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ARTICLE

Managed competition in the United States: How well is it promoting equity and efficiency?

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Abstract

Managed competition frameworks aim to control healthcare costs and promote access to high-quality health insurance and services through a combination of public policies and market forces. In the United States, managed competition delivery systems are varied and diffused across a patchwork of divided markets and populations. This, coupled with extremely high national health spending per capita, makes a more unified managed competition strategy an appealing alternative to a currently struggling healthcare system. We examine the relative effectiveness of three existing programmes in the U.S. that each rely upon some principles of managed competition: health insurance exchanges instituted by the Affordable Care Act, Medicaid managed care organisations, and Medicare Advantage plans. Although each programme leverages some competitive features, each faces significant hurdles as a candidate for expansion. We highlight these challenges with a survey of academic health economists, and find that provider and insurer consolidation, highly segmented markets, and failing to incentivise competitive efficiencies all dampen the success of existing programmes. Although managed competition for all is a potentially desirable framework for future health reform in the U.S., successful expansion relies on addressing fundamental issues revealed by imperfect existing programmes.

Keywords: managed competition; US Health Insurance

1. Introduction

The US health insurance and health care delivery systems are premised on the assumption that competition will promote efficiency and equity. Yet its patchwork of different insurance programmes, high costs, and continuing equity problems challenge that assumption. Managed competition with tightly regulated health plan options has been relatively successful in mitigating and resolving these problems in other developed countries. Why not in US managed competition programmes? In this paper, we examine whether three existing US markets that rely on health plan level competition – in the Marketplaces, Medicare, Medicaid – might be adapted to move the United States towards a unified, more effective system of managed competition. We assess the relative strengths and weaknesses of each programme, as well as factors in the U.S. more generally which inhibit the role of regulation in promoting competition.

Well-run managed competition structures, such as those of Germany and the Netherlands, have much to admire and emulate. These countries have obtained higher life expectancy and higher consumer satisfaction while keeping total health care costs per capita 40 to 50% lower than in the US. Furthermore, managed competition systems tend to exhibit lower rates of *ex-ante*

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economic inefficiency, measured by selection-based issues in both insurance plan design and selection (Layton *et al.*, 2017). Finally, leveraging public policy to incentivise a competitive framework also has the potential advantage that policies can be designed to promote *equitable* competition, with specific focus given to health disparities that persist in the United States (Institute of Medicine, 2003).

At this time, the most common alternative discussed for the US is some form of 'Medicare for All', which would implement a single payer system similar to Canada or the UK. Yet discussing, let alone implementing, this dramatic reform is challenging in a setting in which US employees and employers are strongly attached to their existing private health plans, and entrenched large provider groups and networks also resist change. Standardising coverage, regulating provider prices, and promoting competition in a managed competition system may be more politically attractive than current 'Medicare for All' proposals when attempting to improve US efficiency, quality, and equity.

Our goal is to both highlight the current landscape of managed competition in the United States and to outline the potential barriers to expanding its scope. We examine three existing insurance programmes in the US fostering health plan-level competition as potential candidates for a national, expanded programme: the Affordable Care Act (ACA) Marketplaces, Medicare Advantage, and state Medicaid Managed Care Organizations (MCOs). For each programme, we describe the structure of managed competition underlying the programme and the main advantages and challenges associated with broadening the programme. Following this, we turn to describing the broader institutional landscape in the US healthcare system, focusing on the extent to which certain preconditions for competition are met generally. We rely on a survey of health economists to illustrate the current shortcomings of the US system.

We find that many health economists believe that healthcare organisations in the U.S. fail to incentivise and capture efficiencies from competition in ways conducive to managed competition frameworks. This, along with highly segmented markets and rapid consolidation among providers and insurers, leaves highly imperfect managed competition to build upon. In fact, the surveyed economists disagreed the most with the notion that the U.S. system matched other developed countries in either equity or efficiency, suggesting that these are two of the most central challenges facing the U.S. healthcare system today. In our conclusion, we discuss how some of these barriers stand in the way of comprehensive health reform.

2. The US Healthcare system

Unlike most other high-income countries, the US has adopted an incremental, gap-filling strategy to try to meet the needs of its citizens. This haphazard expansion has tolerated enormous heterogeneity in the degree and forms of insurance coverage, provider fees, payment incentives, as well as in the ownership and coordination of health care providers.

