The Economist

Health care

A new prescription for the poor

America is developing a two-tier health system, one for those with private insurance, the other for the less well-off

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"IT'S time for Dancing with the Stars!", a woman announces enthusiastically. At this New York health centre, wedged between housing projects to the east and Chinatown to the west, "dancing with the stars" means dancing with a physical therapist. An old man stands up with a nurse and begins a determined samba.

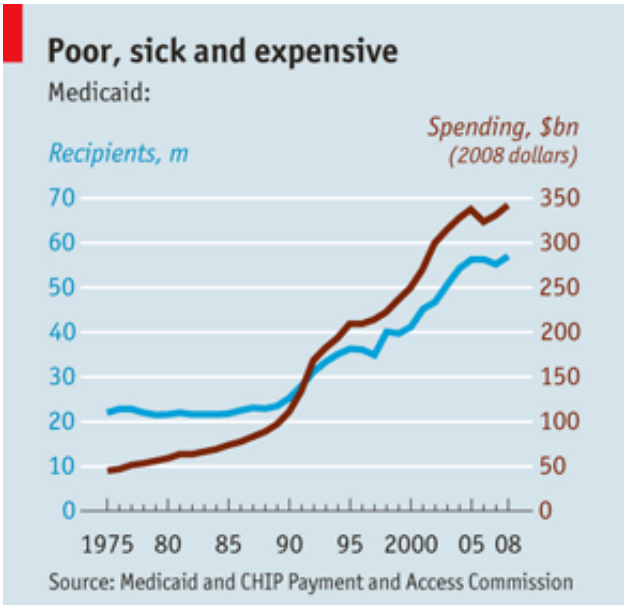
Comprehensive Care Management (CCM), which runs this centre, tries to keep old people active. To do so, explains Joseph Healy, the chief operating officer, is in the company's best interest. The government pays CCM a capped rate for the care of its members. If someone gets sick, his health costs rise and the company's margin shrinks. Mr Healy argues that the system is the best way to provide good care at a low cost. Increasingly others seem to agree.

Medicaid, America's health programme for the poor, is in the process of being transformed. Over the next three years, New York will move its entire Medicaid population into "managed care", paying companies a set rate to tend to the poor, rather than paying a fee for each service. New York is not alone. States from California to Mississippi are expanding managed care. It is the culmination of a steady shift in the way most poor Americans receive their health-care treatment.

Medicaid is America's single biggest health programme. This year roughly one in five Americans will be covered by Medicaid for a month or more. It gobbles more federal and local money than any state programme, other than education. Costs will rise even more when Barack Obama's health-care reform expands the programme by easing eligibility rules in 2014. Congress's "supercommittee" is already considering cuts. However, there are more immediate pressures behind the present drive for change.

Enrolment in Medicaid jumped during the downturn, from 42.7m in December 2007 to 50.3m in June 2010. Mr Obama's stimulus bill helped to pay for some of this, but that money

has dried up. Faced with gaping deficits, some desperate governors slashed payments to hospitals and doctors, or refused to pay for trips to the dentist or oculist. But much the most important result has been structural: the expansion of managed care.



States have dabbled in managed care for decades. The trend accelerated in the 1990s, with the share of Medicaid patients under this form of care reaching 72% by 2009. Now, however, there is a strong push for the remainder. States that did not have managed care, such as Louisiana, are introducing it. Other states are extending it to people previously deemed off limits: California and New York, for example, are moving the elderly and disabled into that system of care. Texas is targeting more than 400,000 Medicaid beneficiaries in the Rio Grande Valley. Local politicians had resisted the move, nervous that care might deteriorate. But the yawning deficit meant that they were overruled.

The result is a country with two distinct tiers of health care. Most Americans with private insurance are still horrified by thoughts of health-management organisations and prefer to pay fees for each medical service. For the poor, managed care is becoming the norm.

Advocates of managed care have high expectations. First, they hope that it will make costs more predictable. Second, they believe that the change will improve patients' health. In managed care, a patient has a network of doctors and specialists. If the programme works properly, doctors can monitor all aspects of care, in contrast to the fragmented fee-for-service system. The contracts that states have with firms can set standards for quality. Texas, for instance, will cut 5% from a company's payment if it does not meet what is required.

The next step is to integrate care for those eligible for both Medicaid and Medicare, the federal programme for the old. These “duals” account for almost 40% of Medicaid's costs and just 15% of its population. “If managed care can really deliver better care than fee-for-service”, says Diane Rowland, chair of the commission that advises Congress on Medicaid, “this is the population that could prove it.”

But some, such as Norma Vescovo, are sceptical. As the head of the non-profit Independent Living Centre of Southern California (ILCSC), Ms Vescovo serves Medicaid patients with severe health problems. Over the years she has often sued California on policies that she thinks will hurt her vulnerable clients. On October 3rd her case moved to the Supreme Court.

The outcome of *Douglas v Independent Living Centre* will have profound implications for

the future of Medicaid. Ms Vescovo's suit concerns cuts to hospitals and doctors. But the case will also guide the course of managed care. If ILCSC and its co-plaintiffs win, private groups will continue to be able to challenge states on policies they think violate federal Medicaid law. Ms Vescovo, who argues that California's payment cuts would eviscerate her clients' access to services, worries that under managed care the disabled might not be able to see the specialists they need.

The question is how to supervise the experiments with managed care that are being carried out in various states. To date, Medicaid beneficiaries have been able to challenge the states in court. However, if the Supreme Court rules against ILCSC, that avenue will be closed. The Centres for Medicare and Medicaid Services (CMS) technically can intervene if states do not provide proper access to care. In reality, CMS has few tools to do so.

“I'm a big fan of managed care”, says Sara Rosenbaum, a professor at George Washington University, “but this transformation may happen with almost no federal oversight.” Medicaid beneficiaries are vulnerable, in worse health than Americans as a whole. Companies may struggle to cut costs and provide good care as well. If states do not draft their contracts properly, or fail to be vigilant in monitoring patients' health, their experiment in managed care could be a disaster. On the other hand, if states are careful they could provide an answer to the question that has vexed America for years: how to provide good, cheap health care.

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