Some Economics of Mental Health ‘Carve-Outs’

Richard G. Frank, PhD; Haiden A. Huskamp; Thomas G. McGuire, PhD; Joseph P. Newhouse, PhD

We discuss the rationale for benefit carve-out contracts in general and for mental health and substance abuse in particular. We focus on the control of adverse selection as a principal explanation and find that this is consistent with the widespread use of sole-source contracting with periodic rebidding. We also find that some degree of risk sharing is common; we interpret this as a method of balancing cost-containment incentives with incentives to maintain access and quality on unmeasured dimensions.

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How employers and public purchasers structure their health insurance plans has changed in recent years. Traditionally, the purchaser, usually an employer, contracted with a single insurance plan to cover a full range of health risks. Increasingly, however, purchasers of health insurance are offering beneficiaries a range of plans. Purchasers may also “carve out” certain benefits, which means that they are separating the health insurance function by disease or service category and contracting separately for the management of those risks. This article addresses the issue of why a health buyer might break up health insurance risks in this way, emphasizing carve-out contracts in the area of mental health and substance abuse (MHSQ).

At present, mental health carve-out contracts are a rapidly growing feature of health insurance. According to Oss,1 approximately 53 million people are enrolled in carve-out programs of all types. Between 20 and 25 million people are enrolled in so-called risk-based carve-out contracts (whereby the carve-out vendor assumes some or all of the financial risk for claims), which account for about 60% of the total revenue of firms that manage MHSQ benefits. Carve-outs are more common among larger firms than smaller firms. Umh1 reports that 35% of employers with 5000 or more employees were contracting with a specially MHSQ carve-out vendor compared with a rate of about 3% for firms with fewer than 500 employees.

The setting for the problem that we analyze is an employer or public agency such as Medicaid that pays for health insurance for a large number of enrollees. Enrollees have a choice of competing managed care plans such as health maintenance organizations that offer a standardized benefit package. The employer must decide if some part of the health insurance risk should be carved out of the general contract and administered separately. If a carve-out approach is chosen, the employer must then choose whether to allow various vendors to compete for employees’ business or to let a single contract cover all employees.

THE RATIONALE FOR CARVE-OUTS IN MHSQ

Most employer-provided health insurance covers MHSQ treatment. Virtually all private plans, however, put special limits on coverage for these conditions.2 Typically, a private plan requires higher co-payments for MHSQ care than for general medical services, limits the number

From the Departments of Health Care Policy (Drs Frank and Newhouse and Ms Huskamp), and Health Policy and Management (Dr Newhouse), Harvard School of Public Health; Department of Economics, Boston University, Boston, Mass (Dr McGuire); and Kennedy School of Government, Cambridge, Mass (Dr Newhouse).
of covered MHSA office visits, limits MHSA-covered hospital days to 30 or 60 per year, and often imposes annual or lifetime limits on plan costs for MHSA care as well. Coverage for medical services is typically not subject to these limits. In spite of less favorable coverage, costs of MHSA treatment have averaged around 8% to 12% of an employers' health benefit costs and have been a special concern for employers in recent years. The presence of a public safety net permits employers to avoid paying for very expensive mental health treatment. Beyond this, there are other reasons for limited coverage that relate to the case for using carve-out contracts. One reason for special limits is that the utilization of MHSA services is more responsive to insurance coverage and payment features than other areas of health care.  

For example, the RAND Health Insurance Experiment showed that utilization of mental health services is twice as responsive to cost-sharing provisions as is utilization of general medical services. This response in terms of utilization to insurance coverage is called moral hazard. A second reason for special limits is that a health plan offering more generous coverage may draw an adverse selection of the insured population. An employer or public agency might carve out MHSA care for 1 or both of 2 main reasons: (1) better management of market failures resulting from moral hazard and (2) better management of adverse selection. We take up these 2 reasons in turn.

Management of Moral Hazard

Firms engaged in managing MHSA benefits argue that they can do a better job of managing the moral hazard associated with mental health services and thus managing the cost of care. By assembling networks of specialty providers who are willing to accept lower prices and by using techniques including care management and utilization review, firms in the "behavioral health" field promise to make care more cost-effective and to generally save employers money while preserving access to necessary services. In one spectacular example, the Massachusetts State government began contracting with a carve-out firm to provide MHSA benefits to almost 200,000 state and local employees in a public insurance group in Massachusetts in July 1993. Based on preliminary research, benefit payouts were reduced by 40%, with no detectable decrease in the rate at which people enter treatment. Other case studies showing favorable results are reported in business publications or unpublished reports.