Fundamentally, individuals may be insured through a private insurance plan (potentially with public subsidies, such as in the ACA Marketplace) or a publicly-funded option, including Medicare and Medicaid. Private, commercial insurance is also offered and typically subsidised by employers acting as sponsors of individual or family coverage for their employees. Following the introduction of the ACA, individuals also have the option of purchasing health insurance directly from a state or federal Marketplace, potentially with subsidised premiums for low- and middle-income households. The US Medicare programme is sponsored by the federal government and available to everyone age 65 and over as well as to individuals with disabilities from specified chronic, expensive conditions including cancers, blindness, end stage renal disease, and HIV/AIDS. The Medicaid programme covers low-income individuals; pregnant women and mothers (Gordon *et al.*, 2022); children and individuals with high-cost, chronic conditions. Medicaid is funded by both the federal government and states, and its generosity varies

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widely, with some states barely offering any coverage to low-income men. Medicaid coverage reaches a broader set of children through the Children's Health Insurance Program (CHIP) which like Medicaid offers free covered services from participating providers. As others have done, for the remainder of this article we will often use the term of Medicaid to include CHIP.

The existence of so many sponsors contributes to the US patchwork system of coverage, with individuals unable to portably transition their insurance coverage when changing programme eligibility (Ellis and Hoagland, 2022). Regulations also limit enrolees' ability to maintain coverage when moving between states, changing employers, crossing age groups (from child to adult or adult to elderly), changing family status (e.g., through marriage, divorce, or death of a spouse) or changing employment (e.g., becoming unemployed or taking a job). These boundaries also create large inequities in both access to any insurance coverage and how generous the coverage is.

US regulations are poorly suited to promoting plan competition: states regulate within-state insurance plans for Medicaid and employer-sponsored insurance, but at the same time federal laws prevent states from regulating large, multistate insurers. State variation in regulations inhibits health plans entry into new states or new public programmes by raising administrative, marketing, and regulatory costs.

Table 1 summarises this heterogeneity in insurance coverage across age groups in 2020. Similar variations could be documented across income, employment, family type (single/married/with children), and states. Of particular interest are three types of regulated competition, corresponding to the 2010 ACA Marketplace, Medicaid MCOs, and Medicare Advantage. The ACA Marketplace was a signature new form of plan competition; in 2020, however, only one to six per cent of the under age-65 population were enrolled through these exchanges. Although the percentage of people without health insurance remains lower than its high of 17 per cent in 2009, by 2020 the uninsured population remains above 10% for of people aged 19–44. The largest block (55% or more) of the under age-65 population has primary coverage either through their employer or through direct consumer purchase.

Medicaid (and CHIP) MCOs cover 27.6% of children aged 0–18, and about 10% of adults under age 65, with states sharing the costs of both programmes. In many regions of the US, Medicaid MCOs typically offer low-cost enrolment options for qualifying individuals, expanding choice and access for low-income households. In 2020, Medicaid MCOs accounted for over 80 per cent of Medicaid enrolment (KFF, 2021a).

The final market using regulated competition is the Medicare Advantage programme, now enrolling about half of all seniors but a tiny fraction of the under age-65 disabled population. Note that some seniors receive MA sponsorship by their current or former employer, depicted in the table as a form of private insurance. The Medicare Advantage programme enables individual choice between many competing health plans – mostly managed care plans with relatively generous coverage – and traditional Medicare, which has higher cost sharing on average but also a broader choice of providers.

Collectively, these forms of managed competition have made a significant impact on the insurance patterns of the US population. Notice, in particular, the jump in the rate of uninsurance at age 18 as many children become ineligible for CHIP or Medicaid coverage, and the decline in rates of uninsurance at age 65 when Medicare becomes a subsidised option available to all.

3. Existing managed competition pprogrammes

In this section we provide more detail about the three existing systems of US insurance that approximate 'regulated' competition: ACA Marketplace, Medicare Advantage, and state Medicaid MCOs. Although each system targets a distinct subset of the population, the programmes are similar in that they each regulate access to providers and services to contain costs. However, given the large differences across programmes, managed competition in the US would look very different based on which programme was used as the basis for its expansion.

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Table 1. US insurance coverage percentiles by age group, 2020

	Regulated competition systems			Largely FFS payment			Other	
Age groups	ACA marketplace (%)	Medicaid + CHIP MCO (%)	Medicare advantage (%)	Medicaid + CHIP FFS (%)	Medicare: traditional (%)	Private insurance (%)	Military (%)	Uninsured (%)
0–18	1.5	27.6	–	5.8	0.4	56.7	2.9	5.1
19–25	4.4	13.2	–	2.9	1.5	61.8	2.2	14.0
26–34	3.7	12.5	–	2.9	1.5	62.5	2.9	14.0
35–44	4.4	10.9	–	2.2	2.2	65.7	2.9	11.7
45–54	5.8	9.4	–	2.2	3.6	65.9	2.9	10.1
55–64	6.6	10.3	0.4	2.2	7.4	62.0	3.0	8.1
65+	–	–	25.2		49.2	24.5	–	1.1

CHIP, Children's Health Insurance Program; MCO, Managed Care Organization; FFS, Fee-for-service; ACA, Accountable Care Act.
Notes: Percentages in the original sources do not sum to 100% due to dual coverage; we present normalised percentages (e.g., rescaled to sum to 100%) in order to highlight relative importance. Dual enrolment in Medicaid or Department of Veteran's Affairs coverage together with other coverage are ignored. Supplemental Medicare ('Medigap') and Medicaid coverage for Medicare eligibles play important roles but are not shown here. Employer sponsored Medicare Advantage was classified as Private insurance for over age 65 sample.
Sources: Kaiser Family Foundation, 2021a, US Census Bureau, 2021.

