Understanding Medicaid Managed Care: The Procured Competition Model

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Abstract

Medicaid is one of the largest public programs in the United States — providing health insurance to over 75 million low-income Americans — and over three quarters of its enrollees receive care via private "managed care" insurers. In this article, we make three central points about the economics of contracting out Medicaid to private insurers. First, the empirical evidence on Medicaid privatization is mixed: contracting out has not meaningfully reduced public costs or improved quality of care. Second, we propose a framework, which we call "procured competition", to describe the unique structure of Medicaid managed care as a hybrid of public procurement and regulated competition. Third, we discuss the key policy levers across procurement, competition, and consumer choice in this model. Throughout, we highlight open research questions, arguing that the enormous variation in how states design these programs — combined with limited evidence on what works — represents a promising area for high-impact scholarship.

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1 Introduction

Medicaid is the primary source of health insurance for low-income Americans, and by far the largest social safety net program in the United States. As of 2025, it covers 77 million people—about one in five Americans—and accounts for about $900 billion in annual federal and state spending. By comparison, the next-largest means-tested program is the Supplemental Nutrition Assistance Program ("food stamps"), which in 2024 cost about $100 billion and served 42 million people per month.

Over the past several decades, Medicaid has undergone a major institutional transformation. Historically, states administered the program directly, paying doctors, hospitals, and other providers through a state-run fee-for-service system. Today, about 85 percent of beneficiaries are enrolled in Medicaid managed care, under which states contract with private insurers to provide coverage and manage care. This shift toward outsourcing has been driven by concerns about rising costs, program complexity, and the limits of states' capacity to administer insurance efficiently.

Yet despite its scale and growth, the case for outsourcing Medicaid to private insurers remains ambiguous. A large theoretical literature emphasizes that contracting out public services can generate both gains and losses when contracts are incomplete (Hart, Shleifer and Vishny, 1997). Private firms may have stronger incentives to reduce costs and innovate, but they may also cut quality in ways that are difficult for the government to observe or contract on. Consistent with these competing forces, the empirical evidence on Medicaid managed care shows mixed effects. There is some well-identified evidence that managed care reduces healthcare spending, but this has not translated into lower costs for taxpayers. Evidence on the effects of managed care on quality is inconclusive, ranging from credible evidence of harms (e.g., increased mortality) to null effects or modest benefits. In short, Medicaid managed care has yet to deliver on its promise of lowering government spending while improving care.

We argue that understanding whether to privatize Medicaid and how best to do so requires a framework that captures how Medicaid managed care operates in practice. Rather than fitting neatly into standard models of either public provision or regulated competition, Medicaid managed care is best understood as a hybrid model of what we call "*procured competition*." States use a procurement process to select a menu of participating insurers and then rely on competition among those insurers to allocate enrollees and discipline performance.

This hybrid structure blends two approaches that have typically been studied separately. In standard *public procurement*—such as contracting for infrastructure projects—the government specifies desired services, solicits bids, selects winners, and manages contracts, often resulting in a single contractor. In *regulated insurance markets*, by contrast, firms generally enter freely and compete under rules governing prices, plan design, and subsidies — as in programs like the Af-

fordable Care Act Marketplaces or Medicare Advantage. Medicaid managed care combines these models: states tightly regulate plan features and select participating insurers via a procurement process, but then allow those insurers to compete for enrollees within the program.

From a procurement perspective, introducing consumer choice and competition can help incentivize insurer effort by allowing beneficiaries to "vote with their feet," rewarding higher-performing plans. From a market perspective, the procurement stage allows the state to shape the set of competitors—excluding low-quality plans and potentially extracting better terms from insurers. But combining these approaches also creates a more complex system that is difficult to design and implement well, particularly in a setting where plan quality is hard to observe and insurers face incentives to select based on risk rather than improve care.

A central theme of this paper is that we still know relatively little about how to make this hybrid model work effectively. The design of procurement processes, market rules, and enrollee choice mechanisms all play critical roles in shaping insurer incentives, yet there is limited theoretical analysis and empirical evidence on how these policies interact or how they affect costs, quality, and access. This leaves policymakers with little guidance on how to design rules for procurement and market competition. There is enormous variation in how state-level Medicaid programs set these policies, presenting both opportunities and challenges for economic research.

In the remainder of the paper, we use the procured competition framework to assess how Medicaid managed care operates in practice and to highlight open questions for research and policy. We begin with background on the Medicaid program and the rise of managed care, including reviewing the mixed evidence on the effects of managed care on costs and quality. We then develop the conceptual framework of procured competition and use it to organize the key policy levers in the program, including procurement design, market rules, and plan choice provisions. Throughout, we emphasize where theory provides guidance, where evidence is informative, and where important gaps remain.

Understanding Medicaid managed care is increasingly important as states continue to rely on private insurers to deliver public insurance—and as similar hybrid models are considered in other areas of social policy. Medicaid offers a valuable laboratory for studying the promise and perils of market forces in the provision of essential social goods.

2 Should States Contract Out? The Make-or-Buy Decision in Medicaid

Why do state governments contract out the administration of Medicaid benefits to private insurers? This section introduces Medicaid managed care as a policy response to rising Medicaid costs, pro-

vides background on the economics of Medicaid managed care, and discusses theory and evidence on the tradeoffs associated with such "make-or-buy" decisions.

2.1 The Medicaid Program

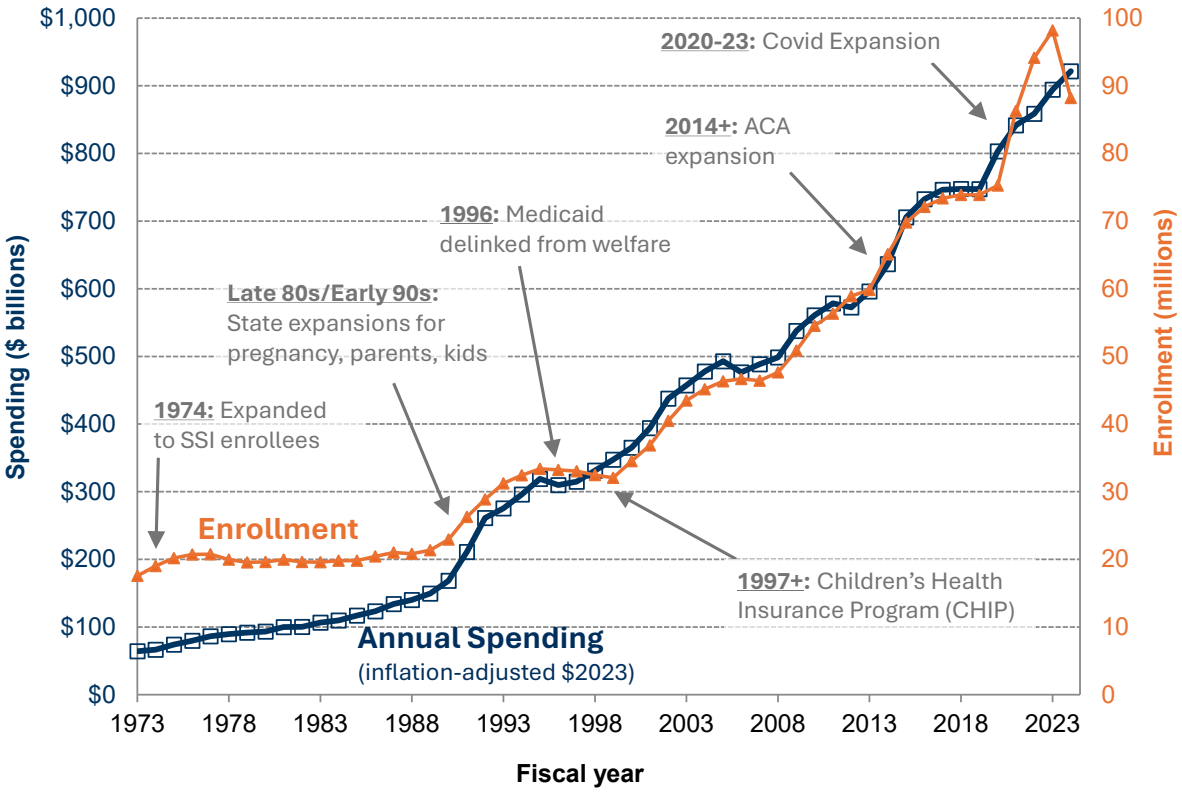
Medicaid was created in 1965 alongside Medicare (the health program for seniors age 65 and over) as a federal-state program originally aimed at covering specific groups of low-income Americans — primarily mothers and children, the elderly, and people with disabilities — but has expanded over time toward broader coverage of low-income adults. Medicaid is both a key source of *health insurance* and a central piece of America's *social safety net*. Without Medicaid, many more low-income individuals would be uninsured, as they generally lack employer-provided insurance that covers most higher-income Americans.

