PARAGON HEALTH INSTITUTE POLICY BRIEF

September 10, 2026

Medicaid's Disadvantage

Why Private Plans Work Better in Medicare Than in Medicaid

By Chris Pope

The Medicare and Medicaid programs both increasingly rely on private insurers to procure health care benefits for their enrollees. These arrangements are referred to as Medicare Advantage and Medicaid managed care, respectively. Policymakers hope that this will reduce costs while improving care for beneficiaries.

This arrangement has worked less well in Medicaid than in Medicare due to three fundamental structural differences between the programs:

1. ***The broad prohibition on beneficiary premiums in Medicaid.*** *This commits the government to covering whatever additional costs are incurred by relatively costly Medicaid plans. In turn, this creates a risk of plans vying to expand benefits at public expense, which prevents the government from permitting substantial competition in Medicaid managed care—eliminating much of the point of private management.*
2. ***The greater ambiguity and discretion in Medicaid eligibility.*** *Publicly financed private insurance allows insurers to profit by enrolling individuals who are ineligible for benefits. Medicaid eligibility is particularly hard to assess due to the ambiguity and fluctuations of beneficiaries' income and simultaneous enrollment in other sources of health insurance.*
3. ***The tension between state management and federal funding in Medicaid.*** *Whereas states are not permitted to increase the cost of Medicare Advantage through taxation and*

KEY TAKEAWAYS

Private management works much better in Medicare than in Medicaid. *Medicare Advantage gives plans meaningful incentives to control costs and compete for enrollees; Medicaid managed care often blunts those incentives through its financing and regulatory structure.*

Medicaid managed care rewards higher rather than lower costs. *Because states must pay actuarially sound rates that cover plans' expected costs—and enrollees generally pay no premiums—higher plan costs tend to feed into higher government payments in future years. Medicare Advantage operates much more like a defined contribution.*

Medicaid's structure shifts competition away from beneficiaries and toward state governments. *States select and heavily regulate participating plans, while beneficiaries are often required to enroll and nearly half of those who do not choose a plan are assigned one. This gives insurers stronger incentives to satisfy state officials than consumers.*

Managed care magnifies Medicaid's improper-enrollment problem. *Plans receive monthly payments for each enrollee, creating opportunities for continued payments for people who have moved, obtained other coverage, are unaware of their enrollment, or otherwise become ineligible.*

States have increasingly used managed care to draw down additional federal Medicaid dollars. *State-directed payments reached $124 billion across 39 states in 2025, with states permitted to require managed-care plans to pay providers substantially above Medicare rates.*

regulation, the federal government provides matching funds for state expenditures on Medicaid without any aggregate cap. As the scope of benefits and payments for specific Medicaid services are subject to limits, states have increasingly used private insurers to obtain additional federal aid with few strings attached and with minimal state contribution.

Why Privately Manage Publicly Financed Health Care?

Medicare Advantage and Medicaid managed care were similarly designed to bring the benefits of private management and market competition to publicly funded health care benefits.

Until the 1990s, private health insurance and public health entitlements operated in largely separate spheres. American health care benefits were either funded and managed by private insurers or funded and managed by the government. But recent decades have seen the development of a hybrid: health care benefits administered by private insurers but financed largely with public funds. Around 100 million Americans are now enrolled in such plans through Medicare Advantage, Medicaid managed care, or Affordable Care Act (ACA) exchange plans.[1] Figure 1 shows the share of Medicaid enrollees and Medicaid spending in comprehensive managed care plans from 1991 to 2025, while Figure 2 shows the share of Medicare enrollees and Medicare spending in Medicare Advantage plans over that same time period.

Both Medicare and Medicaid originally provided open-ended reimbursements for whatever costs providers incurred in the treatment of covered beneficiaries.[2] Congress gradually limited the fees providers could charge for Medicare and Medicaid patients but did little to curb the volume of services that could be billed to the programs and continued to pay for them without regard to cost-effectiveness.

Management by private insurers appeared to offer a solution to this problem. In the 1990s, managed care organizations successfully slowed the growth of health care costs by negotiating discounts, reducing inappropriate utilization, and steering patients toward more cost-effective providers.[3] By providing public funds for Medicare and Medicaid beneficiaries to obtain health care benefits from a variety of private insurers, policymakers hoped that plans would similarly compete to eliminate needless expenditures and maximize the value of services delivered to enrollees. Ideally, this would encourage plans to provide more preventive care, which would also avoid costly hospitalizations.