In this section, we consider each programme in turn, and how an expansion of that programme would differentially affect coverage, costs, and access.

By managed competition, we refer to a system that relies on economic incentives, rather than government mandates, to reduce health costs while increasing access to high-quality medical services. The concept of managed competition, where economic incentives are targeted to reward cost-reduction efforts and innovation, was originally conceived by Alain Enthoven (1978, 1993), and elaborated upon in Enthovan *et al.* (2001), van de Ven *et al.* (2013) and McGuire and van Kleef (2018). It has also recently been discussed in a Canadian context by Blomqvist (2022) and for the US in Handel and Kolstad (2022).

Echoing Enthoven's idea of having active consumers contracting individually with competing health plans, each programme we consider contains multiple regulated health plans that compete to enrol patients. In each programme plans are paid a risk-adjusted premium or base payment that leaves them free to select providers and choose fees, but places plans fully or partially at risk for the health care costs of their enrolees. In each system, at least some of the enrolees are eligible for subsidised coverage, with subsidies reflecting equity considerations.

Each of the three systems differs from other, more conventional managed competition systems (e.g., Germany and the Netherlands) in that the competing plans are not just competing against each other, but also against alternative options. For example, plans attracting enrolees through the Marketplaces compete against many privately-insured health plans, including direct-purchase plans offered to individuals without employer sponsorship. Similarly, Medicare Advantage and traditional Medicare are direct competitors, and Medicaid MCO plans in most (but not all) states compete against the state's Medicaid fee-for-service (FFS) option.

Table 2 contrasts key features of each form of managed competition observed in the US. For contrast, we also included traditional Medicare as an alternative. Because national counts of insurers and health plans do not capture variation in choice sets within each state, the table presents the properties of options available in Massachusetts.[1] All three programmes offer multiple tiers of coverage, and each structure uses a customised risk adjustment formulas and equalisation procedure, giving rise to differences in consumer access to services, the relevant subsidies for coverage, and provider reimbursement. Although many of the payers depicted in the table rely on capitated payments to single plans (or regions of the same plan in the case of traditional Medicare), Medicaid MCOs rely on novel accountable care organisations (ACOs) to control costs by dispersing payments holistically to defined provider networks. Finally, each insurance system uses different metrics for risk adjustment and payment. For example, Marketplace and Medicare Advantage plans use Hierarchical Conditions Categories (HCCs) in their risk adjustment formulae but differ in the classification of HCCs and the timing of the model (e.g., prospective or concurrent models).[2] On the other hand, state Medicaid MCOs choose various risk adjustment formulae; Massachusetts relies on the privately marketed DxCG concurrent risk adjustment models currently marketed by Cotivity.

[1]Given substantial state variation in the structure and availability of Medicaid MCOs, in Table 2 we present a summary from a single representative state: Massachusetts. Massachusetts represents an ideal 'middle ground' in comparing Medicaid programs; MassHealth has the highest Total Medicaid Spending Per Low-income Population and is associated with the highest quality level of adult care based on the CMS Medicaid Adult Core Set, but also imposes high levels of cost-sharing on its enrolees relative to other states.

[2]In addition, each state uses different information for provider payment, including diagnoses, procedures, and information such as resource-based relative value utilizations (RBRVS). The RBRVS, which is built on the idea that physician payments should cover resource costs for providing services, assigns relative weighted value to procedures (rather than incorporating diagnostic information, as is typical in a risk-adjustment framework). Medicare reimbursement fees are then capped based on the billed procedure (typically CPT-4 or HCPCS codes), with fees being updated annually based on physician committees.