Medicaid covers a broad set of benefits, encompassing a wider range of services than most other health insurers. In addition to mandatory coverage of hospital and physician care, states may include "optional" benefits such as dental and vision care. Medicaid also finances a large share of long-term services and supports for individuals with complex medical or functional needs, including care in nursing homes and home-based care. Coverage is provided with little to no cost-sharing, and beneficiaries generally do not pay premiums.

Eligibility for Medicaid varies by state and population group but has broadened considerably since its inception. States must cover certain mandatory populations—primarily low-income children, pregnant individuals, seniors, and people with disabilities—and may also opt to cover additional groups. The Patient Protection and Affordable Care Act of 2010 intended to further expand eligibility by making all adults with incomes below 138 percent of the federal poverty level eligible. However, the US Supreme Court decision in *NFIB v. Sebelius* (567 U.S. 519 (2012)) made this expansion optional. As of 2025, 40 states and the District of Columbia have adopted the Medicaid eligibility expansion.

Medicaid's history is marked by two key trends: *growing size* and *increasing privatization*. Figure 1 shows Medicaid's growth in enrollment and inflation-adjusted spending over time, labeling key policy events. From about 20 million enrollees in the early 1970s, it grew to over 90 million at its Covid-era peak in 2023, after which it declined to 77 million as of late 2025 (not shown in the figure). Total federal and state spending (in 2023 dollars) rose from about $100 billion in the 1970s to over $900 billion today. Almost all recent spending growth has come from expanded enrollment rather than rising costs per person. Real *per-enrollee* Medicaid spending has been constant at around $10,000 per year since the late 1990s.

Figure 1: Medicaid Program Growth and Key Policy Events

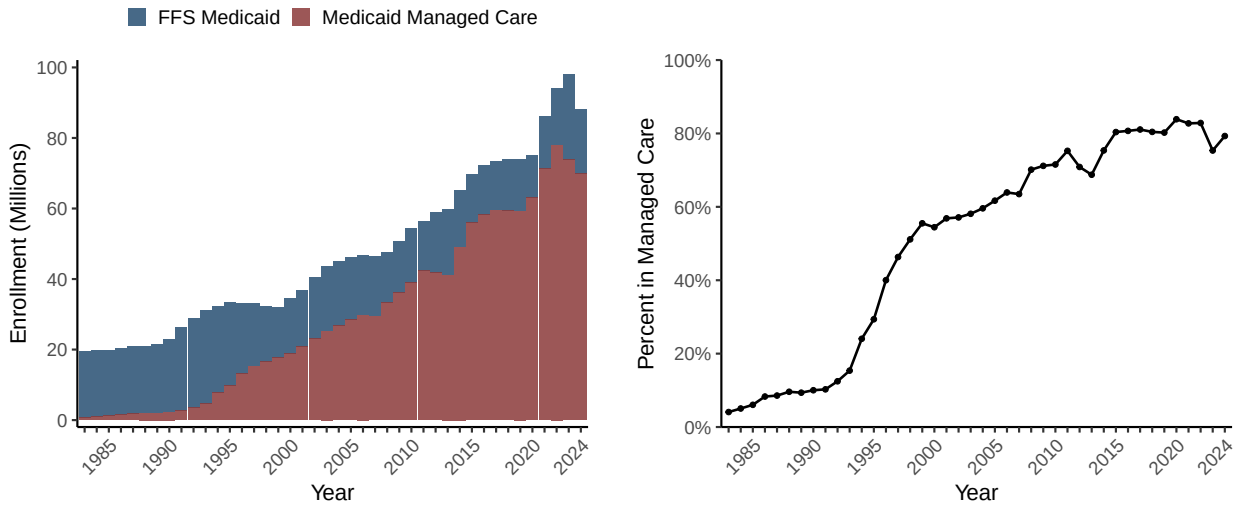


Notes: Figure based on data from MACStats (2024), with 2024 data from MACStats (2026) (exhibit 10). Enrollment is full-year equivalent enrollment in Medicaid and the Children's Health Insurance Program. Spending is total annual Medicaid and Children's Health Insurance Program spending (federal + state), inflation-adjusted to 2023 dollars using the Consumer Price Index (CPI-U). SSI is Supplemental Security Income, in which the Social Security system provides income to the low-income elderly and disabled. ACA stands for the Patient Protection and Affordable Care Act of 2010.

Medicaid's steady growth has placed pressure on policymakers to control costs. Historically, the main ways states have done this have been by reducing optional benefits, restricting eligibility, or cutting payments to doctors, hospitals, and other medical providers. This pressure has contributed to a long-running search for more efficient delivery models, including whether *outsourcing* to private managed care insurers can save money.

Figure 2 shows the trend towards outsourcing Medicaid delivery to private managed care insurers. From a tiny share of Medicaid enrollment in the 1980s, Medicaid managed care grew sharply during the 1990s to cover about 60% of Medicaid enrollees by 2000, following a broader shift towards managed care in U.S. health insurance during the 1990s. Whereas managed care experienced a nationwide "backlash" in the late 1990s, Medicaid managed care enrollment continued to grow during the 2000-2020 period. By 2024, roughly 85 percent of Medicaid beneficiaries were enrolled in some form of managed care. This sharp growth raises important questions about the

Figure 2: Growth of Medicaid Managed Care over Time



Notes: The figure documents the shift in Medicaid enrollment from state-run fee-for-service plans to private managed care plans over 1983–2024. The left panel shows total Medicaid enrollment (in full-year equivalent enrollees) decomposed into fee-for-service and managed care. The right panel plots the managed care share over time (managed care enrollment divided by total enrollment), which rises from near zero in the mid-1980s to 84 percent by 2024. Managed care enrollment is defined broadly to include risk-based plans and primary care case management. Managed care enrollment data come from several sources: Kaiser Family Foundation (1995) for data on 1983-1994, Kaiser Family Foundation (2001) for 1995-2000, Kaiser Family Foundation (2011) for 2002-2011, and Kaiser Family Foundation (2026) for 2013-2024. Managed care enrollment for 2001, 2012, and 2023 is linearly interpolated from adjacent years. Total Medicaid enrollment is from MACPAC (2026), exhibit 10.

efficiency of outsourcing Medicaid delivery, which we discuss next.