But procuring health care through upfront payments to insurers raises its own challenges. Principally, it is difficult to determine in advance how much funding is required to cover each beneficiary, as insurers are eager to profit by attracting enrollees who generate lower expected medical claims compared to premiums, including enrollees who generate little or no medical costs, in comparison to the government payment. If this occurs at scale, risk adjustment (the process by which the government pays less money to plans with healthier enrollees than to plans with sicker enrollees) will be materially imperfect, and payments to plans will tend to accordingly overshoot the true cost of coverage. Under such circumstances, contracting with private insurers may fail to reduce costs for taxpayers.[4]

Figure 1: Share of Medicaid Enrollees and Spending in Comprehensive Managed Care (1991–2025)

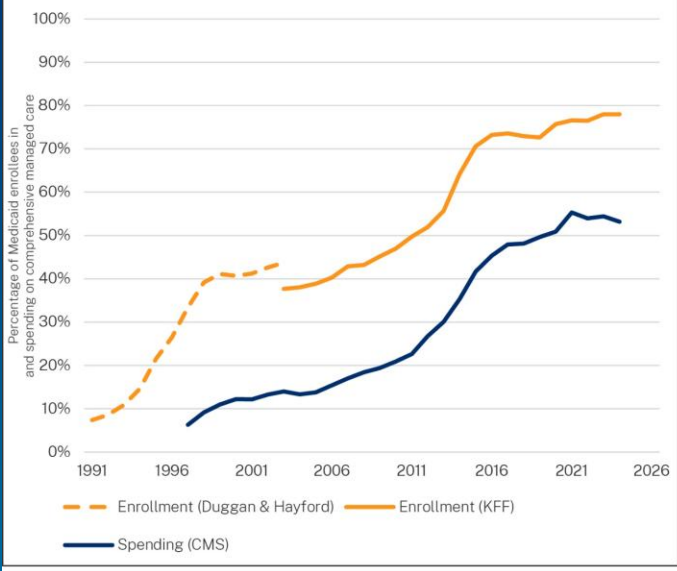
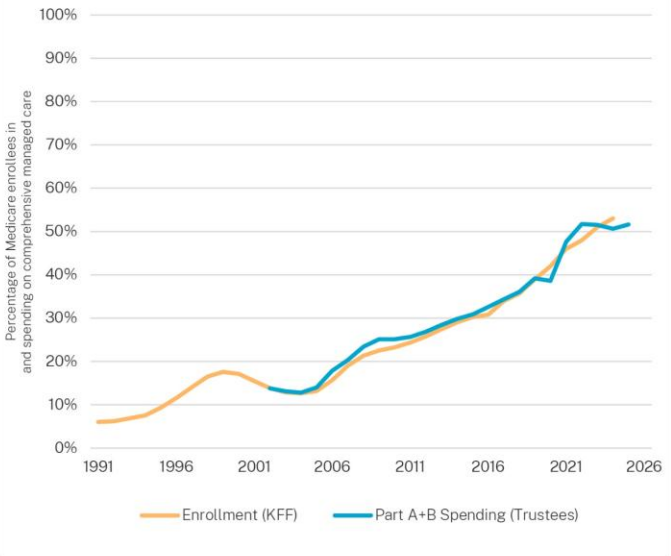


Figure 2: Share of Medicare Enrollees and Spending in Comprehensive Managed Care (1991–2025)



SOURCES: KFF, "Total Medicaid MCO Enrollment," https://www.kff.org/medicaid/state-indicator/total-medicaid-mco-enrollment/; Centers for Medicare and Medicaid Services, "Expenditure Reports from MBES/CBES," https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes; Medicaid and CHIP Payment and Access Commission, "Exhibit 10. Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1973–2023," https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-10.-Medicaid-Enrollment-and-Total-Spending-Levels-and-Annual-Growth-FYs-1973%E2%80%932023.pdf; Mark Duggan and Tamara Hayford, "Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates," National Bureau of Economic Research, July 2011, Table 1, https://www.nber.org/system/files/working_papers/w17236/w17236.pdf#page=42; Centers for Medicare and Medicaid Services, "Trustees Report and Trust Funds," https://www.cms.gov/data-research/statistics-trends-and-reports/trustees-report-trust-funds.

How the Programs Differ

Medicare is a federally funded medical benefit for retired and disabled workers, regardless of means. Medicaid provides federal matching funds for states to provide medical and long-term care benefits to mostly low-income residents. Table 1 contrasts Medicare and Medicaid across several key factors.

All Medicare beneficiaries nationwide have the option to obtain their benefits managed by private insurers through Medicare Advantage. These plans are paid defined contributions and allowed substantial discretion to attract enrollees by adjusting benefit packages, payments to providers, and premiums charged to beneficiaries.