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Table 2. Four possible foundations for universal managed care for all

	ACA marketplace	Medicaid MCOs (MassHealth)	Medicare advantage	Traditional medicare
Target population	Age 0–64, non-low-income, self-insured, no ESI	Age 0–64, low-income, high health cost, children	Age 65 + or disabled	Age 65 + or disabled
Total national enrolment, 2021	12.0 million	40.0 million, (0.7 million in MassHealth)	27.9 million	36.0 million
Plan unit receiving capitation payment	Bidding plans	Accountable Care Organizations	Bidding plans	1 plan, 12 regional MACs
# of Health plans offered in Massachusetts	8 insurers, >30 plans	12	113	1
Risk adjustment formula	Concurrent HHS-HCC model	Concurrent DxCG model with SDOH adjustments	Prospective CMS-HCC model	None, FFS reimbursement, various bundled payments
Information used for payment	Diagnoses, one pharmacy group, eligibility information	Diagnoses, eligibility information, census block demographics, SDOH	DRGs, pharmacy groups, eligibility information, facility type information	RBRVS fees, DRGs, facility type information
Premium determination	Competitive bidding, Income-based	No consumer premium	Competitive bidding	Uniform national schedule
Governing body/source of subsidies	Federal/state plans	State plans with federal subsidies	Medicare (some Medicaid)	Medicare
Risk equalisation formula	*Ex-post,* zero sum game	*Ex-post,* zero sum game	*Ex-ante*	None

CMS-HCC, Center for Medicare Services: Hierarchical Conditions Categories; DRG, Diagnosis Related Groups; ESI, Employer-sponsored insurance; FFS, Fee for Service; HHS-HCC, Department of Health and Human Services: Hierarchical Conditions Categories; MAC, Medicare Administrative Contractor; RBRVS, Resource-based relative value scale; SDOH, Social determinants of health; DxCG, the DxCG risk adjustment software developed by researchers at Verisk Health, Inc. (formerly DxCG Inc.).

Notes: Table summarises features of four publicly-funded or publicly-subsidised coverage paths available in the United States, each of which could be a viable model for expanding access to managed competition. All rows are based on 2021 data. Column 3 presents information only for a single state's Medicaid MCO structure (Massachusetts), due to high variability across states. *Sources*: (column 2) MEDPAC, 2021; KFF, 2021b (column 3) CMS, 2021; KFF, 2022; (column 4) Kautter *et al*., 2014; Mike and Yilmaz, 2021; (column 5). Ash *et al*., 2017; KFF, 2019b.

3.1 ACA Marketplaces

The passage of the Affordable Care Act created online Marketplaces as a direct means to decrease the costs associated with insurance enrolment and increase visible competition among plans. The Marketplaces attempt to simplify the process of finding, comparing, and purchasing insurance with subsidies; however, they do not provide the insurance itself, and the options and subsidies have not yet proven sufficient to attract all eligible enrolees. In contrast with Massachusetts, which fostered and was an early template for the ACA Marketplace, there are no tax penalties for not purchasing insurance, as they were ruled unconstitutional by the U.S. Supreme Court. Finkelstein *et al.* (2019) estimated that absent mandates or large public subsidies (>90% of the total premium), many low-income consumers will be unwilling to purchase insurance. Here we highlight the effects of three key features of the ACA marketplaces affecting managed competition that will exist even if coverage is mandated or premiums are adequately subsidised: market segmentation, entry barriers, and plan quality.

The ACA did not create a single marketplace but created state-specific marketplaces.[3] This restriction, which limits plans to competing in each state separately, perpetuates the widespread problem of insurance portability across states and inherently limits competition. Plus, many states are too small: Wyoming has less than 35,000 Marketplace enrolees split between two insurers. The average number of insurance plans available on the Marketplaces is five, ranging from thirteen options in Wisconsin to only a single plan in Delaware (KFF, 2022). There is evidence that increasing the number of insurers offering plans on a given Marketplace is associated with lower consumer premiums and overall costs (Dafny *et al.*, 2015; Van Parys, 2018); hence, harmonising Marketplaces by allowing national competition may both incentivise competition and reduce geographic disparities in healthcare costs and access. It was unexpected when the Marketplace was introduced that the direct purchase of individual policies without ACA subsidies would be substantial; now these purchases represent nearly as many individuals as the Marketplace subsidises, particularly among younger adults (Table 1).

The success of insurer competition in segmented Marketplaces therefore relied importantly on incentivising new entry of insurers into each state market. Special risk sharing and reinsurance programmes were relied upon in the first five years to promote entry. The Marketplace generated mixed results: many large insurers took heavy financial losses and exited the Marketplace, while smaller insurers earned profits and expanded their foothold (Garthwaite and Graves, 2017). Narrow networks rather than provider competition can be attributed to the structure of the Marketplace: many insurers found that their commercial plan broad networks were unprofitable in the ACA Marketplace and found financial success only by limiting their provider networks. In addition, in many commercial markets, large insurers benefit from economies on administrative costs and marketing with broad multi-state appeal to cushion profits against actuarial risk, while this is not true for the state Marketplaces. As insurers adapted to these unique features, the number of available plans rebounded, with insurers continuing to enter new markets in 2019 and 2020 (RWJF, 2021).

To be profitable, most Marketplace plans now offer narrower provider networks than commercial plans. Haeder *et al.* (2015) find little evidence of a reduction in either access to services or overall quality. Cai *et al.* (2022) find that Marketplace plans may be particularly adept at increasing quality of services offered through vertical integration between insurers and providers, including the use of provider-sponsored health plans.

