The question of whether private firms can provide public services more efficiently than the government is fundamental to public policy and economics. Nowhere is the public versus private question more controversial—and perhaps more consequential—than with respect to public health insurance programs in the United States. In Medicaid (the program that provides health insurance coverage to low-income Americans, including people with disabilities), the proportion of beneficiaries receiving their benefits through a private health plan increased from 60 percent in 1999 to more than 80 percent in 2012. In Medicare (the program that provides health insurance coverage to disabled workers and the elderly), about 19 million people (33 percent of beneficiaries) are enrolled in a private medical plan, while all Medicare beneficiaries who elect Part D prescription drug coverage obtain it through private plans. The use of private plans to provide public health insurance benefits is also widespread in several European countries, including the Netherlands, Switzerland, and Germany.

Prior work on the private provision of public health insurance benefits has produced mixed findings. In theory, competing private plans are incentivized to use the technologies available to them (some of which may not be available to a public program) to efficiently ration access to health care services. Profit-maximizing plans desire to keep spending low because they are often the residual claimants on any savings generated, while the combination of competition for enrollees and regulatory action by government prevents them from rationing too much. In some contexts, there is empirical evidence supporting this theory. However, when competition is weak and regulatory supervision is lax, the potential gains from private provision may not be realized. Indeed, there is evidence that private provision in some settings costs governments at least as much as public provision while also resulting in reduced quality of care. Additionally, when coupled with adverse selection, competition may produce harmful instead of beneficial outcomes.

We investigate the effects of shifting Medicaid coverage from public to private provision in Texas, the second-largest American state by population. During the period we study, Texas had the third-largest number of Medicaid enrollees in the United States, with more than 4.2 million enrollees, or a full 7.5 percent of national Medicaid enrollment, making it important to the Medicaid program in particular and to the U.S. safety net more generally. There are several advantages to using the Texas Medicaid setting to study the more general question of private versus public provision of health insurance. First, Medicaid is where this question is most policy relevant: more than 43 million Medicaid beneficiaries receive...
their health insurance benefits from a private health plan, with $162 billion paid to these plans each year. Second, credible identification is possible in this setting due to the use of a mandate to shift disabled beneficiaries in Texas from public to private plans. Third, Medicaid health care utilization data is available in Texas for both public- and private-plan enrollees, enabling a detailed examination of how these two forms of coverage differ.

To leverage these advantages, we make use of a natural experiment in Texas during the mid-2000s, when the state transitioned adults with disabilities—most of whom qualified for Medicaid due to their enrollment in the federal Supplemental Security Income (SSI) program—from the state-run public insurance plan to private Medicaid plans. The transition was mandatory and abrupt; private enrollment among adults with disabilities rose from around 10 percent to almost 80 percent instantaneously. Moreover, Texas implemented this coverage change in only a subset of counties, providing a clean natural experiment that we exploit in our analysis. We use this setting to estimate how a variety of relevant outcomes changed differentially in counties where private provision was implemented relative to similar, contiguous counties that maintained the publicly managed, fee-for-service (FFS) Medicaid program.

Our focus on the disabled Medicaid population is novel and important. In 2014, Medicaid spending for this population amounted to almost $187 billion, or 40 percent of total Medicaid spending, even though individuals with disabilities make up only 13.5 percent of total Medicaid enrollment. While most states have already shifted healthier Medicaid populations to private plans, the transition of individuals with disabilities to private plans is either recent, ongoing, or currently under consideration. Despite this, we know relatively little about the effects of private provision on this population.

We find clear evidence that private plans rationed health care services to a lesser degree than the public FFS Medicaid program. Specifically, private provision increased outpatient medical spending and prescription drug spending. The increase in outpatient spending comes partly from increased outpatient utilization (8 percent increase in outpatient services) and partly from private plans paying higher prices (8 percent higher on average). This suggests that the supply curve for outpatient services in Medicaid is upward sloping, consistent with previous evidence, and that private plans relax rationing of access to care by paying providers higher rates for the same services.

The mechanism behind the increase in prescription drug spending was different. We find that blunt rationing in Texas’s public program was responsible for the increased spending under private provision. Prior to privatization, the state imposed strict rationing of drugs among public-plan enrollees through a monthly limit of three prescriptions while not imposing this limit on private-plan enrollees and instead allowing the private plans to use their own utilization management methods. Although not widely known, strict rationing of prescription drugs using ad hoc quantity controls is a common feature of public Medicaid plans. Importantly, these limits appear to be binding for a meaningful share of disabled beneficiaries. Indeed, they appear to prevent disabled Medicaid beneficiaries from taking a variety of drugs used to treat the chronic conditions most prevalent in this population. For example, we find strong extensive margin responses to the removal of the drug cap under private provision for insulins, anti-psychotics, anti-depressants, and statins, as well as drugs used to treat asthma and pain. These responses suggest that the drug cap’s removal may have led to fairly large improvements in quality of life for many Medicaid beneficiaries. The relaxation of this limit and the subsequent increase in drug utilization thus represent a second instance of more-relaxed rationing of access to health care services under private provision versus public provision.

As rationing was relaxed for drugs and outpatient care in Texas, we find clear evidence that inpatient spending decreased by at least 8 percent, consistent with other work on private provision in Medicaid and elsewhere. Importantly, this reduction is concentrated in inpatient admissions related to mental illness, diabetes, and respiratory conditions, such as asthma and chronic obstructive pulmonary disease (COPD). While we cannot rule out increased rationing of inpatient services by private plans (i.e., stinting), there was little direct incentive for plans to stint since plans were not liable for these services; somewhat uniquely, inpatient care for the disabled population was carved out of private-plan contracts and directly financed by the state. Because these types of admissions (for mental illness, diabetes, asthma, and COPD) are often considered “avoidable” given appropriate disease management, these reductions are likely a direct product of actions by plans to manage their enrollees’ conditions in order to limit costly inpatient events. Furthermore, we find strong evidence that the decreases in inpatient admissions are related to increased access to prescription drugs. Indeed, we find that the drugs with the largest increases in utilization under private provision tend to treat the conditions associated with the largest concurrent decreases in inpatient admissions. Additionally, we find that the groups of beneficiaries that see the largest increases in drug utilization also have the largest reductions in inpatient spending. Taken together,
these results suggest that the reduction in inpatient spending under private provision reflects an improvement in the quality of health care received by Medicaid beneficiaries—as well as their actual health—rather than stinting by private health plans. Complementary analyses of the effects of private provision on other outcomes such as mortality, employment, and exit from the SSI program also suggest improvements in health and functional capacity, although the associated results are not statistically significant.

Finally, we show that the reduced rationing and improved quality under private provision in Texas came at a cost: fiscal (i.e., program) spending increased by 12 percent under private provision. This increase was mostly due to the fact that capitation payments to private plans were set higher than the counterfactual (i.e., FFS) cost of plan-covered services under public provision and not that private plans were driving up spending on uncovered services that continued to be paid on a FFS basis even for those enrolled in private plans (i.e., drugs). Importantly, however, these spending increases were accompanied by increases in health care utilization. Indeed, we find that in Texas the vast majority (80 percent) of these spending increases were passed through to providers and beneficiaries in the form of additional health care services.

To summarize, we find that private provision leads to higher spending for the state of Texas and weaker rationing of health care services in that state. These results are contrary to the conventional wisdom among policymakers that private provision saves money, though they are in line with previous findings of cost increases in the economic literature. Furthermore, our strong evidence that Medicaid enrollees in Texas were better off in private plans is contrary to the conventional wisdom among economists that private provision typically leads to worse outcomes in Medicaid.

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