

CARVE-OUT

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1. Core Definition

The term **carve-out**, primarily utilized within the fields of managed care and insurance administration, refers to the intentional segregation and exclusion of specific services, populations, or providers from a larger, overarching benefits package or administrative structure. This practice involves systematically removing certain specialized components--such as coverage for specific conditions, types of treatment, or prescription drugs--from the main insurance plan offered by a primary carrier or employer, and subsequently contracting those excluded services out to a specialized, third-party vendor or a dedicated management organization. The fundamental goal of a carve-out is to manage specialized risks, achieve cost efficiencies, and potentially improve the quality of care delivery for those specific services by leveraging the expertise of a focused administrator, rather than attempting to integrate these often complex and high-cost services into the generalist administrative framework of a comprehensive health plan.

While carve-outs are pervasive across various industries, their most critical and frequently analyzed application exists within the healthcare sector, particularly in managed behavioral health (MBH) and pharmacy benefits management (PBM). In this context, the primary health plan typically handles routine medical, surgical, and hospital claims, while the carved-out services--such as mental health, substance abuse treatment, or long-term care--are managed entirely separately. This operational separation means that members must navigate two distinct administrative systems, which handle everything from eligibility verification and claims processing to utilization review and provider network management, leading to significant implications for both administrative efficiency and the continuity of patient care, especially for individuals with complex co-morbid conditions requiring integrated treatment.

The defining characteristic of a **carve-out** is the transfer of both financial risk and administrative responsibility. The primary payer--whether an employer, a government entity like Medicaid, or a commercial insurer--contracts with a specialty vendor, often using a capitated payment model, thereby shifting the responsibility for managing costs and ensuring appropriate utilization for that specific subset of services to the third party. This transfer necessitates rigorous contractual agreements detailing expected service levels, financial accountability metrics, quality control measures, and reporting requirements, attempting to balance the desire for cost containment with the requirement for maintaining accessible, high-quality care, a balance that remains a continuous source of policy debate and regulatory scrutiny.

2. Rationale for Implementation

The strategic decision to implement a **carve-out** is typically driven by several interwoven rationales centered on achieving greater efficiency and control over high-variability or high-cost services. One of the most compelling arguments for using a carve-out model is the recognition that certain specialized areas, such as behavioral health or specialty pharmaceuticals, require expertise in provider contracting, utilization management, and outcome measurement that generalist health plans often lack. By contracting with specialized management organizations, payers can access sophisticated, proprietary algorithms and data analytics designed specifically to predict utilization patterns and control costs associated with these complex services more effectively than an integrated plan might achieve.

Another significant motivation relates directly to **financial risk management**. Services like mental health or drug utilization can be subject to unpredictable cost spikes and wide variations in patient need. By carving these services out and placing the specialty vendor under a capitation arrangement--a fixed per-member, per-month payment--the primary payer effectively fixes its exposure to the financial volatility associated with that service line. This mechanism provides predictability in budget planning, especially critical for government programs like Medicaid, which operate under strict budgetary constraints. Furthermore, the concentration of specific services within a dedicated administrative unit allows for more aggressive negotiation of provider rates and pharmaceutical discounts, contributing to lower overall costs compared to embedding these services within a broader fee structure.

Beyond financial and administrative efficiency, carve-outs are also sometimes justified on the grounds of quality improvement and enhanced accountability. Proponents argue that specialty management organizations can focus exclusively on developing and enforcing rigorous clinical pathways and evidence-based treatment protocols specific to their niche, thereby potentially improving adherence to best practices and optimizing clinical outcomes. For example, a behavioral health carve-out organization may be better equipped to implement targeted crisis intervention programs or specialized screening tools than a general medical administrator. However, this potential benefit is often counterbalanced by concerns that the specialization leads to a fragmented care experience for the patient, undermining the overall effectiveness of treating individuals holistically.

3. Historical Context and Managed Care Evolution

The concept of the **carve-out** gained significant traction beginning in the 1980s and accelerated through the 1990s, coinciding with the rapid evolution and dominance of Managed Care Organizations (MCOs) in the United States healthcare landscape. Before this era, behavioral health services were often managed poorly, or not at all, within traditional indemnity insurance

plans, leading to inefficient spending, lack of standardized quality controls, and significant stigma. When MCOs began taking over the administration of healthcare, particularly for large employer groups and public programs, they encountered specific high-cost areas that proved difficult to manage within their general operational models.

The initial widespread application of the carve-out model occurred within Medicaid, where state governments faced escalating costs associated with mental health and substance abuse services. States began contracting with specialty behavioral health organizations (MBHOs) to manage these populations under capitated rates, seeking to shift financial risk and gain control over utilization. This historical shift marked the formal separation of the "mind and body" in administrative terms, accelerating the structural divide between physical healthcare and mental healthcare that persists today. This administrative separation, while financially motivated, institutionalized the idea that behavioral health treatment operated outside the scope of general medical treatment, further complicating efforts toward integrated care models.

The proliferation of Pharmacy Benefits Managers (PBMs) represents another critical chapter in the history of the carve-out. As pharmaceutical costs soared, driven by specialty drugs and increased utilization, health plans realized significant financial advantages in contracting out the management of drug formularies, purchasing, and claims processing to PBMs. These PBMs, acting as powerful intermediaries, could leverage massive purchasing volume across multiple clients to negotiate substantial rebates and discounts from manufacturers, savings that the individual health plans could not achieve independently. Thus, the **pharmacy carve-out** became standard practice, creating a complex administrative layer that dictates patient access to medication but offers significant cost mitigation for payers.