Nevertheless, is it necessary to carve out the mental health benefit and to separate the risk of mental disorders from risk of other health care costs to apply the technology of moral hazard management used by carve-out firms? The carve-out firms, some of which have now been acquired by large insurers, may have special expertise, and there may be some network economies associated with running a managed care plan in a region. Yet these advantages by themselves do not necessitate an employer's use of a carve-out contract. The employer could instead contract with a single insurer, who would be responsible for all risks including MHSA, as was traditionally done. That single insurer could also hire a specialized management firm, and some do, to manage the risk internally without a formal carve-out. In other words, because all insurers have an incentive to control cost, an employer need not necessarily use a carve-out to have access to the management techniques possessed by the specialized MHSA benefit management firms.

Management of Adverse Selection

A second reason to carve out a MHSA benefit derives from an employer's concern with the consequences of adverse selection. Adverse selection occurs because insurance plans operating in competitive markets have a strong financial incentive to avoid the most costly and difficult-to-treat enrollees by making health plans unattractive to certain subpopulations such as the severely mentally ill. In fact, insurers have historically competed for "good risks" by offering insurance coverage that strictly limited coverage for the treatment of mental illness. Adverse selection is thus an important explanation for the limited coverage of mental health care.

Many MHSA problems are persistent and, therefore, predictable to an individual seeking insurance coverage, so individuals who predict that they will need MHSA treatment will seek a plan with generous coverage of these services. Furthermore, mental health expenditures (in comparison with other areas of spending) are relatively highly correlated with future total health expenditures, implying that competing health plans would like to avoid persons using mental health services. During the 1960s and 1970s, the Federal Employees Health Benefits Program (FEHBP) was an example of how concerns about selection drove competing insurers to lower benefits for MHSA services, as plans with generous MHSA benefits attracted those who wished to use such a benefit. A comparison of the much smaller response to price in the RAND Health Insurance Experiment with those derived from the FEHBP strongly suggests adverse selection in the FEHBP. Mental health care in the "high option" FEHBP can be 2 or 3 times higher than in the low option, even though coverage differences are quite small. Whereas the RAND Health Insurance Experiment randomized the underlying risk among plans, the more generous FEHBP plans differentially attracted the poorer risks, thereby making it appear that generous coverage induced high utilization.

Adverse selection has also played a role in public regulation of insurance benefits for MHSA care over the past few decades. Concern for the effects of competition among insurers to avoid the mentally ill was the principal justification for state regulations, stipulating minimum coverage for mental health care adopted by 22 states during the 1970s and 1980s. However, when costs are controlled by managed care, regulation of the terms of coverage is not sufficient to ensure that competition for...
good risks does not undermine the actual availability of benefits. A managed care organization could, for example, state in its benefit booklet that up to 20 outpatient visits per person per year are covered, but make it very difficult for an enrollee to begin or continue receiving care by using a restrictive case management process or a limited panel of MHSA providers. Thus, the administrative mechanisms that can effectively control moral hazard can also be used to gain favorable risk selection by a managed care organization. By carving out the mental health benefit, an employer eliminates the incentive to "overmanage" mental health costs to attract good risks.

Mandated Minimums

A third, and probably less important, reason why buyers may carve out MHSA is to guarantee that a proportion of total benefit dollars be designated for MHSA treatment. In the context of managed care, a carve-out program can serve a function similar to a minimum-benefit mandate in a fee-for-service world. A carve-out "sets aside" a designated level of funding for MHSA services in a separate contract. This, however, could also be achieved without a carve-out if a health plan set an internal subbudget and enforced this arrangement.

EVIDENCE ON THE EXPLANATIONS

The foregoing theoretical discussion has emphasized the management of adverse selection as a key factor in a decision to carve out MHSA benefits. Empirical support for this view comes from analyzing the decisions of large purchasers. If selection is a concern, one would tend to observe a single MHSA carve-out firm that served all members of the group rather than several carve-out firms competing for individual members of the group. If, on the other hand, management of moral hazard were a primary concern, one might see one firm or several firms serving the group.