2.2 The Rise of Medicaid Managed Care

The shift toward Medicaid managed care—under which states contract with private managed care organizations—began in the early 1970s, though Medicaid managed care did not become the dominant delivery system until decades later. Medicaid managed care represents the "buy" rather than "make" choice.

Under traditional fee-for-service Medicaid, the state Medicaid agency pays providers directly for medical care they deliver. Under managed care, by contrast, the state makes a per-member-per-month "capitation" payment to a private managed care organization. The payment is risk-adjusted based on enrollee demographics—such as age, sex, and eligibility category—as well as health conditions to account for differences across plans in the expected cost of enrollees. For example, a plan would receive a higher capitation payment for an adult enrollee with a disability than a healthy child. In exchange for these capitation payments, managed care organizations—generally large commercial insurers, Medicaid-focused insurers, or provider-sponsored plans affiliated with

safety-net providers—assume responsibility for building a network of contracted providers, paying those providers, and managing enrollee care. In effect, the government outsources care management to private firms while continuing to provide financing and set program rules.

Outsourcing to private firms with high-powered incentive contracts involves a classic set of tradeoffs studied in a large literature in contract theory (for example, Laffont and Tirole (1993); Shleifer (1998)). On the one hand, under capitated insurance contracts, private managed care organizations capture the full benefits of making cost-reducing changes like eliminating unnecessary care, negotiating lower prices, and finding ways to keep people healthy. Private insurers may be better able to reduce costs and improve quality than a program operated by public sector employees. (An important assumption here is that there exist socially efficient ways to reduce costs in health insurance and that private insurers have the tools to implement them, a point to which we will return.)

On the other hand, private insurers may go *too far* in cutting costs because they do not internalize the negative impacts of cost-cutting on "non-contractible" quality (Shleifer, 1998). For example, an insurer could cut costs by denying claims for truly necessary services or by maintaining an inadequate network of doctors or hospitals. If it is infeasible for states to specify what "necessary" or "adequate" means in every situation, then this incomplete contracting may lead to under-provision of quality by private firms.

Thus, the superiority of the "buy" option (private contracting) depends on the extent to which quality is observable and contractible (Hart, Shleifer and Vishny, 1997). If quality is easily specified—as it is likely to be in, say, cement production or garbage collection—then contracting out can leverage private efficiency without suboptimal quality. However, if quality is hard to observe, the effects of contracting on welfare become ambiguous. Because the contractor has the ability to stint on dimensions of quality not observed by policymakers, the result may be lower-quality output, even if private firms are in principle more efficient. Hart, Shleifer and Vishny (1997) develop this argument through a discussion of private prisons where, like health care, quality is important but non-contractible. In their model, private contractors have *too* strong of an incentive to cut costs because they capture the savings but don't internalize the quality reductions. This is because prison quality depends on factors such as guards' judgment, which are impossible to specify ex ante. Prison contracts can mandate training hours or restrict the use of force, but these crude proxies leave substantial discretion to contractors.

The experience of California as a pioneering Medicaid managed care state illustrates the potential pitfalls of contracting out. California expanded Medicaid managed care in 1972—taking a *laissez-faire* approach to encourage rapid market entry—and within a year, there were 132,688 beneficiaries enrolled in 22 Medicaid managed care plans (Chavkin and Treseder, 1977). However, subsequent investigations revealed that this rapid growth was fueled by predatory marketing prac-

tices. Plans engaged in aggressive door-to-door solicitation, utilizing inducements ranging from fried chicken to football tickets, as well as deceptive tactics such as having enrollers disguised in medical uniforms threaten a loss of benefits. Once enrolled, patients often faced significant barriers to access care, with restrictive policies linked to at least one patient death. There were also allegations of "cream skimming" in which plans selectively enrolled healthier, lower-cost beneficiaries. Auditors found that only 48 percent of the capitation payments to plans had been expended on health care services.

Ultimately, these California Medicaid scandals precipitated a swift policy backlash; the resulting state and federal reforms stalled the momentum of Medicaid managed care for decades. However, the reforms also shaped the regulatory framework that would eventually govern a nationwide resurgence for Medicaid managed care.

Medicaid managed care enrollment accelerated during the "managed care revolution" of the 1990s. One catalyst was rising Medicaid costs—often termed the "Pac-Man" of state budgets. Another was the removal of the "75/25 rule" that no more than 75 percent of the enrollment of a managed care organization be composed of Medicaid and Medicare enrollees. This rule was originally designed as a "private market test" for plan quality, limiting participation in the Medicaid program to plans that also operated in the commercial market. It was repealed as part of the Balanced Budget Act of 1997, with the intent of removing a barrier to entry in Medicaid.

Enrollment in Medicaid managed care surged from under 10 percent in 1990 to over 50 percent by 1998, and has now reached approximately 85 percent of all beneficiaries (Figure 2). Over the past decade, the federal government has issued new Medicaid managed care regulations (in 2016) and updated regulations (in 2020) to tighten oversight, but there remain open questions as to whether the Medicaid managed care model is the right approach and how best to structure it.

2.3 Make or Buy? Evidence on the Effects of Medicaid Managed Care

States have articulated several additional rationales for the shift to Medicaid managed care. One is cost containment. Another is budget predictability: states claim that the capitation model stabilizes expenditures relative to the open-ended liability of fee-for-service models. Yet another is the potential for competition among managed care organizations to spur innovation and improve the efficiency and quality of care delivery.

The evidence is mixed on whether Medicaid managed care achieves cost control, with estimated effects going in both directions and differing across states, populations, and services studied. Figure 3 presents estimates of the effects of Medicaid managed care on government spending (top panel) and healthcare spending (bottom panel). The distinction between government spending and healthcare spending turns out to be critical for interpreting the evidence. Studies that focus on

government spending as the outcome generally report null or positive effects of Medicaid managed care. That is, privatization does not appear to have reduced, and may have increased, the cost to taxpayers. This is a striking result given that cost containment was the primary rationale for the shift to managed care.

By contrast, studies of the effects of Medicaid managed care on *healthcare spending* tend to find negative or null effects of Medicaid managed care. For example, Macambira et al. (2025)—which uses variation due to the random assignment of enrollees to Medicaid managed care vs. fee-for-service in Louisiana—finds that managed care reduces overall healthcare spending by 7 percent relative to fee-for-service, driven by a 25 percent reduction in pharmacy spending.[1] Hence, while there is limited evidence that Medicaid managed care reduces government spending, there is some well-identified evidence that it reduces healthcare spending.