The trajectory of Marketplace plans suggests that expanding managed competition using the strategy of the Marketplace, with large subsidies or mandated coverage with penalties for noninsurance, may hold promise for reducing costs without sacrificing quality. However, even with

[3]Eighteen states, including Massachusetts and California, have chosen to manage their own Marketplace and its risk equalization formula, while 32 states plus DC rely upon the federal government to organize enrolment and manage plan entry and exit (KFF, 2022).

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more affordable premiums, enrolment in the Marketplace has proven to be highly responsive to premium fluctuations, particularly for those receiving coverage without subsidies (KFF, 2019c). Given that people in the Marketplace can move into and out of the programme as their employment, income or preferences change, increased, persistent enrolment will require sizeable premium subsidies to reduce enrolment volatility in this individual-based insurance market (Finkelstein *et al.*, 2019).

3.2 Medicare advantage

Medicare advantage programmes were created in the 1980s in response to increasing costs associated with traditional Medicare programmes (McGuire *et al.*, 2011). By incentivising physicians to provide comprehensive care, the programme passed on financial risk to providers to curb utilisation. While the programme initially struggled due to low subsidy rates and strong cream-skimming incentives, more comprehensive risk-adjustment programmes spurred large growth in MA enrolment in recent decades, although problems of premium setting and sorting persist (Glazer and McGuire, 2017).

Medicare Advantage has several advantages over the other programmes explored here. First, its system of capitation payments allows MA plans to offer a wider selection of benefits. Second, plans can set their own payment mechanisms in order to attain efficiency and quality goals (Butler, 2020). Finally, MA plans even serve as the model to expand beyond the traditional scope of health benefits to address broader social determinants of health, including food deliveries and transportation to doctors' offices (Jaffe, 2018). However, expanding MA plans in the US requires dealing with two issues: market concentration and patient selection.

Today, market concentration plagues MA coverage. Most Medicare enrolees are served by few insurers, and 97 per cent of the US county markets in the MA programme are 'highly concentrated' using the FTC and DOJ measures (Frank and McGuire, 2019). This may be the result of overall consolidation in the insurance market, but also may have arisen from direct features of the managed care structure of MA plans. For example, Medicare policies changed in 2011 to require all MA plans to create provider networks, which prompted some health insurers to cancel up to ⅔ of the affected plans and resulted in increased consolidation (Pelech, 2017). Expanding MA-style plans may need to accommodate these features to adequately encourage competition.

A second issue with MA plans is patient selection. Only relatively healthy Medicare patients tend to enrol in MA plans, an adverse selection problem which persists even after risk adjustment (Morrisey *et al.*, 2013; Brown *et al.*, 2014). There is controversy over the extent of this bias, the related issue of diagnostic upcoding, and whether existing adjustments by Medicare undoes some of this systemic bias (Newhouse *et al.*, 2019; Geruso and Layton, 2020). These concerns bias discussion about the effect of expanding access to these plans. Although there is some evidence that this selection problem may be mitigated by reducing or eliminating the switching costs into and across Medicare plans, pursuing managed competition in the style of MA plans would require evolving past enrolling only the healthiest subset of the population.

3.3 Medicaid MCOs

Finally, we consider the potential implications of expanding the availability of Medicaid managed care organisations (MCO) coverage. As of 2019, 83% of all Medicaid patients were in MCOs (KFF, 2019b). Here, we document two features of Medicaid MCOs that would impact managed competition in the US: low reimbursement rates and enormous state variation.

Unlike traditional FFS-based Medicaid, Medicaid MCO plans may set their own rates with providers. These rates vary across states, but are typically very low, averaging only 72% of what traditional Medicare pays. This dramatically reduces the costs associated with Medicaid MCOs relative to both traditional Medicaid and the other programmes we have considered thus far, but these low rates create a key challenge in the expansion of Medicaid MCOs in the

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form of provider incentives. Low provider reimbursement is a principal driver of both availability of services and wait times, with only 70% of physicians accepting new Medicaid patients compared to about 90% accepting patients covered with ESI (Holgash and Heberlein, 2019). In fact, as many as half of providers in a Medicaid MCO plan's network could not accommodate new patients and wait times for enrolees in managed Medicaid can be dramatically higher than other plans (Levinson, 2014). These differences are even starker for specialty care than for general practitioners.

Low reimbursement rates, rather than the presence of managed care or Medicaid expansion overall, appears to be the principal limiting factor on physician supply to treat Medicaid patients. Access to Medicaid services typically did not decrease because of a state's Medicaid expansion (Mazurenko *et al*., 2018). On the other hand, increasing reimbursement rates may make expansion of Medicaid MCO-style plans more feasible. Physician acceptance rates increase by nearly 1 percentage point (0.78) for every percentage point increase in the ratio between Medicaid and Medicare fees (Holgash and Heberlein, 2019). Another option to encourage supply of services is to expand on the model of extra payments mandated for services furnished by Federally Qualified Health Centers (MACPAC, 2017).