In Medicaid, states may enroll beneficiaries in privately managed plans. Federal actuarial soundness regulations require state payments to insurers to fully cover the expected costs of benefits. States typically stipulate rules for how plans must compensate medical providers. Table 2 contrasts Medicare Advantage and Medicaid Managed Care across several key factors.

Table 1: Contrasting Medicare and Medicaid

	Medicare	Medicaid
Eligibility	Retired and disabled workers (60 million in 2024)[a]	Low-income residents (88 million in 2024)[b]
Benefits	Hospital, physician services, and prescription drugs	Hospital, physician services, prescription drugs, nursing home care, home health, and social services under waiver
Operation	Federally managed	State managed, under broad federal rules
Funding	86% federal spending; 14% beneficiary premiums[c]	35% state spending; 64% federal matching funds; 1% beneficiary collections[d]
Beneficiary costs	Part B and Part D premiums; coinsurance and deductibles.	Some states impose limited copays or collect long-term care expenses from estates.
Fiscal cost	$1.118 trillion (2024)[e]	$0.932 trillion (2024)[f]

NOTES:
a. Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund, 2025 Annual Report, p. 10, https://www.cms.gov/oact/tr/2025#page=16.
b. Medicaid and CHIP Payment and Access Commission, "Exhibit 10. Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1974–2024," https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-10.-Medicaid-Enrollment-and-Total-Spending-Levels-and-Annual-Growth-FYs-1974%E2%80%932024.pdf.
c. Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund, 2026 Annual Report, Table II.B1, https://www.cms.gov/oact/tr/2026#page=18.
d. Medicaid and CHIP Payment and Access Commission, MACStats: Medicaid and CHIP Data Book, February 2026, https://www.macpac.gov/wp-content/uploads/2026/02/MACSTATS_Feb2026_WEB_508.pdf.
e. Centers for Medicare and Medicaid Services, "National Health Expenditure Accounts: Historical," https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.
f. Centers for Medicare and Medicaid Services, "National Health Expenditure Accounts: Historical."

Key Differences

1. *Cost-Based Contribution: Medicaid Payments to Insurers Must Increase with Costs*

Medicaid's requirement that states entirely cover insurers' expected costs gives insurers little incentive to reduce expenses.

Medicaid insurers are generally prohibited from charging premiums to enrollees, and what nominal premiums exist do not vary across plans. As a result, public funding alone must suffice to assure the profitability of plans, and federal law requires state payments to plans to exceed the expected cost of benefits.[5]

These "actuarial soundness" regulations require states to cover plans' likely future costs, which are determined with standard actuarial practices based on health care prices, utilization, and overhead expenses from existing Medicaid

Table 2: Contrasting Medicare Advantage and Medicaid Managed Care

	Medicare Advantage[a]	Medicaid Managed Care[b]
Availability	Nationwide.	42 states for select beneficiary categories. Those with severe health care needs often carved out.
Beneficiary participation	All may choose between public and private plans.	States typically require those eligible to enroll in private plans.
Insurer participation	All satisfying program requirements.	Typically selected by states.
Public subsidy	Defined contribution based on county Medicare fee-for-service spending, adjusted for enrollee expected medical risks.	Must fully cover expected costs of every insurer. Rates set directly by 36 states; competitive bidding in 6. Risk-adjustment methods vary.
Plan choice	Voluntary by all beneficiaries.	Median state assigns 45% of enrollees who did not pick plans.
Premium competition	Plans may reduce Part B and Part D premiums or charge supplemental premiums.	None.
Benefit competition	Plans may unilaterally reduce out-of-pocket costs or add supplemental benefits.	Additional services as negotiated with states.
Scope	All Medicare benefits except hospice.	Most Medicaid medical care but drug, behavioral health, and long-term care services are often carved out by states.
Provider payment	Plans may negotiate discounts from Medicare fees with preferred networks of providers.	States typically set fees for providers and often require payments higher than Medicare fees.
Enrollment	53% of Medicare beneficiaries.[c]	78% of Medicaid beneficiaries.[d]
Spending	51% of Medicare spending.[e]	53% of Medicaid spending.[f]

NOTES:
a. Medicare Payment Advisory Commission, "Medicare Advantage Program Payment System," October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_MA_FINAL_SEC.pdf.
b. Timothy Layton et al., "Health Plan Payment in Medicaid Managed Care: A Hybrid Model of Regulated Competition," National Bureau of Economic Research, June 2017, https://www.nber.org/system/files/working_papers/w23518/w23518.pdf.
c. Meredith Freed et al., "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026, https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/.
d. KFF, "Total Medicaid MCO Enrollment," https://www.kff.org/medicaid/state-indicator/total-medicaid-mco-enrollment/.
e. Centers for Medicare and Medicaid Services, "Trustees Report and Trust Funds," https://www.cms.gov/data-research/statistics-trends-and-reports/trustees-report-trust-funds.
f. Centers for Medicare and Medicaid Services, "Expenditure Reports from MBES/CBES," https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes.

