Reconsidering Medicaid Privatization:

Weighing the Evidence and the Alternatives

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Abstract

Medicaid is the largest single provider of health-care coverage in the United States, covering one in every five Americans. But over the past 25 years, this public health-care program has been largely privatized. Today, 70 percent of Medicaid beneficiaries—approximately 54 million Americans—receive their Medicaid coverage from a private insurance company. The literature shows some reductions to medical spending, which is a primary supporting argument of the move, but these reductions tend to be driven either by reductions to providers' fees or by reductions in medical utilization due to added administrative requirements on the authorization of care. Both of these avenues can hinder beneficiaries' access to care. Moreover, these savings have been found to be absorbed by the private insurers themselves, yielding little to no evidence of a net fiscal benefit to the state. We argue that private insurers' profits derived from the administration of Medicaid represent a transfer of wealth from the taxpayer, beneficiary, and safety-net medical provider to the administrators and shareholders of private insurance. After examining this evidence, we then review the modern political history of how this financing approach came to dominate Medicaid in the 1990s, and two state case studies from more recent history—one that recently embraced private insurance and another that has developed an effective public alternative.

1. Introduction

Medicaid provides health-care coverage to one in every five Americans, but nearly 70 percent of them receive that coverage through a private insurance company (KFF 2021a). State governments are the primary administrators of Medicaid, and they usually allocate a plurality of their budget to do so. Additionally, the federal government subsidizes the program, to the tune of about 10 percent of the overall federal budget—making that subsidy the third largest domestic federal expenditure behind Social Security and Medicare (CBO 2019).

Starting in the 1990s, almost every state and territory in the country hired private insurance companies to run their Medicaid programs. The crux of the idea behind this contractual arrangement is the design of its financial incentive, which is assumed to promote cost savings and fiscal stability. States effectively purchase private insurance for each beneficiary:

The state pays the insurance company a capitation fee—a fixed amount per enrollee, per year—out of which the insurer pays for any health-care use, keeping the difference for operating costs and shareholder profits. Proponents argue that this financial design has two benefits: It provides an incentive for the insurer to control medical spending, because leftover capitation income accrues as profits, and it removes financial risk from the state budget, because the per-person cost remains fixed.

States turned to this model during the 1990s, in search of a solution to unexpected increases in the program's costs. Early in the decade, the federal government mandated substantial expansions in eligibility during a time of rapid medical price inflation. In this environment, purchasing insurance appeared to be a logical move for a state; insurance, as a product, is intended to provide financial protection against an uncertain future. Moreover, during the preceding decade, the insurance industry had developed its administrative techniques for medical cost containment, and additionally, a number of insurers had developed Medicaid-specific insurance products over that time as well. Insurers argued that, adopted more widely, these products could introduce stability to states' Medicaid budgets.

While the financial incentives are clearer, incentives on quality push in two opposing directions. First, capitated payments can incentivize under-provision of care, as insurers seek to maximize retention of revenue by minimizing medical outlays. Insurers reduce what they deem to be unnecessary medical spending through administrative techniques like requiring prior authorizations and negotiating lower payment rates with providers. These practices are more pronounced in Medicaid than in private markets and can hinder access to care (Cunningham and O'Malley 2008; Dunn et al. 2021). At the same time, the insurer does not want to restrict care excessively. The insurer benefits financially when its enrollees require less high-level care, like hospitalizations. Insurers lose out financially if their enrollees, unable to adequately access primary care, are driven to seek emergency services because their condition has grown severe or because they simply could not find a suitable alternative source of care. This countervailing incentive keeps quality in check, as insurers strive to deliver a profit-maximizing quality and quantity of care.

Overall, the move to contract with private insurers was intended to reduce costs, stabilize budgets over time, and at least have no negative impact on quality. Quality could even potentially improve due to the introduction of market competition. If firms have to compete

for beneficiaries or compete for state contracts, then, like in any competitive marketplace, the least efficient producers would be forced out of the market in favor of those offering the same or better quality at a better price.

As we review in this issue brief, the arguments do not hold up well to scrutiny and have not been substantiated by empirical evidence in the time since the administrative change took place. First, to the extent that capitated payments incentivize cost control, the savings have not passed through to the states: The reduction in medical spending is retained by insurance companies. Second, the concept of purchasing insurance for the purpose of financial risk protection does not translate well to this context. The drivers of uncertainty in state spending, namely medical price inflation and spikes in eligibility, are not absorbed by the insurer in a capitation scheme. The state simply pays more per person when prices increase and pays for more beneficiaries when eligibility does the same. Finally, the Medicaid market lacks a source of competitive pressure for the program to benefit from private market discipline. Rather than competing with one another to offer the best plan, most insurers offer identical costs and coverage with customers assigned to them by randomized auto-enrollment. States tend not to monitor, let alone enforce or incentivize, aspects of plan quality like provider networks or access to medical services (Centers for Medicare & Medicaid Services n.d.; Layton et al. 2018; Office of Inspector General 2014).