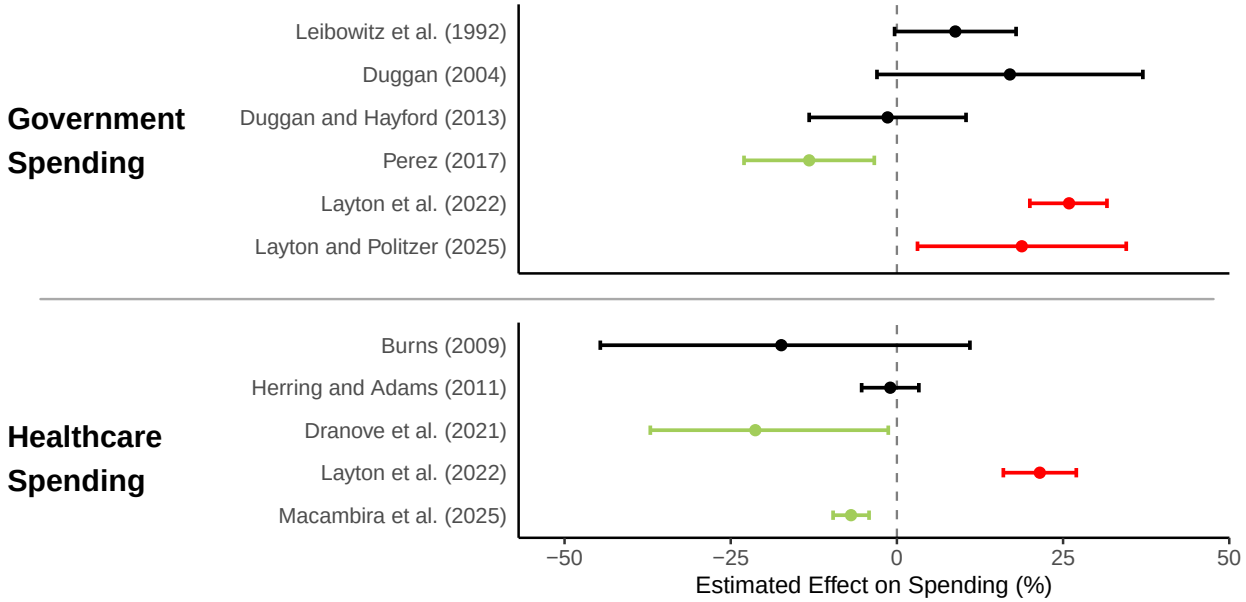
The gap between these two sets of spending results is an important area for future research. Reduced healthcare spending need not translate into lower government spending for several reasons: managed care plans may capture the savings as profits; the increased administrative costs of operating a managed care system may offset lower healthcare spending; or fiscal dynamics—under which states base future capitation payments on plans' historical costs—may increase capitation payments to plans over time (Layton and Politzer, 2025). At the same time, the evidence that managed care reduces healthcare spending suggests there may be efficiency gains from contracting out and raises the question of whether procurement can be redesigned so that states capture more of the savings.

Research on the impacts of privatization on quality of care and enrollee health is inconclusive (Sparer (2012), Franco Montoya, Chehal and Adams (2020)). While several studies document severe health harms, including increased mortality and worse birth outcomes (Aizer, Currie and Moretti (2007); Kuziemko, Meckel and Rossin-Slater (2018); Duggan, Garthwaite and Wang (2021)) and lower enrollee satisfaction (e.g., Macambira et al. (2025)), others find evidence of expanded access and patient benefit or no evidence of harm (e.g., Chorniy, Currie and Sonchak (2018); Dranove, Ody and Starc (2021); Layton et al. (2022)). The variation in findings is not easily explained by differences in the populations or states studied, making it difficult to draw general conclusions about when managed care helps or harms enrollees. Understanding the sources of this heterogeneity remains an important area for future research.

Collectively, the evidence on cost and quality suggests that the "make vs. buy" decision remains an open question in Medicaid. We note, however, that many states have moved on from this issue and are committed to the Medicaid managed care contracting approach. Therefore, how to design

[1] This result is similar to Dranove, Ody and Starc (2021), who find that Medicaid managed care reduces pharmacy spending by 21 percent using a different source of identifying variation—the state-level carve-ins of pharmacy services from fee-for-service to Medicaid managed care.

Figure 3: The Effects of Private Managed Care vs. State-Run Fee-for-service on Spending



Notes: The figure shows estimates of the causal effects of private Medicaid managed care (relative to a state-run fee-for-service plan) on Medicaid spending, drawing on key papers from the literature. The top panel shows the impact on government spending—what the state pays to insurers. The bottom panel shows impacts on healthcare spending—the cost of healthcare actually used by patients. The gap between the two includes insurer administrative costs and profits. Green indicates a statistically significant decrease in spending. Red indicates a statistically significant increase in spending. The included studies differ based on the geography, populations, and services studied. Most studies are national in scope—with the exception of Leibowitz, Buchanan and Mann (1992) [Unidentified state], Duggan (2004) [California], Layton et al. (2022) [Texas], and Macambira et al. (2025) [Louisiana]—and focus on total spending (government or healthcare). The one exception is Dranove, Ody and Starc (2021), which studies the effects of Medicaid managed care on pharmacy spending.

Medicaid managed care, rather than whether to do it, is the relevant policy question for most policymakers.

3 Medicaid's "Procured Competition" Approach

Classic debates in economics focus on *whether* governments should intervene in markets, but an equally important question is *how* governments intervene. Public involvement can range from lightly regulated competition to direct public provision. Between these extremes lies a wide range of institutional arrangements whose structure and economic logic can be difficult to parse. Nowhere is this clearer than in health care, where governments rely on a diverse and often confusing mix of market- and non-market-based approaches.

We start from the premise that Medicaid's goal is to ensure low-income people can access needed basic health care at an efficient public cost. Federal and state rules specify a detailed set

of covered services—e.g., hospital care, physician care, and prescription drugs, and more—but determining when care is truly needed and how it can be delivered most efficiently is operationally complex. This is a central function of modern health insurance, which "manages" care and negotiates prices to contain costs. But how can the government ensure that the private insurers perform well, rather than stint on needed care to boost profits?

3.1 The Role of Government in Health Insurance

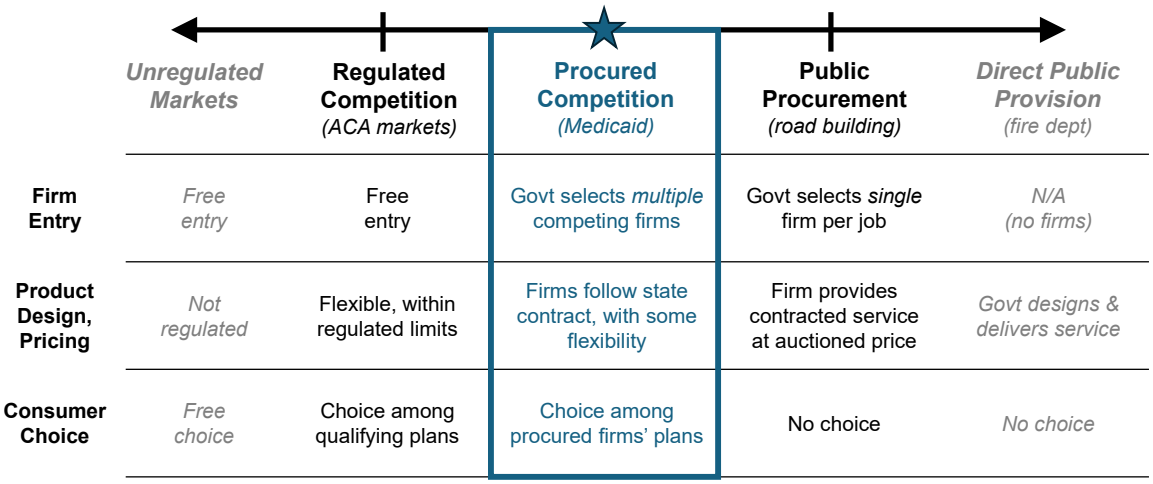
Figure 4 presents a framework for organizing the government's involvement in delivering social goods, from free markets at one end to direct public provision at the other. Along this spectrum, the government's role varies across three primary dimensions: (1) which firms can compete (firm entry), (2) how services are designed and priced (product design and pricing), and (3) the degree of consumer choice.