beneficiaries over the past three years. An increase in plans' costs will therefore tend to oblige states to push up their rates in subsequent years. Because the actuarial soundness requirements are largely based on recent Medicaid spending levels, they discourage plans from reducing the utilization or payment for medical services.[6]

By contrast, in Medicare Advantage, insurers are paid a fixed monthly amount based on the level of Medicare fee-for-service spending in each county, adjusted for enrollees' expected medical risks. As the program's benchmarks are set independently of activities that plans may undertake (with the limited exception of quality bonuses), they do not allow plans an unlimited capacity to push up public subsidies.

Medicare Advantage therefore effectively functions as a defined contribution, giving plans an incentive to reduce the cost of procuring health care for their enrollees. If these payments are expected to fall short of the cost of benefits, plans may charge supplemental premiums to make up the difference. Conversely, plans that lower their costs can use most of those savings to attract beneficiaries by reducing Part B, Part D, and supplemental premiums—or offering supplemental benefits.[7]

Unlike the ACA exchanges, neither Medicare Advantage nor most Medicaid managed care programs rely purely on competitive bidding to set public payments to insurers. In Medicare, this is because full competitive bidding would leave managed care plans at a disadvantage relative to the fee-for-service benefit option.[8] In Medicaid, it is because states do not wish to leave the market dominated by whatever insurer submitted the lowest bid, as this would establish a monopoly that is hard for states to discipline and control.

To maintain a multiplicity of plans operating at substantial scale, states must pay costlier and less efficient Medicaid managed care plans more to retain their participation in the market. This acts as a subsidy to plans with higher costs and potentially allows insurers to obtain inflated profits. Moreover, because Medicaid managed care depends almost entirely on public funding—with payment levels and market participation often being determined on a discretionary basis from plan to plan—the system is highly susceptible to political influence.

Medicare Advantage can allow competing private plans to offer greatly differing benefit packages, because insurers are deterred from unduly expanding expenses by the prospect that this would force them to impose higher premiums on enrollees. By contrast, because the government is fully liable for costs incurred by Medicaid managed care plans, states typically limit the freedom of participating insurers to unilaterally expand benefits. That leaves little scope for beneficial competition in provider payment arrangements, cost-sharing structures, or supplemental benefits.

The need to prevent plans from competing to expand Medicaid benefits at ever-greater public expense helps explain Medicaid managed care's distinctive character. Federal and state statutes, regulations, and policies leave insurers little discretion in designing benefits and leaves plans mostly concerned about gaining the favor of state officials, which makes them more like state contractors than competitors for consumers. By contrast, Medicare Advantage can allow plans substantial freedom to compete for the favor of beneficiaries as consumers, because public payments to them are more effectively limited to a defined contribution.

Most states reserve the arbitrary power to determine which plans are permitted to participate in Medicaid managed care, and they use it to micromanage the plans' activities. Furthermore, whereas all Medicare Advantage enrollees have voluntarily opted to participate in the program, Medicaid managed care enrollees are typically required by law to do so — and almost half of those enrolled fail to pick plans by themselves.[9] That further skews the attention of Medicaid plans from the preferences of beneficiaries toward those of state officials, who allocate the rest of enrollees to plans.

2. *Improper Enrollment: Ambiguous Eligibility for Medicaid Makes It Harder to Control*

Private insurers in Medicaid create a uniquely severe problem of improper enrollment.

Whereas traditional fee-for-service reimbursement is vulnerable to improper claims for specific medical services, it is relatively easy to determine whether a hospital that bills for a hip replacement actually performed the procedure. By contrast, managed care payments to insurers are not directly tied to claims. Instead, insurers are paid a rate every month for each enrollee. That creates a risk of a different kind — that managed care organizations maintain ineligible people on their rolls and continue to receive monthly payments, even if such an enrollee moves out of the state, gains other coverage, or loses eligibility for some other reason.

This risk is exacerbated by the fact that Medicaid beneficiaries are typically not required to pay any premiums for coverage. In some cases, insurers have obtained substantial payments on behalf of beneficiaries who did not even know they were enrolled. In 2022, the government paid for 26 million more Medicaid enrollees than federal surveys registered as believing they were covered by the program.[10] In 2024, the Centers for Medicare and Medicaid Services (CMS) estimated that about 3 million individuals were covered by multiple state Medicaid programs or by both an ACA exchange and Medicaid.[11] Many more were also covered by employer-sponsored benefits.