For decades, the consensus among economics researchers has not supported the list of benefits that state legislators have associated with private insurance administration of Medicaid, such as cost savings, fiscal stability, improved health, improved health-care access, and market competition (Gruber 2017; Layton et al. 2019; Montoya et al. 2020; Sparer 2012). Nevertheless, state legislators continue to argue that private insurers will shield the state from financial risk, reduce costs, and inject quality-improving market discipline into public health-care coverage. As we review further in the brief, as recently as 2021, North Carolina joined the bulk of its peers in transitioning beneficiaries to a system administered by private insurance corporations.

By contrast, we also examine the alternative policy avenue taken in Connecticut, where 10 years ago, state officials made the opposite transition, ceasing to contract with private insurers for Medicaid delivery and instead establishing a publicly managed system of Medicaid coverage. Connecticut's experience aligns with what the literature might suggest.

The state spends less than 5 percent of its Medicaid budget on administration and overhead, approximately one-third the national average of privatized programs; maintains below-average growth rates in per-person costs; and has improved on a number of quality indicators like emergency care use and provider participation (Andrews 2021; Beck 2016; Lassman et al. 2017; Palmer et al. 2021).

This brief argues that states and the federal government can now reconsider the decision to administer Medicaid through private insurance. The financial design creates an incentive for insurers to deliver a profit-maximizing quality and quantity of care by establishing administrative structures that review and restrict utilization and then retain medical savings as insurer overhead and profits. In Connecticut, the private insurance model of Medicaid delivery invested relatively more in administrative care restriction, and administrators, while the publicly managed system invests relatively more in clinical care delivery and the providers of health care. This result indicates an opportunity for other state policymakers to rearrange existing Medicaid dollars toward beneficiary care. A more effective system that reduces overhead and offers better pay to Medicaid doctors could attract more doctors to accept Medicaid patients. That system could mitigate the segregation of providers and facilities that Medicaid beneficiaries now face as a result of the program's low fees and high administrative burdens (Ludomirsky et al. 2022). Reallocating funds away from private insurer overhead and profits and toward care provision could improve access for Medicaid beneficiaries without requiring additional public resources. The remainder of this brief examines in more detail the evidence and political processes behind the move to administer Medicaid via private insurers, and underscores the opportunity for legislators and analysts to investigate the potential gains from establishing public administration of Medicaid benefits.

2. What Privatization Can and Can't Do

Costs

Virtually every literature review examining the potential for private insurance to create fiscal savings in Medicaid concludes that the evidence is at best "quite mixed" (Gruber 2017; Montoya et al. 2020; Sparer 2012). There is evidence that insurers can implement strategies that are effective at reducing utilization of and spending on medical care, relative to

fee-for-service (the non-capitation system in which medical providers are simply paid a fee for their service) (Geruso et al. 2020; Montoya et al. 2020). Yet, it does not appear to translate as savings to state budgets. For example, Layton et al. (2019) find that private insurers in one state reduced inpatient hospital admissions by a substantial one-third to one-half relative to fee-for-service, yet they also found that state spending remained unchanged. One exception has been found in states with particularly generous public programs that paid higher-than-average fees to Medicaid providers, and then allowed private insurers to drop the fees (Duggan and Hayford 2013). By contrast, some states with poorly funded public programs have had increased costs, by loosening health-care restrictions alongside privatizing administration (Layton et al. 2019). These effects are not strictly tied to the capitation incentive central to private insurance. In most states and in the nationwide aggregate, contracting with private insurers does not reduce costs (Duggan and Hayford 2013). Thus, reviews of this literature conclude that the approach is "either cost neutral or could actually end up costing more than traditional fee-for-service programs" (Sparer 2012).

Additionally, beyond the net cost of Medicaid, there is no evidence that the approach reduces variability or increases stability in state Medicaid budgets. The only empirical study to assess the relationship directly finds no change in the variance of Medicaid spending and no effect on budget stability as a function of private insurance administration (Perez 2017).