At one extreme is *unregulated (or free) markets*, in which firms can freely enter and set prices and product features, and consumers can freely choose among competing options. While free markets can be efficient under textbook conditions, health insurance is an industry that departs sharply from this benchmark. Insurance is a classic *selection market*, in which competition is distorted by firms' incentives to avoid high-risk consumers (the sick) rather than improve quality and value (Einav, Finkelstein and Fisman, 2023). These problems are compounded by high concentration and *market power*, for which there is increasing evidence and which interact with selection incentives (Dafny, Duggan and Ramanarayanan (2012); Mahoney and Weyl (2017); Kong, Layton and Shepard (2024)). In addition, insurance is a *complex product*, and extensive evidence shows that consumers struggle to make fully informed and rational choices among plans (Abaluck and Gruber (2011); Handel and Kolstad (2015); Bhargava, Loewenstein and Sydnor (2017); Ericson and Sydnor (2017)). Finally, *efficiency* is not the sole objective: ensuring *equitable* access to health care—especially for the poor, for whom most modern medicine is unaffordable—is a priority that markets alone cannot deliver.

Some argue that health insurance departs so fundamentally from a standard market good that *direct government provision* is warranted. While the classic example is municipal fire departments, direct provision is also common in healthcare. Examples include the UK's National Health Service and America's Veterans Health Administration—systems that are owned, operated, and financed entirely by government. Direct provision of health *insurance* is used in nations like Canada and Taiwan, even if most hospitals and doctors are private. Fee-for-service Medicaid is an example of this type of direct public provision of insurance.

Between these extremes lie two common middle-ground approaches for health insurance: *regulated competition* and *public procurement*. Regulated competition retains market entry and con-

Figure 4: Framework for Government's Role in Social Services



Notes: The figure shows five models for government's role in social services, ranging from minimal role (free markets) to full control (direct public provision). The models differ in three dimensions: (1) which firms can compete (firm entry), (2) how services are designed and priced (product design and pricing), and (3) the degree of consumer choice. Examples of each model are shown.

sumer choice but imposes rules on pricing and product design to address selection, quality, and market power concerns. The goal of such regulations is not to replace markets, but to "manage competition" to make insurance markets work (Enthoven, 1993). The health insurance Marketplaces established under the Affordable Care Act are a familiar example.

By contrast, *public procurement* starts from government control but *outsources* implementation to private firms. In this model—familiar from road construction and public infrastructure—the government specifies the desired product and then invites firms to compete for a contract, often via bidding on a formal auction. The government selects a single "winning" firm, which then supplies the contracted services at the agreed price. The government's role then shifts to contract management and enforcement—raising familiar principal-agent issues around effort, incentives, and monitoring.[2]

Despite decades of experience, there is no consensus on whether regulated competition or more centralized approaches like public provision or procurement, work better for health insurance. Market-based models have expanded substantially, as seen in growth of Medicare Advantage and the Affordable Care Act Marketplaces.[3] On the other hand, dissatisfaction with cost, complexity,

[2]Although often overlooked, both traditional Medicare and fee-for-service Medicaid rely heavily on contracting for administrative functions like claims processing, with evidence that these contractors matter for outcomes like claims denials (League, 2023) and fraud detection (Shi, 2024).

[3]From a small program in the early 2000s, Medicare Advantage has grown to cover over half (54 percent) of Medicare enrollees in 2025. Affordable Care Act marketplace enrollment more than doubled between 2020 and 2025, driven by larger subsidies and stronger insurer competition.

and access in these programs remains widespread.

Medicaid managed care offers a distinctive alternative. By combining elements of public procurement with regulated competition, it occupies a middle ground that seeks to harness the strengths—and limit the weaknesses—of both approaches. We turn next to the defining features of this model of *procured competition*.

3.2 Procured Competition: Medicaid's Hybrid Model

Medicaid managed care blends public procurement with market competition. Unlike standard procurement, where a single winner takes all, Medicaid selects *multiple* insurers that then compete for enrollees in a market. This blended model injects market discipline into a classic contracting environment, but it also creates a complex set of incentives that states must actively manage.

To understand this hybrid model, note that Medicaid managed care is, at its core, much closer to public procurement than regulated markets, along three main dimensions. First, government *selects* insurers via procurement. To participate in Medicaid, insurers must submit bids and be chosen by the state; participation is determined by state selection rather than free entry.

Second, government *specifies* most plan features and prices. States specify detailed provisions via managed care contracts that are often hundreds of pages long. These contracts define covered services, patient cost-sharing (essentially zero), rules for provider networks, insurer compensation arrangements, and provisions for quality reporting and oversight. They also specify insurer prices (payments per enrollee) and other compensation provisions, such as risk adjustment. Insurer flexibility is limited to a few features like provider networks and care management rules. Additionally, Medicaid insurers each offer a *single* plan, limiting insurer flexibility but simplifying enrollee choice. By contrast, markets like the Affordable Care Act markets and Medicare Advantage allow insurers to offer multiple plans and feature dozens or even hundreds of available plans.

Third, government *oversees* insurer performance. States retain ultimate responsibility for program performance, even as they delegate implementation to private firms. States actively manage contracts over time, monitor insurer behavior, and can impose sanctions or exclude underperforming plans.

At the same time, Medicaid managed care incorporates a limited role for market competition. Because states contract with multiple insurers, beneficiaries can choose their preferred plan and switch if they become dissatisfied. Evidence suggests enrollee choices respond to plan quality, implying that choice injects real market discipline (Geruso, Layton and Wallace, 2023).[4]

Why adopt this hybrid structure? Consider the overall goals of Medicaid managed care: (1) selecting the right health insurers to participate (*procurement*); (2) getting those plans to exert

[4]Of course, if the consumers who switch plans are unhealthy and therefore unprofitable, the incentive can go in the opposite direction (Shepard (2022); Kreider et al. (2024). This is the perverse logic of adverse selection.

costly effort (*contract management*); and (3) sorting consumers into plans that best fit their needs (*matching*). Contracting with multiple insurers helps limit concerns about incumbent lock-in and market power, especially given the disruption associated with insurer exits (Politzer, 2024). At the same time, consumer choice can complement traditional contract tools—such as monitoring and pay-for-performance—by rewarding plans that perform well on dimensions that consumers can see but that are difficult to specify or enforce in contracts. Finally, offering multiple plans allows the state to accommodate heterogeneous preferences, particularly for provider networks.

