The democratic nominee for president, former Vice President Joe Biden, has made the availability of a public option (a Medicare-like health plan operated by the federal government) a central component of his health care platform. One goal of this policy is to lower costs for consumers who purchase coverage in health insurance marketplaces. Biden would also increase population coverage by making his public option available at no cost to income-eligible adults in the 12 states that have still not expanded Medicaid as a part of the Affordable Care Act. In the states that have already expanded Medicaid to low-income adults, he would allow these states to convert their expansion population to the federal public option, provided the state maintains its contribution toward the cost at the level it had been through the state’s Medicaid program.

Although Biden envisions a federal public option as an alternative to a state’s Medicaid program for its expansion population, states themselves might want to also consider the benefits of using a state or local public Medicaid managed care plan to improve the quality of care throughout their programs.

Flexibility for States
States are given substantial flexibility in administering their Medicaid programs within the boundaries of requirements established by federal law. One choice that an increasing number of states have made over time is to contract with health plans to manage health care services. Currently, 39 states and the District of Columbia rely on managed care health plans to furnish comprehensive services for at least some of their most common eligibility groups. As of 2017, more than two-thirds of Medicaid beneficiaries nationwide were enrolled in a managed care plan.

States vary in how they make use of and organize health plans and the degree to which beneficiaries have a choice of plans where they live. In most states, private for-profit plans are the dominant option and sometimes the only choice.

When there is an alternative to a for-profit plan within a state, the option is almost always a nonprofit plan rather than a public plan. California is unique in that in 13 counties, accounting for nearly 8 million Medicaid beneficiaries, for-profit plans compete directly with county government-operated public plans. This provides a natural experiment to evaluate the performance of public vs for-profit plans in the care they provide to Medicaid beneficiaries.

Quality of Care
California’s Department of Health Care Services performs standardized assessments of the quality of care provided by health plans at the county level using the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). These tools are used by most US health plans (whether they participate in Medicaid or not) to evaluate performance related to care and service. All of California’s Medi-Cal health plans, regardless of ownership type, have been required to report on the same HEDIS performance measures for more than a decade.

A head-to-head comparison within each of the 13 California counties where there is a Medicaid public health plan option reveals that over a 10-year period between 2009 and 2018, the annually reported HEDIS and CAHPS scores have been significantly better in the public plan than in the for-profit plan. Differences in breast cancer screening between Anthem, which is the for-profit plan in 7 of these 13 counties, and public plans is an example. Based on the HEDIS measure, the percentage of eligible women who received breast cancer screening in 2018 in these 7 counties was consistently higher in the public plans than in the Anthem plans with an average difference of 6% (58% vs 52%, respectively). In addition, for-profit plans were significantly more likely than public plans to have HEDIS scores that were below the state’s minimum performance level, which was only 25% of the national average among Medicaid plans. Although beneficiaries are not randomly assigned between the public plan and the for-profit plan in these counties, these plans are competing with the same benefit package within a limited geographic area in a way that is cost neutral to enrollees, making it unlikely that underlying differences in the characteristics of individuals enrolled in each plan is the explanation for the observed differences in quality.
Unlike for-profit plans, public plans are not expected to pay out regular dividends to shareholders and can apply their Medicaid revenues to improving the accessibility and quality of care for their enrollees. In addition, California’s public plans have a stated mission that is closely aligned with the safety-net clinicians with whom they typically contract to furnish services.

This is not lost on Medi-Cal beneficiaries. In every California county in which there is a choice, enrollment in the public plan is higher than in the for-profit plan. And it is not a subtle difference. As of July 2020, there were 5.1 million beneficiaries enrolled in the public plans and 1.6 million enrolled in the for-profit plans in the 13 counties with a choice of both. In fact, the only way that for-profit plans have increased market share in California over the past decade is by expanding into counties where there is no public option. Incidentally, in counties lacking a public health plan option, the quality of care for Medi-Cal beneficiaries as measured by HEDIS and CAHPS is significantly worse than in counties that offer public health plan options.

California’s experience with public Medicaid health plans is no small matter. California is the state with the greatest number of Medicaid beneficiaries who receive services through managed care (10.8 million). It is the mandatory delivery model for children, low-income parents, seniors, persons with disabilities, and the expansion population of childless adults. Nationwide, 1 in 5 Medicaid beneficiaries who are in managed care reside in California. In addition, many of the same for-profit plans that come up short in direct comparison with public plans in California—including those offered by Anthem, Centene, and Molina—are providing managed care services in other states’ Medicaid programs.

If Biden is elected president, there will be increased attention to a federal public option. State Medicaid programs might find his proposal for a federal public option attractive for their expansion population. But if Medicaid programs want to improve the quality of care for all of their population groups in managed care, they will want to consider all of their options, including the introduction of either state-operated or local government–operated Medicaid health plans to either replace or compete with for-profit plans.

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