The logical problem with the fiscal stability argument is that private insurers have little capacity to offer financial risk protection to a state. Economic theory says that consumers demand medical insurance because their medical needs are uncertain but potentially catastrophic financially—say, in the rare event of a car crash or burst appendix. Insurers can shoulder this uncertainty on a consumer's behalf by pooling many enrollees together. If one out of a thousand has a catastrophic event, the other 999 will pay enough into the pool to cover the claim. The insurer can even build in a little extra for their own profit, for which the consumer will happily pay, in exchange for the peace of mind afforded by this law of large numbers. Consumers are willing to pay insurers for offering a place where a large number of persons can come together and pay for one another's catastrophes and—if it should so happen—get help with their own.

However, unlike an individual consumer, a state already represents a large pool of Medicaid enrollees, numbering in the millions. The state is the one financing each of these

beneficiaries' care no matter which one experiences the catastrophe. Thus, the state need not hire an insurer to perform the service of gathering a pool. If one beneficiary gets unexpectedly sick, that individual simply realizes a greater share of that year's budget, but it all comes from the same source. In fact, it is not clear how an insurer offers a relative advantage as a site for pooling a state's risk. It's something like bringing a pool to the pool.

Moreover, states transfer only limited aspects of Medicaid's financial risk to the insurer. The capitation payment is set to reflect projected medical needs based on the enrollee population's recent medical spending, prior diagnoses, and demographic characteristics such as age. The risk taken on by the insurer is only what is unpredictable beyond those inputs. Thus, the capitation design cannot protect the state against unpredictable spending caused by spikes in eligibility, which precipitated the private insurance transition in the early 1990s and has been repeated more recently as eligibility grows alongside unemployment during recessions. States simply continue to pay the capitation fee for every additional beneficiary (Fairbrother et al. 2004).

Furthermore, states are less likely to purchase private coverage for their most medically complex beneficiaries—those for whom the medical uncertainty might be most relevant. Across Medicaid programs nationwide, private insurers covered 86 percent of children, 81 percent of non-disabled nonelderly adults, and 63 percent of adults age 65 and up or with a disability (KFF 2021b). In Medicaid, the rate of private insurance penetration is inversely correlated with the degree of financial risk of insuring the beneficiary population. This is the opposite of what one might expect from a market solution for relieving states of burdensome risk, and it also limits the capacity of the arrangement to deliver meaningful financial protection. Finally, states tend to require, and some directly provide, back-end insurance through stop-loss coverage. For example, New York State covers 80 percent of beneficiary hospitalizations over a given threshold, as a way to insure the insurer.

Quality

One of the critical aims of any form of health-care coverage is to facilitate access to providers of medical care. Medicaid has long struggled with this goal and continues to do so under private insurers (Caswell and Long 2015; Gilchrist-Scott et al. 2017; Grogan 1997; Holgash and Heberlein 2019). Medicaid beneficiaries face heavily restricted networks of physicians willing

to accept them as patients, and are therefore concentrated among the few safety-net providers willing to take the appointment (Ludomirsky et al. 2022). The problem is not just one of recruitment, but of retention. More than one-third of a Medicaid plan's primary care providers exit the network within five years (Ndumele et al. 2018). Physicians tend to cite the program's heavy administrative burden as a primary deterrent, even more than the program's low payment rates (Gordon et al. 2018). Rigorous evidence corroborates their concerns (Decker 2018; Dunn et al. 2021; Long 2013). However, private insurers are not incentivized to improve administrative burdens. One of their primary tools for constraining unnecessary medical care is to require administrative reviews of prescribed treatments.

Arguably, the strongest indicator of clinical quality is the impact of private insurance administration on the health of Medicaid beneficiaries. Here, again, the evidence does not favor our predominant approach. Several studies from the economics literature have found negative health effects, including worsened maternal and infant outcomes, associated with a county-by-county rollout of insurer-managed care in California (Aizer et al. 2007) and widened racial disparities in maternal health outcomes upon a more recent transition to insurer administration in Texas (Kuziemko et al. 2018). Another recent study, from California's transition of disabled beneficiaries to insurers, finds, among other troubling outcomes, an increase in mortality, with the greatest increases in mortality among those who are sickest at baseline (Duggan et al. 2021).

Finally, one recent study finds that the transition to private insurers in Texas caused substantial improvements to the health and well-being of disabled beneficiaries, which the authors acknowledge goes "against the conventional wisdom among economists" (Layton et al. 2019). The key mechanism to which they attribute their finding is the removal of a prescription drug cap. Prior to insurer administration, beneficiaries could fill no more than three prescriptions per month, and many were hitting up against this barrier regularly. The cap was eliminated alongside the introduction of private insurers. The authors argue that while simply relaxing the cap without involving private insurers would likely have generated the same improvements in well-being, nevertheless, the "political economy" in Texas is such that legislators would never have done it. Thus, they ultimately attribute their findings to insurer administration. This brings us to perhaps the best way to understand why states have chosen to invest in this administrative structure, given the lack of evidence for health or fiscal benefits: a political orientation toward private markets.

