access to Care

MADBs improve access to and use of dental care for low-income communities and also support financial stability - people with Medicaid dental benefits spend hundreds of dollars less per year on dental care. Lessons from several states show that when these critical benefits are cut, access to dental care declines significantly.

For example, when **Oregon** made changes to its Medicaid program that eliminated dental benefits for some low-income adults, those affected were less likely to have an annual dental visit and had more unmet dental care needs. Similarly, the elimination of MADBs in **Massachusetts** resulted in 100,000 fewer adults receiving dental services; adults with Medicaid coverage were half as likely to receive dental services after the benefits were cut.

Cuts to Medicaid Adult Dental Benefits Shift Costs

When states face budgetary challenges, optional Medicaid services like adult dental benefits are often among the first to be cut. While these cuts are intended to reduce spending, experiences from several states show that eliminating or reducing MADBs often simply *shifts* costs from one part of the health care system to others. In many cases, ***when MADBs are cut, limited access to dental care leads more people to seek treatment in ERs,*** which are ill-equipped to meet oral health needs. Critically, ERs are also a much more expensive site of care, ultimately costing the health care system more than it would

spend to provide high quality, preventive services in dental settings. On average, a dental ER visit costs about $750, three times more than visiting the dentist. These costs add up, with dental-related ER visits costing the health care system $1.6 billion annually, about $533 million of which is paid for by Medicaid.

For example, MADB cuts in **Oregon** resulted in increased per-person spending on ER dental care. In **California**, eliminating MADBs led to an increase in dental-related ER use among people with Medicaid, even as overall ER use declined. This policy change resulted in nearly 2,000 additional dental ER visits and a 68% increase in costs. Similar effects were observed in other states: in **Maryland**, the elimination of Medicaid reimbursement for adult dental services led to a 21% increase in dental-related ER visits, despite a decrease in overall ER visits among people covered by Medicaid. In, **Pennsylvania**, spending on ER dental care has increased by more than 60% since the state cut MADBs in 2011.

While ERs are a common site where cost shifts occur following MADB cuts, these policies also affect a state's broader dental safety net. Cuts often drive more patients to seek care at Community Health Centers (CHCs), increasing uncompensated care costs. Following MADB cuts in **Oregon**, affected individuals not only sought dental care in ERs, but were also more likely to use both emergency *and* non-emergency medical settings for dental problems, further demonstrating how cuts to dental benefits redistribute, rather than reduce, health care costs.

Other states have had similar experiences. After **Missouri** implemented steep Medicaid cuts, including to MADBs, CHCs struggled to maintain financial sustainability as patients continued seeking needed dental care in the absence of available Medicaid reimbursement for those services. Similarly, after MADB cuts in **California** and **Massachusetts,** costs in both states were shifted to other care settings, including CHCs. In **Massachusetts**, private dentists, who had provided the vast majority of dental care for adults with Medicaid, experienced a 14% drop in Medicaid reimbursements. These cuts hurt private dentist revenue while also straining the capacity and financial sustainability of CHCs, which experienced an influx of patients who had previously accessed care in private settings.

Cutting MADBs also often leads dental providers to leave the Medicaid network, worsening existing provider shortages and constraining access for children and others who maintain Medicaid coverage. These provider shortages create long-term access issues, as provider re-enrollment is difficult even if MADB are restored. In **Massachusetts**, there was a substantial reduction in dental providers participating in Medicaid after MADBs were cut.

State Experiences Show the Need for Improved Coverage, Not Cuts

State experiences clearly show that any potential short-term savings derived from MADB cuts are far outweighed by long-term harms. Put simply, these cuts are not worth it. In both **Oregon** and **California**, initial "savings" derived from cuts to MADBs were quickly offset by increased ER costs and ***MADBs were ultimately restored in both states***. **Massachusetts** expected to save about $30 million annually by eliminating MADBs; however after taking into account loss of federal matching funds, state "savings"

from the MADB cuts constituted less than one percent of total state Medicaid spending. **Pennsylvania** similarly expected to save $18.9 million by cutting MADBs; instead, the state currently spends $35 million per year on dental-related ER visits. When **Massachusetts** partially restored MADBs in 2013, dental-related ER visits decreased by 16% within five months.

The evidence from multiple states is clear: cutting MADBs undermines access to essential care, shifts costs to more expensive and less appropriate health care settings like ERs, and destabilizes both dental care providers and CHCs. Far from generating meaningful savings, these cuts often result in higher system-wide costs and worse health outcomes. MADB cuts force people to make impossible choices: forgoing care they need or going into debt to pay for it. Going without needed care worsens oral health problems, which in turn makes it more difficult for people to find a job and leads to missed days of school and work. Conversely, having dental coverage yields widespread health and economic benefits: access to dental care can improve employment outcomes and increase earning potential.

As Congress considers changes to federal Medicaid spending, the experiences of these six states offer a powerful warning: reducing or eliminating MADBs is a short-sighted decision that harms patients, burdens health systems, and ultimately costs more in the long run. Instead of pursuing cuts, policymakers should focus on protecting adult dental coverage to ensure access to care and promote both individual and systemic health and financial stability.