Additionally, Medicaid MCOs differ widely across states, making them in essence 52 separate plans (50 states plus D.C. and Puerto Rico). In addition to statewide variation in fees, enrolment expansions, and services covered by Medicaid programmes, states also differ in the structure of managed care.[4] Some states require automatic enrolment in MCOs (e.g., California), while others allow voluntary participation (e.g., New York and Massachusetts). Additionally, states typically use one of two structures: capitation contracts with health maintenance organisations (HMOs) and primary care case management (PCCM) programmes, which incentivise providers to increase the coordination of care while retaining FFS payment models. Some state MCOs, such as New York, include regulated competition principles like plan choice, open enrolment periods, and risk adjustment; others, however, (e.g., Missouri) restrict the entry of plans to maintain high quality among the admitted plans.

Hence, expanding managed competition in the US using a Medicaid MCO model would require harmonisation of multiple different styles of care and creativity to maintain access to providers. This might require increased subsidies for provider reimbursement or new reimbursement schemes altogether and would certainly require novel ways to leverage many of the preconditions of managed competition. In addition, MMC expansion may leverage a government's power to provide additional 'managing' that improves quality of outcomes, such as restricting entry or automatically assigning enrolees into plans (Layton *et al*., 2018). These actions would substantially alter how managed competition ultimately takes shape in the US

3.4 Traditional Medicare as a foundation for regulated competition

Given that 'Medicare for All' is a commonly discussed alternative to relying on regulated competition, we benchmark our discussion of managed competition against the single payer alternative of expanding traditional Medicare. A variety of proposals have been made for the US in which there is only one health insurer, with competing but regulated price providers (KFF, 2019a; Liu and Eibner, 2019; CBO, 2020).[5] Many countries around the world rely upon only one primary insurer (e.g., Canada, France, and Spain) or very few insurers (e.g., Israel and Belgium),

[4]In general, state- and even health plan-level variation in physician fees and coverage decisions cause severe distortions and inequities in which patients maintain affordable access to high-value health services. For example, even the ACA's cost-sharing exemption for preventive services has resulted in inequitable reductions in cost-sharing across those enrolled in different forms of health coverage (Hoagland and Shafer, 2021).

[5]The natural single payer would be traditional Medicare in the US, which is currently the largest insurer. However, even traditional Medicare in the U.S. is administered by distinct insurers for separate geographic regions, in which each carrier is a local monopoly for this population subgroup (see Table 2).

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so a single plan should be part of the discussion of the merits of managed competition against alternative reforms. In general, single-payer systems tend to promote equitable access to coverage and services; in addition, single-payer systems have the potential for strong negotiating power to control prices. For example, although most health plans in the US negotiate their own payment rates for each provider, the traditional Medicare programme has a standardised, national fee schedule as well as bundled payment for many other types of facility charges. This, coupled with a significant reduction in overhead expenses, makes a consolidation of health services into a single national insurer an encouraging option.

However, a Medicare-for-all programme may struggle to meet diverse health needs and incentivise quality of outcomes, control costs, or promote the diffusion of health innovations (McGuire and van Kleef, 2018). Recent work has highlighted that regulated competition frameworks can leverage price benchmarks to generate nearly equivalent cost savings, while passing on higher surplus to enrolees in the form of health benefits (Curto *et al.*, 2021). In addition, reforms implementing single-payer systems tend to be much costlier than even broad reforms aimed at encouraging managed competition (Ellis and Hoagland, 2022). Finally, political support for a single-payer system in the US continues to be weak, particularly when the costs associated with such a plan are communicated (KFF, 2020).[6] Although there are values in promoting single-payer reforms in the US and elsewhere, we see some attractions in balancing pure competition and pure regulation using the framework of managed competition.

4. To what extent are the preconditions for managed competition met?

Making a greater push for managed competition in the US requires first understanding whether the elements necessary for economic incentives to work effectively are in place. Our literature analysis and survey suggest that none of the existing programmes examined contain sufficient competitive pressure to successfully achieve the promises of managed competition as identified in van de Ven *et al.* (2013) and developed in the subsequent literature.

To understand more precisely the ways in which existing US programmes fail or succeed at achieving these preconditions, and to expand the perspective beyond those of only the authors, we conducted a web-based survey of US-based health economists and knowledgeable healthcare systems experts from other disciplines. The survey was sent to a mixture of junior and senior faculty, researchers and post docs at top research universities and think tanks in 12 states. We received 14 respondents from eight states and all four census regions, a 47% response rate. Their responses allowed us to summarise a broad range of views on this complicated question.