Competition

Even in the absence of accrued fiscal or health benefits, policymakers could in theory value privatization for its potential to harness competitive market forces toward innovations in plan quality, innovations that will perhaps become beneficial to the state in the future. In theory, only the most efficient producers can survive in a competitive marketplace. Others will lose out to competitors offering a lower-priced option that still meets consumers' needs. Critically, that process of market competition hinges on consumer preference. Consumers must be able to discern cost and quality differences and use that information to make the best choice for themselves, thus rewarding the best producers and driving the poor performers out.

In practice, however, Medicaid consumers cannot apply much discriminating pressure. First, there is little difference across plans in the cost or quality of coverage. Beneficiaries' out-of-pocket costs, and the medical services covered, are both set via statutes. The statutes are needed, as they protect Medicaid's low-income beneficiaries from high out-of-pocket costs and coverage denials and exclusions. Yet, with minimal difference between plans, consumers have little basis on which to develop a preference and make a choice consistent with that preference, both necessary components for competition to work effectively (Gruber 2017). Instead of the competitive pressures of consumer discretion charting the course, the truth is that most beneficiaries do not select a plan at all, and are randomly assigned one by the state in such a way as to even out market share across insurers (Layton et al. 2018)—hardly a source of competitive pressure. The following quote, from a qualitative study of Medicaid insurance plans, illustrates the weak state of health plan choice from the perspective of a beneficiary:

> I didn't feel like I had a choice. When they give you the brochures, they try to make you feel like you have a choice, but you really don't. The choices are made for you. The decision of what services you are supposed to receive, that decision is already made. The only decision you have is to pick a name . . . It makes you feel like you have the power to make the decision about your health care but you don't. You don't have that power at all. (Maskovsky 2000)

One might argue that in Medicaid, the real customer isn't the individual beneficiary, but is instead the state. By designing a competitive procurement process, states could set and enforce standards and reward improvements (Layton et al. 2018). The problem here is that states engage in very little oversight or enforcement—far less than in Medicare Advantage, the private arm of the Medicare program, which enjoys federal oversight. For example, unlike in Medicare Advantage, Medicaid insurers have no federally mandated minimum medical loss ratio—the share of revenues that must be spent on medical care versus retained for administration and profits. While states are required, as of 2017, to collect data on the medical loss ratios of their Medicaid plans, officials in several states, in response to public records requests we submitted as recently as 2021, told us they do not collect this information (Zewde et al. 2022). Figure 1, below, provides an example of a response we received to a public records act request submitted in Hawaii. In it, state officials informed us that they do not maintain any of the requested information on plans' financial operations, including the share of their revenues allocated to medical care versus administrative expenses as mandated by federal regulations (see 42 CFR § 438.604). As of 2019, only half of the states set a minimum loss ratio for Medicaid plans, which may have precipitated higher-than-average profits for Medicaid insurers during the low-utilization periods of the early pandemic (CBPP 2020). It is possible that despite failing to collect these federally mandated data on plans' administrative overhead, states are nevertheless finding alternative ways to discern and reward administrative efficiency, but we were unable to find evidence of such activity.

Figure 1. Response from Hawaii Department of Human Services to Our Uniform Information Practices Act Request

THIS NOTICE IS TO INFORM YOU THAT YOUR RECORD REQUEST:

☐ **Will be granted in its entirety.**

☐ **Cannot be granted. Agency is unable to disclose the requested records for the following reason:**

- ☐ Agency does not maintain the records. (HRS § 92F-3)
  Other agency that is believed to maintain records: ____________
- ☐ Agency needs further clarification or description of the records requested. Please contact the agency and provide the following information: ____________
- ☐ Request requires agency to create a summary or compilation from records, but requested information is not readily retrievable. (HRS § 92F-11(c))

☒ **Will be granted in part and denied in part, OR** ☐ **Is denied in its entirety**

Although the agency maintains the requested records, it is not disclosing all or part of them based on the exemptions provided in HRS § 92F-13 and/or § 92F-22 or other laws cited below.
(Describe the portions of records that the agency will not disclose.)