Conversely, procurement can be understood as a way of addressing well-known market failures in insurance (Cuesta and Tebaldi, 2025). Even with strong regulations and corrective incentives, growing evidence suggests that adverse selection, market power, and consumer choice frictions remain potent forces that distort insurance competition. Medicaid addresses these problems by tightly *standardizing* plan features while giving states authority to *select the menu* of competitors. If used well, this authority could let states curate a desirable set of plan options, limit insurer profits, and allow consumers to choose within an approved menu of "sufficiently good" options. If used poorly, however, outcomes could be worse than what emerges from a less tightly controlled approach.[5]

Together, these features illustrate the central theme of this paper: Medicaid's procured-competition model blends government control with selective use of market forces in an effort to manage incentive problems inherent in outsourcing. The effectiveness of this hybrid design depends not only on whether states contract out to managed care, but on how they design the specific policies governing procurement and competition, which we examine next.

4 Key Policies for Medicaid's Procured Competition

Having outlined the goals of contracting out Medicaid to private managed care insurers (Section 2) and introduced the "procured competition" model at a high level (Section 3), we now turn to the key policy choices involved with implementing it. We organize our discussion around three core areas: (1) the *procurement process*, (2) *market design* rules, and (3) *plan choice* rules. For each, we describe current practice, how it maps to economic theory, and the existing evidence and open questions for policy and research. Table 1 summarizes these features and the main areas where additional research is needed.

[5]Medicaid is not unique in using elements of procured competition. Large employers commonly select a limited set of health plans through procurement, and some Affordable Care Act Marketplaces—such as those in California and Massachusetts—use "active purchasing" models in which regulators negotiate terms and determine which plans are offered (Shepard and Forsgren, 2023). These suggest additional settings in which economists can gain insights about the effectiveness of procured competition policies.

Table 1: Key Features of Medicaid's Procured Competition Model

Policy Area	Medicaid's Distinct Features	Key Questions for Policy/Research
Procurement Process	1. Insurer costs/prices play little role in procurement (*prices are set administratively*)	Should states use *competitive bidding* to set prices subject to regulatory constraints?
	2. Medicaid selects *multiple* winning insurers *(vs. standard auctions with a single winner)*	Should states be more selective? Or should they forgo auctions and accept "any willing plan"?
	3. Medicaid uses complex scoring auction for selecting winners, often with little weight on cost.	What are the optimal scoring auction weights to put on cost, quality, and other features?
Market Design Rules	4. Most benefits are standardized (*exception: provider networks, utilization management, customer service*)	Is standardization optimal? How best to ensure adequate networks and appropriate prior authorization?
	5. Enrollees pay zero premiums ($\rightarrow$ *no incentive to choose cheaper plans*)	Should there be premium competition? Should low-cost plans be allowed to offer supplemental benefits (as in Medicare Advantage)?
	6. Cost-cutting incentive limited by *risk sharing* and *dynamic cost-plus rate setting*	Do these provisions raise costs? What is the optimal balance between risk sharing vs. cost-cutting incentives?
Plan Choice Rules	7. Large share of enrollees are passively *auto-assigned* to plans ($\sim$45% in median state)	What are implications of assigning based on quality or cost? What does an optimal auto-assignment algorithm look like?
	8. Public fee-for-service plan operates alongside private managed care organizations	Should market be public only, private only, or a choice ("*public option*")?

Notes: The table shows distinct features of Medicaid's procured competition model, grouped into three policy areas. The final column lists key open questions for policymakers and economic researchers.

4.1 Medicaid's Procurement Process

A central feature of the Medicaid managed care model is that the state selects insurers via a *procurement process*. The entire process can take 18 to 24 months and involves a strategic planning phase in which the state specifies the desired product characteristics, issues a request for proposals, collects proposals, announces the winning bidders, and negotiates final contracts. Economic theory points to three key considerations for states: (1) the role of cost and quality in the auction scoring rules; (2) how many winners to select; and (3) for how long to award contracts.

A growing body of evidence suggests that the stakes of procurement auctions are high in Medicaid, due to the large differences in cost and quality of performance across health insurers. For example, exploiting random assignment across Medicaid plans, Geruso, Layton and Wallace (2023) find that insurer costs varied by 25 percent—with the enrollees preferring higher spending plans.

In a commercial setting, Handel and Kolstad (2015) found similar-sized differences in health care spending across insurers. Insurers also seem to vary in quality. Studying plan exits in Medicare Advantage, Abaluck et al. (2021) find meaningful differences in mortality and show that consumers placed little weight on this in their choices. These results also raise questions about the apparently limited ability of consumers to observe quality.

States must decide how to incorporate cost and quality into the procurement process. Medicaid contracts involve multiple dimensions—such as price, benefits, provider networks, and quality—so states typically rely on *scoring auctions* that evaluate bids along several attributes rather than price alone. This approach is well suited to settings where key aspects of performance vary in their levels of contractibility (Asker and Cantillon, 2010). Evidence from other public procurement settings suggests that these design choices can matter. For example, when the California Department of Transportation awarded some highway contracts using a scoring system that rewarded both lower prices and faster completion times, projects were completed 30–40 percent faster, and the resulting benefits to commuters exceeded the increase in procurement costs (Lewis and Bajari, 2011).

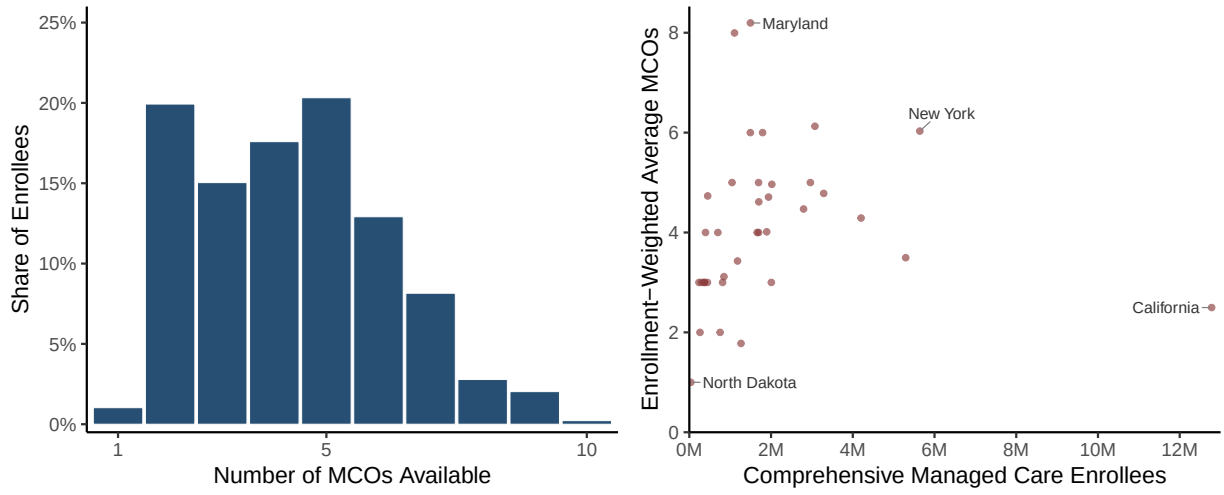
Despite the widespread use of scoring auctions in Medicaid, states vary substantially in how they structure them—for example, in the relative weight placed on price versus quality or provider network adequacy (Baumgarten, 2020). This variation suggests a promising opportunity for empirical research. Several states have revised their procurement methods over time or adopted more formal scoring systems, and procurement records and contract outcomes are often publicly available. Yet there is little systematic evidence on how these auction designs affect which insurers are selected, the prices states pay, or the quality of care delivered.