Eligibility determinations for Medicaid are often questionable, because they are contingent on income levels, which are often ambiguous and hard to monitor, and they tend to fluctuate substantially over time. By contrast, Medicare eligibility is relatively straightforward to determine, as it depends only on old age or certified disability and the existence of numerous prior payroll tax contributions. It is typically a once-and-for-all decision.

Improper enrollment in Medicaid is further exacerbated by the responsibility of states to review eligibility, as they have little incentive to reduce the inflow of federal matching funds.[12] This is particularly problematic for able-bodied adults, for whom the federal government provides $9 in aid for every $1 that states spend.[13] Federal audits found incorrect eligibility determinations for at least 22 percent of enrollees sampled in New York and 23 percent in Colorado.[14] In California, the state claimed excessive payments for at least 11 percent of those enrolled — with a further 44 percent of beneficiaries being enrolled without adequate proof of eligibility.[15]

3. *Fiscal Federalism: States Can Use Private Insurers to Inflate Federal Medicaid Funding*

In general, the delegation of administration to private insurers makes it harder for the federal government to stop states improperly inflating Medicaid costs.

Whereas Medicare's funding and benefits are both controlled by the federal government, states can obtain additional federal matching funding by increasing the program's expenditures.[16] Although CMS is attempting to rein in the practice, 22 states taxed Medicaid insurers for the purpose of inflating federal matching funds.[17]

States are also increasingly requiring Medicaid insurers to pay for non-health-care benefits ("in lieu of service") as a condition of their contracts.[18] This allows them to obtain federal matching funds for expenditures beyond the permitted scope of the Medicaid program. As a result, insurers are increasingly paying for the development of "affordable" housing, nutrition programs, and community services.[19]

Whereas federal law assures Medicare Advantage plans freedom to procure medical services from the most cost-effective providers, states regulate the terms of payment for health care by Medicaid managed care. In practice, this subjects Medicaid insurers to highly politicized micromanagement designed to bolster local hospital revenues, which negates the capacity of plans to trim needless costs—and much of the purpose of managed care.

Federal law limits direct payments for health care services by both Medicare and Medicaid to the Medicare fee schedule.[20] As Medicare Advantage plans have the freedom to negotiate discounts with preferred networks of providers, they pay an average of *8 percent less* than Medicare fees for equivalent hospital patients.[21]

Yet, over recent years, CMS has allowed states to obtain greater federal funding for Medicaid services by requiring managed care plans to pay up to *150 percent more* than Medicare rates for equivalent procedures.[22] Following the formal recognition of this loophole in 2016, the cost of such state-directed payments surged to $124 billion across 39 states in 2025.[23]

Management by private insurers has done much to impede accountability in Medicaid more generally. A 2021 federal audit found that fewer than a quarter of states provided complete and accurate data on the utilization of medical services on which payments to Medicaid plans were based.[24]

Conclusion

Medicaid managed care was originally promoted as a method of reducing the cost of health care benefits and improving the quality of treatment received by beneficiaries. But, after decades of experience, there is little evidence to support the claim that it has achieved either of these goals. The most distinctive consequence of the involvement of private insurers within the program now appears to be allowing states to circumvent fee-for-service payment limits and use financing techniques to claim additional federal matching funds for state-directed payments. These arrangements can push Medicaid managed care payments well above Medicare rates.[25]

By contrast, Medicare Advantage plans have generated improvements in the quality of care and benefits received by Medicare beneficiaries while reducing hospitalizations.[26] There is an active public debate regarding the magnitude of payments to Medicare Advantage plans. Importantly, the program is relatively transparent in comparison to Medicaid, and the level of payments to plans can be assessed on its merits.

About the Author

Chris Pope is a senior fellow at the Manhattan Institute, where his research focuses on

entitlement reform, insurance markets, and healthcare payment policy.

Pope is the author of The American Way of Welfare – an assessment of the historical development, current effectiveness, and opportunities to reform the welfare state. He has recently published reports on Medicaid managed care, the extent of redistribution by age and income, social determinants of health, and rural hospital finance.

Previously, Pope was director of policy research at West Health, health-policy fellow at the U.S. House Committee on Energy and Commerce, and research manager at the American Enterprise Institute. He holds a B.Sc. in government and economics from the London School of Economics and an M.A. and Ph.D. in political science from Washington University in St. Louis.

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