As of summer 1995, approximately 19 states had received approval for waivers from Medicaid program regulations to develop managed care plans. Eleven of these states chose a carve-out plan for mental health. In 10 of the 11 states adopting carve-out programs for mental health and/or substance abuse care, all competition for enrollees between carve-out plans has been eliminated. By contrast, in most of the states with a carve-out program there is competition between general health plans. In 5 of the 10 cases, a single vendor was selected to serve the entire state Medicaid population. In the other 5 states, several managed care organizations were given exclusive contracts to cover a particular geographic area within the state. The actions taken by the great majority of states are consistent with a desire to prevent competing for good risks or adverse selection.

Recent experience with private health plans also suggest that use of carve-outs relates to concerns about selection. The state of Ohio's health plan for state employees recently created a carve-out program for MHSA that is common to all health plan choices. Thus, enrollees choosing health maintenance organizations, preferred provider organizations, and more conventional indemnity plans are all covered by a single carve-out plan for MHSA. Several large self-insured firms such as IBM and Pacific Gas and Electric have adopted similar approaches to that found in the Ohio State employees' plan. All of these experiences offer support for a linkage between organizational design of MHSA benefits and adverse selection concerns.

Further support for the selection explanation comes from data we collected. These data come from the Requests for Proposals (RFPs) for carve-out programs that a large behavioral health care company received over the past several years, as well as data on the contracts between a large insurer and various behavioral health care firms that manage the MHSA benefit for regional populations. Of the 74 contracts and RFPs that we examined, in every case a single vendor supplied MHSA carve-out services to all eligible enrollees (in a few cases, enrollees of health maintenance organizations were not eligible for the carve-out program). In no case did a private employer set up competition between organizations for MHSA risks. We did find some contrary behavior among some public buyers. Franklin County (Columbus, Ohio) has proposed paying any 1 of 5 community mental health centers a capitation rate (including some risk adjustment) for enrolling a Medicaid-eligible individual.

In creating the TennCare program, the state of Tennessee initially created 3 competing MHSA carve-out programs that operated statewide. The state of Connecticut is also an exception; it recently offered multiple choices of managed health plans to its Medicaid recipients. Each plan in Connecticut has an MHSA carve-in.

One possible reason for the discrepancy in public and private buying patterns just noted is that private employers and public buyers may have different goals, particularly with respect to the public mental health system. For a private employer, being "fair" to the local mental health providers or supporting the local public system are low priorities at best. The goals of a public buyer, however, may include strengthening the local public system (perhaps by promoting quality competition among local organizations), structuring the supply of services to distribute public funds in a "fair" way (for example, by ensuring that each existing public provider has a chance to serve the buyer's enrollees), or providing choice of providers for enrollees. These goals could lead a public buyer to use the competing contractor approach, but this approach to structuring the market may come at substantial cost by creating incentives for adverse selection.

COST-SHARING FEATURES AND INCENTIVES IN THE CONTRACT

The parties to an MHSA carve-out contract have differing objectives. The vendor is concerned primarily with maximizing profit (or mini-
mizing costs in the case of a non-profit vendor), whereas the buyer cares about minimizing payments to the vendor and guaranteeing a particular level of access to care and quality of services for its enrollees. Because the vendor has an information advantage over the buyer regarding the costs of managing the benefit (or managerial effort) and because the quality of care being delivered is poorly measured, it is difficult for the buyer to monitor the vendor’s performance. The “quality” measures that can be written into a contract at this point are very primitive. As a result, the buyer seeks to write a contract that aligns the vendor’s objectives with its own. To do so, the buyer employs 2 mechanisms: competition for the contract and risk sharing within the contract period.7

**Competition for the Contract**

The contract award process is competitive. First, an employer’s staff or a benefit consultant typically develops purchasing specifications and a list of qualified potential bidders. Then the purchaser issues an RFP to potential bidders that usually includes information on the benefit structure, financial risk-sharing arrangements, historical utilization and expenditure data, and quality standards. The bidders’ proposals consist of a technical component that describes the delivery of clinical services and the management process and also a cost-reimbursement component. Larger purchasers may make site visits to a set of finalists and subsequently sign a contract based on final negotiated costs and technical specifications. Most contracts are 2 or 3 years in duration. Typically between 4 and 10 firms bid for contracts for larger population groups, whereas a rather generous health plan has been in place. Thus, vendors compete for the contract. The purpose of competition is to keep the contract cost down and to seek commitments from vendors on specifications (such as network size) that can be written into a contract. To enhance the competition, at the end of the 2- or 3-year periods, buyers procure a new contract so that the current contractor must compete with other vendors to secure the new contract. Buyers, including public employee programs such as the Ohio State employees health plan, have commonly switched managed care vendors after the initial carve-out contract expires. Thus, even in cases where a single contract is let, competition serves to drive down costs.