One defining feature of Medicaid's procurement model is a near absence of cost/price competition across most states. States generally set capitation rates administratively using actuarial analyses and select the winners based on non-price dimensions (i.e., with essentially zero weight on price/cost in scoring auctions).[6] Even states that collect competitive cost bids are constrained in rate-setting by federal rules that specify "actuarially sound" rate ranges.

At first blush, the limited role of cost in Medicaid procurement auctions appears to be a puzzle. However, cost-based auctions may lead to a "winner's curse" where the winning firms are those most likely to have *underestimated* their costs (Decarolis, 2014). Minnesota's 2015 procurement offers one such example. To reduce cost, Minnesota allowed cost to account for 45 percent of the auction score, and two new entrant insurers with low bids won most of the statewide contracts (Baumgarten, 2020). Within months, these insurers reported large losses, and one eventually exited. Minnesota subsequently removed cost from its Medicaid procurement scoring. While Min-

[6]Based on data for 2014, Layton, Ndikumana and Shepard (2017) report that 32 states use administrative rate setting, six states use negotiated rates, and six use competitive bidding. A more recent report by MACPAC (Forbes and Dunbar, 2022) does not report data but gives the following summary: "Most states have MCOs [managed care organizations] compete on program elements, not price."

Figure 5: Variation in Number of Medicaid Managed Organizations per County



Notes: The figure shows the distribution of number of Medicaid Managed Care Organizations (MCOs) available per county. Panel A shows the enrollment-weighted distribution of MCO availability; bars reflect the share of enrollees residing in counties with a given number of MCOs. Panel B plots each state's comprehensive managed care enrollment against its enrollment-weighted average number of MCOs per county. Comprehensive managed care enrollment in Panel B is from the CMS Medicaid Managed Care Enrollment Report, 2022; all other data are from T-MSIS Analytic Files (TAF), December 2022. We restricted the sample to 36 states with comprehensive Medicaid managed care programs with high quality data.

nesota's experience illustrates the risks of weighting cost heavily in procurement, it is only a single case; more systematic evidence is needed on whether and how states should incorporate cost into scoring auctions.

That Medicaid nonetheless remains among the lowest-cost forms of US health insurance suggests that aggressive price bidding may not be essential for cost control. But it also leaves open whether factoring price into procurement could generate even lower costs.

A second defining feature of Medicaid procurement is how many winners are selected. States vary widely in the number of competing managed care organizations per county, even after accounting for market size, as shown in Figure 5. Commonly, about half or more of bidding insurers win a contract.[7] However, a few states allow "any willing plan" to participate if they satisfy contract requirements—a policy closer to free entry than competitive procurement.

[7]While comprehensive data on bidding and plan selection do not exist, a few examples are illustrative. Oregon's 2019 procurement awarded contracts to 15 of 19 bidders (Baumgarten, 2020). California's 2022 procurement ultimately awarded contracts to five of eight bidders (three bidders initially, and another two after appeals, as reported in Kelly 2023). Florida's 2024 procurement awarded contracts to five of eleven bidders: see bidders at `ahca.myflorida.com/download/23423` and winners at `ahca.myflorida.com/download/24478`. Nebraska's 2022 procurement selected three of five bidders: bidders are listed at `das.nebraska.gov/materiel/purchasing/112209-03/Respondents.pdf` and winners at `das.nebraska.gov/materiel/purchasing/112209-03/Intent-To-Award.pdf`.

States may have several reasons to favor broader participation. Contracting with multiple insurers can preserve beneficiary choice, improve plan-consumer matching (for example, access to preferred providers) and create market discipline through consumers' ability to switch plans. A larger set of participating plans may also limit incumbency advantage and strengthen states' ability to discipline underperformers (Anton and Yao, 1987). Finally, Medicaid procurements are often contentious, and greater selectivity would increase the risk of costly and time-consuming legal challenges from losing bidders. These legal challenges are an interesting area for research. Anecdotally, they play a large role in the formal structure of procurement, because agencies know they must justify decisions or face the risk of lawsuits, but whether this threat improves procurement or makes it overly "rigid" is an open question.

These benefits must be weighed against arguments for greater selectivity, including the potential to secure better terms and reduce cross-plan adverse selection—in this case, any factors or strategies that may tend to concentrate high-cost patients in a few plans (Ryan (2023); Cuesta and Tebaldi (2025)).

Finally, states must decide for how long to award Medicaid managed care contracts. Anecdotal evidence suggests that these contracts are generally more than three years long (Baumgarten, 2020). On the one hand, longer contracts avoid the administrative costs of re-procurement and strengthen incentives for long-term investments (Laffont and Tirole, 1993). On the other hand, shorter contracts increase performance incentives due to a more credible threat of near-term replacement (Albano and Cesi, 2008), but increase re-procurement costs and may lead to more frequent disruptions of members. Research is needed to document the variation in contract lengths and terms, and then to tie these differences to strategic insurer behavior and program outcomes.

4.2 Market Design Rules

After states select participating insurers through procurement, how should they structure *market design* rules to create incentives for insurers to deliver high-quality care while controlling costs for taxpayers? Again, the goal of market design is to induce insurers to assemble provider networks, manage care, and deliver services in ways that optimally balance access to care vs. costs. In practice, this effort involves tradeoffs.

The classic concern is that plans will stint on quality—limiting access "too much" to cut costs and earn profits. The incentive to stint, and to hope that stinting might not be observed by the state, arises from two types of asymmetric information. First, insurance "quality" is complex: it depends on detailed features of networks and care-management practices that are hard for both the state and enrollees to observe. In other words, there is meaningful *non-contractible* quality. Second, the enrollees best positioned to detect quality are sicker individuals who attempt to use complex care.

These sicker individuals are often unprofitable to insurers. An insurer who improves quality may be penalized by attracting many sick enrollees (that is, by adverse selection).

As a concrete example illustrating these forces, Kreider et al. (2024) study access to a world-class cancer hospital in New York's Medicaid program. Although access to the hospital was highly valued by cancer patients, it was also substantially more expensive. Prior to 2005, no Medicaid managed care plan covered the hospital. When one plan briefly added the hospital to its network, it experienced a large influx of cancer patients, an increase of about 50 percent. Because of relatively weak risk adjustment at the time, the change proved unprofitable, and the managed care organization dropped the hospital the next year. The result was an equilibrium in which no plan covered the top cancer hospital—a pattern echoed for other "star" hospitals in other insurance settings (Shepard (2022); Serna (2025)).