RECORDS OR INFORMATION WITHHELD	APPLICABLE STATUTES	AGENCY JUSTIFICATION
Plan spending in different care settings (i.e. inpatient, outpatient, emergency, Behavioral health)		DHS does not maintain the information
Amount of capitation rate spent on Allowable and non-allowable administrative		DHS does not maintain the information
Expenses by category (e.g. personnel, Advertising and marketing, claims processing)		DHS does not maintain the information
Net reinsurance		DHS does not maintain the information
Net income, the types, level and cost of various services provided to members under the plan, and the number of members by eligibility pathway receiving different types of services or no services.		DHS does not maintain the information

Similarly, oversight and enforcement of plan quality also appears lacking. Most states "simply accept managed care plans' assurances that their provider networks meet the states' minimum standards for access," according to an investigation by the US Inspector General (Office of Inspector General 2014). Those states that brought in rigorous third-party evaluators, who independently assessed outcomes like distance to an in-network primary care provider and average wait time for an appointment, were also the states that found violations of these standards. States' Medicaid offices have failed to conduct adequate oversight of a number of programmatic activities (GAO 2018; Lopez et al. 2020), seriously undermining their ability to apply the discriminatory pressure needed for a competitive marketplace to function as theorized. Even when a state conducts oversight and identifies plan shortcomings, they have struggled to overcome insurer power to effectively enforce standards. In 2022 alone, California and Louisiana each reversed course from an attempt to implement competitive procurement that would cease contracting with poorer performing plans, in both cases the reversal was due to the threat of drawn out legal battles initiated by litigious insurers with losing bids (Wolfson and Young 2023).

If not fiscal stability, health outcomes, or market discipline, what is motivating states to pay for private insurers? Ultimately, we lack the grounds on which to prove the political aims of state legislators when they choose insurance administration for their Medicaid programs or for more of their Medicaid services, as they continue to do annually. Some experts have theorized that the appearance of externalized accountability helps shield legislators from dysfunctional aspects of the system (Grogan 2015). This notion was echoed by Matt Salo, executive director of the National Association of Medicaid Directors, who described the move to managed care as "creating a public-private partnership where the *accountability* around better care is a joint responsibility of the state and the plans" (Hoban 2021, emphasis added). But we cannot weigh the importance of this particular avenue of political expediency relative to any other political benefits legislators might garner from engaging in this public-private partnership.

In the next section, we step back for a brief overview of the modern political context in which private insurers came to dominate Medicaid, before taking a closer look at two more recent state transitions.

3. Policy and Political Context

Medicaid was privatized in the 1990s amid an era of widespread privatization. It was the "end of history," capitalism had won, and actors at every level of US government were actively seeking opportunities to swap government waste for private-market efficiency (GAO 1997; National Performance Review 1993; Thompson 2000; Glaser 2014). Privatization primarily occurred via contracting out an otherwise public function to a private firm for implementation (Chi 1998; Winston et al. 2002), and this is the working definition of privatization we use here. During the 1990s, state agencies began contracting out public transportation, incarceration, and even enforcement of child support payment (Chi 1998; Winston et al. 2002). Another outgrowth of the era was welfare reform, and states hired private firms to advertise the new labor pool generated by the reform's work requirements (Rice 2001).

Concurrently, states' Medicaid programs were also growing in the early 1990s, further prompting administrators to seek outside support to control program costs. Medicaid eligibility was de-linked from welfare, which was then known as Aid to Families with Dependent Children (AFDC). By the early 1990s, Medicaid would cover not just those receiving cash assistance through AFDC, but nearly all poor and near-poor children and pregnant women (Dubay and Kenney 1996). In addition to absorbing sizable enrollment increases due to the eligibility change, states also faced growing medical inflation rates, with double-digit growth in per-person Medicaid spending in each of the decade's first three years, coinciding with the early 1990s expansion of eligibility (Boben 2000; MACPAC 2021).

The insurance product that states would eventually use to administer Medicaid emerged in the right place at the right time to serve as the private-market solution to states' growing Medicaid programs (Etheredge 2007). The administrative cost-containment entity known as the Health Maintenance Organization (HMO) had only grown to the necessary scale and strategic capacity over the preceding decade. During a whirlwind first year in office, in addition to cutting the top tax rate by more than one-fifth and firing more than 10,000 striking air traffic controllers, the Reagan administration also changed the role of the federal office of HMOs from publicly funding health insurers to actively, and successfully, soliciting private investors on their behalf (Davis 1981; Ginsberg 1987; Pear 1982). These investors would then exert pressure on the insurance companies to scale up their operations and to turn a

profit. As a result, the industry moved away from the direct-employment model (what we might associate with Kaiser Permanente) in favor of the external contracting role that most insurers play today, which was far easier to scale up. To turn a profit and provide "proof of value," insurers developed their administrative cost-control techniques, which could be implemented from their position external to a provider's office (Gruber et al. 1988; Institute of Medicine 1989). For a safety net program, states would need to rely on these administrative techniques, like requiring prior authorizations for care, given federal statutes preventing them from imposing out-of-pocket payments on Medicaid beneficiaries as a way to control their health-care use.