**Risk Sharing**

Through the contract’s risk-sharing arrangement, the buyer seeks to balance the vendor’s incentives to reduce costs with those aimed at maintaining adequate levels of access and quality. The extreme risk-sharing arrangement is pure capitation, whereby a vendor receives a specified dollar amount per enrollee per period and is at full financial risk for that enrollee’s claims. The use of some risk sharing is becoming more common, however. In a typical arrangement, risk corridors are defined around a per person expenditure target \( t \). For example, a common risk corridor will be defined as \( \pm 10\% \) of \( t \). If claims costs fall below 90% of \( t \), the difference between the target and the actual amounts will be fully recovered by the buyer, whereas claims costs above 110% of \( t \) will be absorbed by the buyer (ie, all financial risk below 0.9t and above 1.1t is kept by the buyer). For the “at risk” portion of the payment schedule, between 90% and 110% of \( t \), contracts will specify a risk-sharing rate such as 50% between the buyer and the vendor.

**Why is a risk-sharing contract in the buyer’s interest?** One possible reason is that the contractor may be small relative to the buyer and less able and willing to bear large financial risk (and thus require a higher fee to take on large amounts of risk). So, although risk sharing dulls the vendor’s incentives to reduce cost, it may lower the payment the buyer must make to the contractor for bearing financial risk. Indeed, many MHSA carve-out firms are small in relation to the buyers. In its first contract, Options Mental Health, Norfolk, Va, accepted a segment of the risk of MHSA claims from the Commonwealth of Massachusetts. The largest behavioral health care companies have revenues on the order of $300 million (with value added or profit less than 10% of this), while the annual budget of the Commonwealth is approximately $5 billion.1 Extensive cost sharing of financial risks by the Commonwealth may enable vendors to make a lower bid on the cost target by reducing the “cost of risk.”

A second reason stems from the possibility that managed MHSA plans will respond to capitation contracts by reducing utilization and quality of care to unacceptable levels in ways that are not easily monitored by the buyer. Capitation offers the managed care organization no payments for providing extra services. A common concern is that such incentives will encourage managed care organizations to place too much weight on profits compared with access and quality. Because individuals with mental and addictive disorders often function poorly as consumers and because quality of care indicators in the MHSA area remain crude, there are few other mechanisms that can be used to attenuate the incentives for managed MHSA care vendors to stint in ways that cannot be detected.

The data that we collected on RFPs and contracts in behavioral health care illustrate a range of risk-sharing features. These data come from RFPs contained in the marketing department of a large behavioral health care firm in March 1995. This firm had been in operation for several years and had a nearly complete collection of the major RFPs from private employers in the early 1990s. Public system RFPs, eg, Medicaid, are not included in these data, although state government as private insurer RFPs are. In less than a fifth of the RFPs (9 of 50), the employer specified that it sought a full-capitation contract in which the vendor would be paid a per person per month payment for MHSA costs and would bear all the risk. More frequently (16 of 50), the employer explicitly stated it did not want a
full-risk contract with a vendor. In the most common case (25 of 50), the employer did not specify the terms of the financial risk sharing to be proposed by the vendor. Nonetheless, vendors sometimes proposed risk-sharing contracts even when they were not invited by an employer. Thus, an RFP that reads like a full-capitation request can result in a contract with risk sharing.

CONCLUSIONS

Our analysis leads to 2 initial conclusions concerning carve-out contracts for managed behavioral health care. The first relates to competition for “good risks.” We believe that adverse selection has long undermined the insurance market for MHSA coverage, resulting in inefficient forms of insurance. The era of managed care and capitation has heightened the incentives for health plans to avoid “bad risks.” Buyers of health care can limit these incentives by carving out the MHSA benefit to a single vendor. The second relates to achieving the objective of minimizing cost for a given level of access and quality. Buyers rely on periodic competition for the contract to do so. Additionally, they rely on risk-sharing arrangements that attenuate the incentive to undertreat MHSA patients while preserving an incentive to reduce costs. Thus, they seek to balance cost containment with access and quality of care objectives.

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Reprints: Richard Frank, PhD, Department of Health Care Policy, Harvard University, Parcel B, First Floor, 23 Shattuck St, Boston, MA 002115.

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