Medicaid programs address these concerns using a mix of two broad approaches. First, states impose regulatory limits on plan design. For example, states use a standardized benefit design for covered services and cost-sharing rules across insurers. As a result, competition is limited to a few flexible (and harder to standardize) attributes: provider networks, care-management strategies, and customer service.[8] Wallace (2023) demonstrates that the network differences across plans have consequences. Exploiting random plan assignment in New York's Medicaid program, he finds that narrower networks decrease spending by generating hassle costs that constrain the utilization of needed and unneeded services and reduce enrollee satisfaction, suggesting networks are an important but blunt instrument for reducing spending. In addition, states set premiums equal to zero for all Medicaid managed care plans, eliminating premiums as a possible competitive margin. This prevents low-cost plans from growing by offering discounts. It also limits the ability of low-quality plans to risk-select healthy enrollees by undercutting higher-quality plans.[9]

In the second broad approach, states use compensation incentives that encourage insurers to provide quality and/or to soften cost-cutting incentives. For example, states use pay-for-performance incentives that often give bonuses or tie a portion of compensation to meeting quality metrics, such

[8]While states set network adequacy requirements—rules specifying minimum numbers of provider by type and maximum time and distance to reach them—these are crude measures of access. This is a concrete illustration of the non-contractibility of quality problem discussed by Hart, Shleifer and Vishny (1997): what matters for enrollees is whether they can see a qualified provider in a timely manner, but what states can measure is only a rough approximation. States also struggle to enforce compliance with network adequacy standards. A growing body of evidence documents that many of the providers listed in provider network directories do not actually see Medicaid patients (Ludomirsky et al., 2022; Zhu et al., 2022).

[9]For health care systems as a whole, the question of whether it is useful to have competition in premiums paid remains open. For instance, national insurance systems in Switzerland and the Netherlands include premium competition, whereas the main systems in Germany and Colombia do not. Medicare Advantage allows premium competition, but in practice a large number of plans "bunch" premiums at exactly $0 (Stockley et al., 2014). For Medicaid, zero premiums reflect equity goals and limit adverse selection, but they also prevent plans from funding more generous (and more expensive) offerings through higher premiums. Outcomes from Medicaid may offer an opportunity to quantify the tradeoffs of a zero-premium design.

as ensuring enrollees get preventive screenings or can access care in a timely manner.[10] While useful, these metrics tend to capture only a small dimension of quality. Another approach involves risk sharing in compensation. Rather than having insurers bear full risk if enrollees have unexpectedly high costs—and therefore, giving insurers a strong incentive to cut costs—states share risk through *risk adjustment* (which pays more for sicker enrollees), *reinsurance* (which covers a portion of enrollees' very high costs), and *risk corridors* (in which the state shares a portion of insurers' overall profits/losses). A final approach to compensation incentives involves dynamic "cost-plus" contracting, in which states base payments on plans' historical costs. While this approach reduces the risk of current underpayment if past costs were already high, it also creates disincentives for cost-cutting because successful cost containment today leads to lower payments tomorrow (Layton and Politzer, 2024).

Together, these regulatory limits and compensation incentives make Medicaid managed care quite different from a standard regulated insurance market. Managed care organizations operate less like risk-bearing firms competing on price and product design, and more like state contractors whose incentives are shaped to limit selection and protect access.

The key question is whether Medicaid managed care is striking the right *balance* between cost-cutting vs. quality-encouraging incentives. This question has not yet been answered. At a concrete level, if an insurer cuts costs by $1 today (whether that cut happens by stinting on care or scrupulous cost containment), how much of that dollar does it retain vs. share with the state via the many layers of risk sharing, dynamic cost-plus contracting, and other provisions. It may be worthwhile to consider potential gains from alternative payment mechanisms—such as yardstick competition (Shleifer, 1985) or greater reliance on external benchmarks—but more empirical work is needed to understand the tradeoffs.

4.3 Plan Choice Rules

Medicaid managed care relies on rules for plan choice that shape how competition operates. In a standard market, consumer choices (demand) are the main driver of competitive incentives. But in Medicaid managed care, two additional provisions play a large role and offer opportunities for future research.

First, many Medicaid beneficiaries—45 percent in the median state, as of the latest available data (Smith et al., 2015)—do not actively choose a plan; instead, they are *auto-assigned* by the state. This makes the auto-assignment algorithm a key driver of market shares and incentives for managed care organizations. In principle, auto-assignment rules could reward high-quality or low-cost plans by directing passive enrollees toward them, thereby spurring competition (Buitrago

[10] These metrics are often based on the widely used "HEDIS measures" (which stands for Healthcare Effectiveness Data and Information Set) developed by the National Committee for Quality Assurance (NCQA).

et al., 2025). In practice, however, relatively few states take this approach, perhaps because traditional measures of plan performance are mired by selection concerns (Wallace et al., 2022, 2025). As of 2022, only 10 states reported incorporating quality-related performance measures into auto-assignment, and none explicitly assign enrollees based on plan costs (Hinton et al., 2022). States vary widely in how they approach auto-assignment: while some states assign enrollees in equal shares across plans, others weight assignment toward larger plans (to reward sought-after plans) or smaller plans (to balance enrollment and ensure sufficient scale.) This variation likely reflects, in part, competing policy priorities, but the absence of a clear best practice suggests there is significant scope to improve program efficiency through smarter defaults. For interested researchers, the fundamental starting points are to collect updated data on both how many enrollees are auto-assigned and how states set their auto-assignment rules—neither of which has been measured systematically since 2015—and to seek out administrative data that contains indicators for which enrollees are auto-assigned.

Second, states vary in whether they rely entirely on private managed care organizations for Medicaid (34 states) or entirely on a public fee-for-service plan (five states), or on a mixed model. A few states offer "primary care case management," which is a state-run plan that pays most claims as with standard fee-for-service, but also pays a primary care physician a small fee to manage an enrollee's care. Although primary care case management is not full-risk managed care—the state, not the primary care physician, retains the insurance risk—it introduces gatekeeping and coordinating functions that distinguish it from pure fee-for-service. Eight states offer enrollees a choice between private managed care organizations and primary care case management, effectively creating a public option within Medicaid markets. Some form of "public option" has been a major proposal for the state-run Marketplaces for individual health insurance, and Medicaid provides an interesting opportunity to gain evidence on its impact.

These plan choice rules remain largely unexplored in the Medicaid context, and have relevance to broader debates about health insurance reform. They would seem to be a particularly promising area for future work.

5 Conclusion

Medicaid managed care sits at the center of some of the most important questions in health economics and public policy. Medicaid is a massive public program with the dual goals of ensuring access to essential health care for low-income populations and doing so at an acceptable public cost. Over time, states have increasingly turned to *private insurers* to help meet these goals, fundamentally reshaping how Medicaid operates. Yet Medicaid managed care does not resemble either a standard insurance market or a conventional public procurement setting.

We have argued that Medicaid managed care is best understood as a hybrid model of *procured competition*. States use procurement to tightly specify benefits, prices, and oversight, while preserving a limited role for market competition through plan choice and enrollment. Viewing Medicaid through this lens helps clarify both its distinctive institutional features and the policy tradeoffs embedded in its design. Compared with regulated insurance markets, Medicaid relies far more heavily on standardization and administrative control; compared with traditional procurement, it incorporates consumer choice and multiple contractors.

This framework highlights a set of unresolved policy questions. How selective should procurement be? How much risk should insurers bear? How should plan choice, auto-assignment, and public options be designed? And do current payment and incentive structures strike the right balance between cost control and quality? As Medicaid continues to evolve—and as other insurance settings consider whether to draw lessons from Medicaid—understanding how procured competition works in practice remains a central task for researchers and policymakers alike.

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