Medicaid enrollment in HMOs grew rapidly through the mid to late 1990s, even as private markets experienced a backlash. Medicaid HMO enrollment doubled in 1994, and by January 1995, 49 states had some element of their Medicaid program administered by a private insurance company (Grogan 1997). Under the 1997 Balanced Budget Act, federal law began to allow states to mandate private-insurance enrollment for Medicaid beneficiaries, further spurring enrollment through the end of the decade (Boben 2000). While HMOs also expanded into private markets in the 1990s, consumers had grown frustrated by the administrative cost-cutting techniques. By the mid 1990s, private insurance and Medicare consumers stopped enrolling in HMOs (Marquis et al. 2004). During what came to be known as the "managed care backlash," state legislators passed more than 1,000 bills to address public concerns about HMOs' cost-cutting behaviors and potential negative consequences for enrollees' health (Blendon et al. 1998). Yet, at the very same time, state legislators continued establishing the contracts for Medicaid beneficiaries, never "retreating" from the new reality of Medicaid as an HMO endeavor (Fossett and Thompson 1999; Marquis et al. 2004).

A Tale of Two States

While private insurance initially came to dominate the administration of Medicaid in a bipartisan privatization wave (Grogan 1997; Winston et al. 2002), in the years since, states have continued to adopt the private insurer model and to expand the populations covered through that mechanism. In this section, we examine the political context in which states have more recently made decisions around private insurance administration. North Carolina and Connecticut offer an illustrative contrast. Each state had access to a similar body of evidence, but made opposite decisions. North Carolina implemented private insurance

administration in the summer of 2021. Legislators there argued that private insurers would bring budget stability and fiscal savings, though some opponents pointed to weak evidence generated by other states' experiences. By contrast, Connecticut adopted Medicaid HMOs much earlier, in 1996, but is now one of the few states with publicly managed Medicaid. State advocates and elected officials in Connecticut used legal mechanisms to investigate and ultimately remove private insurers from the program.

North Carolina

Up until the summer of 2021, North Carolinians with Medicaid coverage had a publicly administered system of care management. In the absence of private insurers to oversee and authorize services, the state's program paid for care coordination to take place in a clinical setting. The setup included patient-centered medical home teams and primary care case management, wherein one provider or provider team would oversee a patient's care and coordinate referrals and follow-ups. High-need or at-risk populations were enrolled in dedicated case management with nurse navigators. The state additionally established a specific "pregnancy medical home" designation that would pay extra for pregnancy care coordination if it included steps like screening for and closely monitoring high-risk pregnancies and avoiding elective deliveries before 39 weeks (Allen et al. 2022; NC Medicaid n.d.). Otherwise, the state paid providers on a fee-for-service basis, with care coordination and all other covered medical services billable directly to the state rather than to an insurer. No entity in the system operated under capitation incentives.

External evaluations consistently concluded that the model was beneficial for health outcomes, reducing tertiary and emergency care, and saving money (Allen et al. 2022). Treo Solutions (a subsidiary of 3M) and Milliman each found lower emergency department use and fewer inpatient admissions among the higher-risk patient population enrolled through the public managed care systems relative to lower-risk populations who did not qualify for enhanced care (Cosway et al. 2011; Treo Solutions 2012). While the researchers did implement risk adjustment, for example using the 3M risk-score model in the case of the Treo evaluation, this always leaves some residual bias in the absence of randomization. Nevertheless, because the publicly managed program enrolled a higher-risk population, that bias would diminish estimated program benefits, suggesting the program likely was truly effective. By comparison, Medicaid programs managed by private insurers have not been found to outperform

fee-for-service delivery on costs or quality, despite covering a less complex population. Furthermore, the state's public system boasted an "exceptional" provider participation rate, with 86 percent of the state's physicians seeing Medicaid patients prior to the introduction of private insurer networks. This is well above the two-thirds average across states nationwide (Allen et al. 2022; Decker 2018; Hoban 2013).