Respondents were asked to rate on a scale from 1 to 5 their agreement or disagreement with a paraphrased summary of the thirteen preconditions. We presented each respondent with thirteen precondition prompts and asked them to rate the extent to which the precondition was met in each of the three programmes surveyed in this article (on a scale of 1 to 5 with 1 = disagree strongly, 2 = disagree somewhat, 3 = Neither agree nor disagree, 4 = Agree somewhat and 5 = Agree strongly). We also included two overview questions about the extent to which the programme at hand achieves equity and efficiency relative to other international health systems. This survey gathered opinions about the success of existing programmes, rather than about some future programme after healthcare reform. The results give insight into how well current federal and state programmes take advantage of (or ignore) the conditions that may allow regulated competition to flourish in the US.

Figure 1 presents results from this survey. Pooling responses across all survey questions, the average ratings for each programme (with their 95% confidence intervals) are 2.55 [2.38, 2.71]

[6]On the other hand, variants on this proposal – including a public option – engender much more substantial bipartisan support. Handel and Kolstad (2022) provide a useful careful analysis of the options, while Blomqvist (2022) provides insights about Medicare for all from the perspective of Canadian experience.

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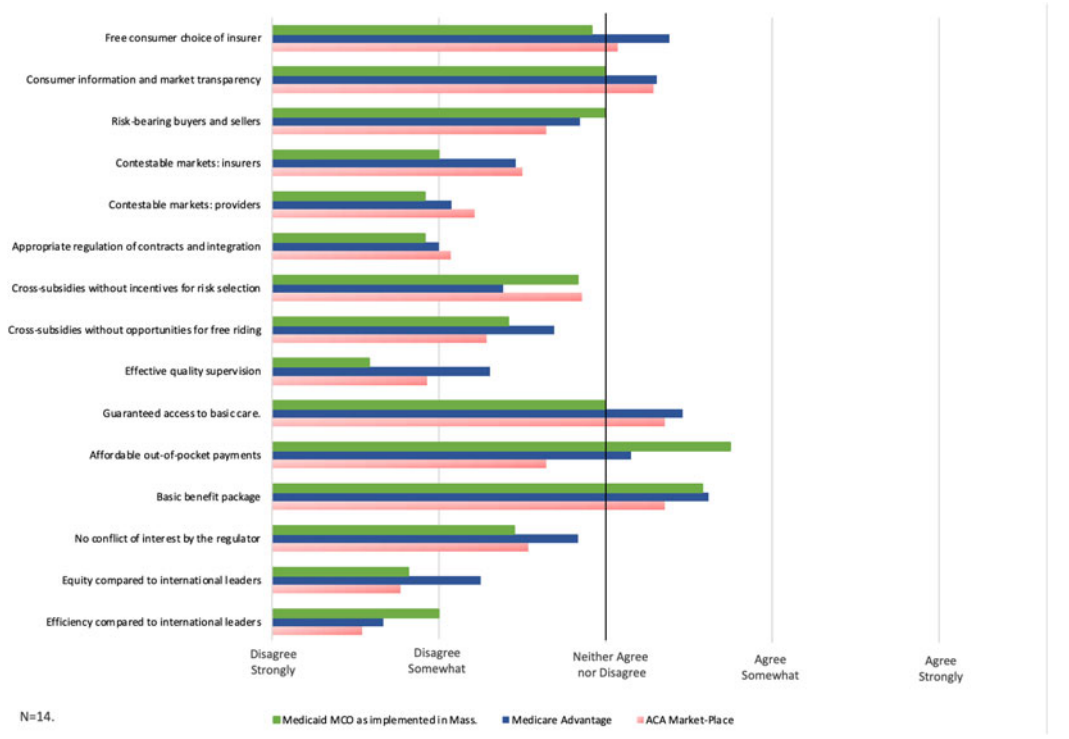

Figure 1. Economist opinions on existence of US preconditions for effective managed competition.
Notes: Figure shows results of $N = 14$ health economist opinions on the extent to which preconditions are met across Medicaid MCOs, Medicare Advantage, and the ACA Marketplace. Respondents rated the three programmes on a scale of 1 (strongly disagree) to 5 (strongly agree) on each of the thirteen preconditions, plus two additional questions on equity and efficiency. Averages for each response are presented.

for the ACA Marketplace, 2.55 [2.38, 2.72] for Medicaid MCOs, and 2.70 [2.54, 2.87] for Medicare Advantage. Taken together, this indicates that survey respondents may have a slightly higher opinion of the Medicare Advantage as a form of managed competition than the other two programmes, although the differences are not statistically or economically significant ($p = 0.18$ and $p = 0.22$, respectively). In general, there is no system of regulated competition in the US that is rated positively on more than 5 preconditions.[7]