4. Types of Carve-Outs (Specific Examples)

While the source material focuses on health services like mental health and substance abuse, carve-outs are categorized based on the specific service or population being excluded from the main plan. The most prominent example is the **Behavioral Health Carve-Out**, where all services related to mental health, counseling, psychological testing, and substance use disorder treatment are removed from the general medical plan and administered by a specialized MBHO. The administrative complexity here arises when a patient presents with psychosomatic symptoms or dual diagnoses, requiring providers from two separate systems to coordinate care, often leading to communication barriers and delays in necessary authorizations.

Another essential type is the **Pharmacy Carve-Out**, managed almost universally by PBMs. In this arrangement, the PBM assumes responsibility for maintaining the drug formulary (the list of covered drugs), negotiating rebates, processing claims, and implementing utilization management tools such as prior authorizations and step therapy protocols. A notable distinction here is between

plans that "carve out" pharmacy benefits (the majority of commercial plans) and those that "carve in" or integrate them, typically associated with tighter management and closer alignment of medical and drug usage data, although the PBM still often performs the administrative functions even when benefits are technically integrated.

Additional examples of carve-outs include specialty dental or vision plans, which are almost universally administered separately due to the specific professional networks and utilization patterns required. More complex examples involve **Disease Management Carve-Outs**, where specific high-cost chronic conditions (e.g., end-stage renal disease or complex cancer treatments) are administered by highly specialized vendors focused only on managing the care and associated risks for that disease cohort. Furthermore, in government programs like Medicaid, some states utilize **Population Carve-Outs**, where specific subsets of beneficiaries--such as individuals with intellectual disabilities or long-term care needs--are segregated and assigned to specialized managed care entities due to their unique service requirements and extremely high per-capita costs.

5. Impact on Patient Care and Access

The implementation of a **carve-out** model has a dichotomous impact on patient care, presenting both potential benefits through specialization and significant challenges related to care coordination. On the positive side, specialized vendors often boast deeper knowledge regarding the optimal management and utilization review of their specific service line. This specialization can lead to the establishment of provider networks composed of practitioners who are highly expert in the treatment of specific, complex conditions, theoretically resulting in higher quality and more appropriate care than might be available under a generalist plan attempting to cover everything. For instance, a dedicated MBHO might ensure better access to empirically supported therapies for depression or anxiety than a general MCO.

However, the most persistent and serious criticism leveled against carve-outs is the inevitable creation of **fragmented care**. When a patient requires services from both the primary medical plan and the specialized carve-out vendor--a common scenario for individuals with chronic conditions complicated by depression, or for those whose physical health issues stem from substance abuse--the administrative separation inhibits seamless coordination. Providers from the two systems often use different medical records, authorization forms, and communication channels, forcing the patient to act as the primary intermediary for their own complex care plan. This administrative burden can lead to delays in treatment, discontinuity in medication management, and, ultimately, worse health outcomes, particularly among vulnerable populations who already struggle with system navigation.

The issue of access is further complicated by utilization management practices inherent in the

carve-out model, particularly when the specialty vendor is operating under capitation and thus has a strong financial incentive to limit service utilization. While designed to prevent unnecessary services, stringent prior authorization requirements and limitations on covered benefits within the carved-out system can create significant barriers for patients seeking timely access to necessary specialized treatment. This dynamic often requires continuous regulatory oversight to ensure compliance with federal mandates, such as the Mental Health Parity and Addiction Equity Act (MHPAEA), which aims to prevent differential treatment of mental health services compared to surgical or medical benefits, a primary challenge when those services are administered by two separate entities.

6. Debates and Criticisms

The ongoing debate surrounding **carve-outs** centers heavily on their long-term viability and ethical implications concerning patient well-being versus cost control. Critics argue that while carve-outs may deliver short-term budget predictability for payers, they fundamentally undermine the movement toward holistic and patient-centered integrated care. The structural separation incentivizes the specialty vendor to focus solely on their narrow service line without fully accounting for the external costs or benefits their decisions impose on the primary medical plan. For example, delaying adequate mental health treatment (managed by the carve-out) may result in higher utilization of emergency room services or inpatient hospital stays (managed by the primary plan), creating a net overall cost increase despite the apparent savings in the carved-out budget.

A significant criticism, particularly in behavioral health, involves the potential for **stigma reinforcement**. By administratively separating mental health and substance abuse coverage from physical health coverage, the system implicitly suggests that these conditions are fundamentally different or less important than traditional medical ailments. This separation can complicate efforts to destigmatize mental illness and discourages primary care physicians from proactively screening and referring patients for necessary behavioral health services when the administrative pathway is complex and separate from their usual referral systems. Furthermore, the specialized provider networks used by carve-out vendors are often smaller and more geographically constrained than general medical networks, potentially reducing the overall availability of care in rural or underserved areas, contributing to disparities in access.

Finally, regulatory complexity represents a continuous source of debate. Ensuring that carve-out organizations comply with mandates like MHPAEA requires intense auditing, as specialty vendors have historically been scrutinized for imposing stricter limits (e.g., fewer covered inpatient days or more stringent clinical necessity definitions) on mental health services compared to physical health services. The administrative friction between the two distinct payer entities--the general plan and the carve-out--creates fertile ground for compliance failure, claims disputes, and consumer confusion, often requiring substantial regulatory intervention to enforce parity and accountability

across the fragmented system.

Further Reading

[Health Policy](#)

[Managed Care](#)

[Health Economics](#)

[Pharmacy Benefit Management](#)

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