So why, as of June 2021, were beneficiaries transferred to an insurance-based private system? It depends on whom you ask. Some, for example, anticipated that competition would drive down costs and improve quality of care (Allen et al. 2022; Hoban 2013). Proponents within the state legislature, who ultimately decided on the switch, primarily cited an interest in cost savings and fiscal stability, which they associated with the capitation-based payment structure of private insurance. According to the state's Speaker of the House Tim Moore, private insurers allow "the opportunity to move away from fee for service, to get the incentives right consistently and to be able to partner with the state in saving money in the Medicaid system" (NC Health News 2014a). Legislative proponents, primarily in the state's Senate, argued that the existing system was plagued by cost overruns that were impossible to plan for. As State Senator Brent Jackson (R-Autryville) explained:

> In my short term of . . . being here, going on four years, and watching our shortfalls in Medicaid and not having the budget predictability, and watching DHHS be the only agency that we have, that I'm aware of, currently, in this state that a budget appears to mean nothing to, because it's always overrun, and we have to fill in those black holes, I think this is a step in the right direction. (NC Health News 2014b)

Whether there was in fact a budget overrun, like much in the state's privatization process, was itself a point of contention. John Oberlander, a professor of social medicine at the University of North Carolina, described the situation as a crisis that was manufactured "in order to justify what they wanted to do, which is privatize" (Klein 2007; NC Health News 2013). Suspicion grew when a local reporter obtained a tracked-changes draft of a state report showing where an appointed official had deleted the explanation behind the cost overrun. The Medicaid agency needed federal approval to make the changes necessary to meet the legislature's requested cost cuts and could not obtain approval in time for that year's budget. As a result, they would have to continue operating in a manner similar to that of the year before, thus over-running the legislature's reduced budget. However, the final report omitted

this explanation, instead describing the Medicaid program as fundamentally "broken" and in need of private-market discipline (NC Health News 2013).

Opponents voiced concerns about the care incentives of financialization. One representative pointed out that South Carolina's legislature was considering withholding payment from insurers due to poor quality of care, while under their own system, citizen complaints were "very rare" (Hoban 2015). Additionally, provider groups expressed trepidation about the move. A qualitative study of the state's transition finds that health-care providers were concerned that private insurance would shift the allocation of resources away from patient care and toward administrative tasks: "[O]ur already scarce resources now are going to have to go towards the administrators. That's gonna pull money away from direct care" (Allen et al. 2022).

Others criticized the wealth transfer represented by privatization. Democratic State Representative Graig Meyer argued: "If we put this plan into action, your taxpayer dollars are going to turn into profits for insurance companies based on their ability to limit and cut services to poor people" (Hoban 2015). From Robert Sligson, head of the North Carolina Medical Society: "Today the Senate had a clear choice between the health of our state's most vulnerable citizens and the health of Wall Street corporations, and they chose the corporations" (NC Health News 2014b). Despite impassioned pleas, the legislation passed in 2015, largely along party lines, but with five Republicans joining the opposition.

Connecticut

Connecticut offers a useful contrast. That state implemented private-managed care in 1996, in line with the predominating thinking of the time. Like many of the early-adopter states, administrators in Connecticut assumed that insurers would save the state money, almost by definition, because for the first few years insurance underwriters charged the state 95 percent of the costs projected under a fee-for-service system (Grogan 1997).

Legal advocates in Connecticut began to push back early on. In the first lawsuit against a Medicaid insurer nationwide, Connecticut legal advocates argued that prior authorizations preclude beneficiaries' right to due process. They collected evocative tales from patients and providers about insurer denials of needed medical care, which were picked up by the local press (Poitras 1999). Furthermore, as insurers raised their capitation rate to 100 percent of

projected medical expenses, plus administrative allowance, legal advocates began pressing for greater transparency into the firms' financial operations. Lawyers from the Legal Aid Society sued to obtain records of the rates that insurers were paying Medicaid providers, arguing that this information is subject to the state's regulations on public-record disclosure. The proceedings garnered more attention from the press and the public, with hearings that were "standing room only," and articles asserting that insurers "just want to take the money and not be accountable" (Archer 2022). Insurers argued that rates and networks are proprietary information—"trade secrets"—and that disclosing these rates would compromise their ability to negotiate across providers and to compete with other health plans (Sorrel 2006). Insurers began to pull out of the state's Medicaid system before the case was decided, which precluded any official ruling on the public's right to these payment data.

State administrators were left scrambling amidst the insurers' retreat. They began to offer reimbursement at more than 100 percent of cost to any insurer willing to stay and potentially be subject to information disclosure. But the end of privatization was in sight for Connecticut. The Democrat-controlled legislature shortly commissioned the comptroller's office to audit the Medicaid program. The audit revealed what was already assumed to be true, that the state was now over-paying the few remaining insurers for their services (Wyman 2009). The report argued the state should not be "held fiscal hostage" to private insurance contractors. When Democrat Dannel Malloy took over the governorship the following year, his administration heeded the suggestion of a legislative committee and announced the end of private insurance in the state's Medicaid program. The change took effect January 1, 2012.