The Medicare advantage programme has the highest average ratings with 5 positive attributes (consumer choice, consumer information/transparency, guaranteed access to care, affordable out-of-pocket costs, and basic benefit coverage), 1 neutral and 9 negative. The Medicaid MCOs and the ACA marketplace share the lowest average ratings. Across the three systems, the ratings that are most negative are for appropriate regulation of contracts and integration; contestable markets: providers; equity considerations; and efficiency considerations. The highest average ratings are for the basic benefit package, affordable out-of-pocket costs, and guaranteed access. Not surprisingly, Medicaid MCOs rate highly on affordability, given that fees for all services are all zero, however that system rates very poorly on quality and equity. The overall correlation of responses between the Medicare advantage programme and the ACA marketplace is 0.82, and the ratings of these two programmes are most correlated among contestable markets: providers (0.97); appropriate regulation of contracts and integration (0.94); and efficiency considerations (0.93).

[7]To interpret the results, we define 'positive sentiments' as the fraction of preconditions with mean responses of 3 or higher, and 'negative sentiments' as those with an average less than 3.

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Overall, survey results about the three systems give little support for the view that the US has found a workable model for managed competition as envisioned by Enthoven (1993) or van de Ven *et al.* (2013). The programmes examined in this article, unsurprisingly, fall seriously short. Some of these programmes partially or fully subsidise cost-sharing at the consumer level, leaving insurers no way to 'pass through' cost savings to enrolees and thereby gutting any efficiency gains from price competition (Layton *et al.*, 2018). Instead, these programmes rely on other forms of state power to control costs, including fixing reimbursement rates, arbitrarily excluding plans from the market, and assigning consumers automatically to lower-priced plans. US programmes differ greatly from what is proposed by Enthoven (1993) or van de Ven *et al.* (2013).

5. Road maps to managed competition

Given the historic complexity of the US healthcare system and its present rate of consolidation, increasing reliance on managed competition appears to be an uphill struggle. In general, all US health systems currently struggle with market segmentation, resulting in a patchwork of both private and public insurance systems that are rarely portable across states. Hindering consumer substitution severely restricts competition among both insurers and providers, and dampens each programme's ability to control premiums, costs, and quality. This problem is further complicated by the increased rate at which provider and insurance markets are consolidating. Any move to expand the role of regulated competition in the US should first and foremost resolve the problem of overly localised markets, either by creating a method for plan portability or otherwise by introducing a harmonised system of coverage.

Each of three large publicly funded programmes in the US utilising principles of regulated competition could form the foundation of a new universal managed competition structure. However, whichever path is taken, challenges remain. These three programmes each struggle – in their own ways – to encourage insurer and provider participation or to meet a diverse set of needs from the most vulnerable groups, including children, individuals with chronic conditions or disabilities, and others with reduced access to the health care system. A roadmap to expanding managed competition in the US requires carefully weighing the tradeoffs associated with universal access and meeting the unique needs of diverse individuals in the healthcare system.

Even once the structure of managed care is determined and harmonised, expanding access to such a programme will require careful consideration. Given the close integration of health insurance and employment, any sweeping health reforms have the potential to significantly alter employer behaviour and wages, ultimately imposing significant general equilibrium macroeconomic effects. Additionally, as noted previously, expanding affordable access to *coverage* may disrupt supply-side incentives of physicians, leading to new problems of access to *services* if the pendulum is swung too far in the opposite direction. Finally, any potential health reform must consider the political climate, including both the immediate viability of reform and the timeline of any phase-in associated with the change. Such considerations may ultimately lead to reforms which are socially optimal only subject to an added constraint of political feasibility (Ellis and Hoagland, 2022).

6. Concluding remarks

In this analysis, we have documented the wide degree of fragmentation in the US health insurance system, examined three forms of existing regulated competition in the US, and considered the extent to which these programmes might be expanded to encourage managed competition more broadly. We augment our synthesis of the literature with results from a survey of US health economists, which suggests that transitioning to a more competitive framework may be difficult to achieve in today's system.

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In order to encourage managed competition for all in the US, we argue that systemic changes are necessary on two levels. First, the current patchwork system of coverage – built around market segmentation across state lines and significant variation eligibility and coverage in publicly-funded Medicaid MCO programmes – requires harmonisation to promote more effective competition. Only after reducing the silos dampening competition can other changes take place, such as more unified approaches to providing health plan subsidies, standardisation and regulation of provider-level fees, and reducing market consolidation at the plan and provider levels.

While a clear road map to workable managed competition in the US remains unclear, managed competition health systems remain interesting possibilities for a radically redesigned US delivery system. Countries who have been successful in embracing this system achieve more attractive health outcomes and greater equity at much lower costs than the US. Whether they are feasible to attain in the US today we leave for future research.

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