For over 10 years, Connecticut has not contracted with private insurers for its Medicaid system. Instead, the state sets universal reimbursement rates, offering every provider the same fee for the same service, and then pays the provider directly out of state coffers if they treat a beneficiary. The system contracts with "administrative services organizations" tasked with identifying higher-need patient populations for more intensive follow-up, and contracts with primary care providers to serve as patient-centered medical homes that carry out a majority of care-coordination tasks, like referrals and ongoing case management for chronic disease. State officials based the design, in part, on the system in place in North Carolina prior to their shift toward private insurers (Dube 2008).

The move appears to be a success. Connecticut realized a sharp net reduction in spending in the short term and maintained low growth rates in the years following, in part due to its ability to keep overhead costs to a much lower rate (under 5 percent) than states with privatized programs, which average above 15 percent (Andrews 2021; Beck 2016; Lassman et al. 2017; Palmer et al. 2021). In the years following the change, the state boasted improvements in access metrics, including increased participation of primary care and specialist providers (measured as the share of licensed providers realizing Medicaid patient revenues, a more stringent measure than appearance on an in-network list), and improvements in quality metrics including higher rates of preventive care use and lower rates of hospital and emergency admissions (Connecticut Department of Social Services 2015). This model has not spread to other states, though some have taken notice. The caucus of Black legislators in Illinois's state government put forward a bill to remove private insurers from that state's Medicaid program, but it was ultimately negotiated out of their overall equity package for the 2021 legislative session (Hancock 2021).

4. Conclusion

There is no evidence that private insurance improves the fiscal stability or quality of state Medicaid programs. The primary arguments, of fiscal savings and stability, are theoretically weak and empirically unsubstantiated. First, states already pool risk across millions of beneficiaries, leaving no clear advantage to risk-pooling by insurers. Second, states cannot insure against enrollment fluctuations, a major driver of variability. Third, they shoulder much of the remaining risk by keeping their most variable populations out of these contracts and by mandating or directly providing stop-loss coverage, effectively insuring the insurer's greatest remaining risk. The only empirical study finds no improvement in fiscal stability. Furthermore, any cost savings from reduced medical spending are absorbed by the insurers themselves. While the flat per-person capitation payment may encourage the insurer to spend less on beneficiaries' medical care, the reduced medical spending has not translated into reduced state spending.

Moreover, the private insurance system in Medicaid does not serve the health of beneficiaries. The savings generated by capitation incentives weigh against beneficiary access to care. The set of services that minimize overall spending in the near term, in line with the incentive to insurers, is not necessarily the care that promotes adequate or optimal functioning for

beneficiaries over their lifetimes. We do not have the empirical evidence on which to stake the claim that capitation improves health in Medicaid, and multiple rigorous studies find the opposite—that private insurance worsens health outcomes in Medicaid (Aizer et al. 2007; Kuziemko et al. 2018). Nor is there a strong case that market competition will drive quality improvements in a privatized Medicaid. Plans differ very little from each other, beneficiaries frequently do not make a choice, and states do not monitor plan behavior. This setting leaves few, if any, degrees of freedom on which to reward quality or push out low-quality plans.

State advocates, policymakers, and policy analysts may benefit from a clearer scholarly consensus on the lack of evidenced gains from Medicaid insurers. For example, one recent report states that transitioning Medicaid to private insurance administration could either "improve or worsen access to and quality of care among Medicaid beneficiaries, or improve or exacerbate health care disparities" (Allen et al. 2022). Put another way, we lack evidence that the move is good for health. As policy researchers, we should seek consensus with economists for whom the "conventional wisdom" is that "private provision typically leads to worse outcomes in Medicaid" (Layton et al. 2019).

As outlined above, insurers entered Medicaid administration on a widespread tide of government privatization: nationally, twenty-five years ago, and in North Carolina, five years ago. But state advocates and policymakers still have a role to play in investigating claims in favor of privatization. Connecticut's Medicaid journey suggests that states may be able to design and implement an effective and efficient public alternative.

With the benefit of hindsight and the accumulation of evidence, states now have an opportunity to reconsider the choice to administer Medicaid through private insurers. Policymakers may have anticipated improvements in health or medical access for beneficiaries, fiscal savings for their budgets, or both. Yet the literature has substantiated neither outcome. Thus, the added administrative cost associated with private insurers may represent an opportunity to rearrange the funds in such a way that more efficiently delivers health-care access. If a budget is a moral document, as posited by Dr. Martin Luther King, then the potential to realign funds away from administration and toward health and well-being is worth evaluating.

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