NOVEMBER 2014

BEHAVIORAL PRESCRIPTION DRUG AND SERVICES COVERAGE: A SNAPSHOT OF EXCHANGE PLANS

PREPARED BY BREAKAWAY POLICY STRATEGIES FOR MENTAL HEALTH AMERICA

SPONSORED BY TAKEDA PHARMACEUTICALS U.S.A. AND LUNDBECK U.S.

BREAKAWAYPOLICY
A JOINT VENTURE WITH INVENTIV HEALTH

Table of Contents

Executive Summary

Background

Breakaway Policy Strategies (Breakaway) was commissioned by Mental Health America (MHA) to analyze coverage of, and access to, services, treatments, and providers needed by people who have behavioral health care needs. This work was supported by Takeda Pharmaceuticals U.S.A., Inc. (TPUSA) and Lundbeck U.S.

There are many components of health plan coverage that impact patient access to care. Whether a service or treatment is covered is a baseline access measure. However, patient access is also contingent upon whether a provider, service, or drug is on a tier (preferred or non-preferred), the amount of patient cost sharing at the point of service, and whether the service must be specifically authorized by the plan. All of these aspects were researched in this study.

Breakaway Policy Strategies (Breakaway) conducted research in the summer of 2014, into behavioral health services coverage in four Bronze and four Silver Exchange plans in nine states, using HMO, PPO, POS, and EPO models in the study. We used publicly available plan documents.

Results in Brief

Drug Coverage

A major finding of the review of 17 generic (off-patent) and 8 branded (patented) pharmaceutical treatments is that access to newer, branded treatments is quite restricted by a majority of the 72 plans studied. Branded products were often not covered by some of the plans; in this study, HMOs and EPOs have more restrictive brand coverage than either the PPO or POS models. This is important because, while there is a process for a patient to appeal to obtain a coverage exception for a product or service, if that is not successful, the full cost of the product is the patient's responsibility and that expense does not count toward a deductible or the annual patient protection out-of-pocket spending limit.

Generics are generally placed on the lowest patient cost sharing tier – tier 1, although in some states, plans have put some generics on tier 2 – a non-preferred generic tier with higher cost sharing. The branded products were generally placed on tiers 2, 3, or 4, with tier three as the most prevalent brand placement. The higher the tier level, the higher the consumer cost sharing.

Even if a plan covers a particular drug on a higher cost tier, there can still be other impediments to access in the form of quantity limits, step therapy, or prior authorization – collectively referred to as "utilization management (UM)." This research showed that POS plans employed UM more often for more products than other plan types. The research also showed that quantity limits was the most common type of UM for these products and plans, although step therapy (a patient must fail on other treatments before accessing a particular drug) was employed with some frequency for the newer branded products. Of the 25 products in the study, only Lamictal, Lithane, and Tegetrol were not subject to any type of UM by any of the 72 plans in the study. Conversely, there are some generics such a Cymbalta, Resperdal, Seroquel, and Zeldox that have some type of UM applied by more than half of the plans in the study. There is no difference between Bronze and Silver plans in terms of if and how drugs were covered.

Drug Cost Sharing

Unlike actual coverage of drugs, there is a sizeable difference in the amount of cost sharing between Bronze and Silver plans, which would be expected. The average Bronze drug copay, before and after the deductible is met, is $30 and $14 respectively; it is $17 and $3 for Silver plans. For plans that employ coinsurance rather that copayments, the average coinsurance after the deductible is 23% for Bronze plans and 11% for Silver plans.

Service Coverage

Plan public documents indicate mental health parity insofar as coverage of inpatient, outpatient and community provider coverage service limits (if any) and cost sharing; however, it is not clear from pubic documents how utilization management might be applied to behavioral health relative to other services, since that information is not typically available in public plan documentation. All plans used the same federal definition of medical necessity, which is very broad and inclusive but subject to interpretation. How individual health plans apply that definition to behavioral health services is not likely to be uniform. It is anticipated that the definition will develop greater specificity over time through federal guidance, and even possibly some case law. Although not expressly stated in plan documents, it does appear that behavioral health providers are considered "specialists" and subject to specialist cost sharing.

Provider Networks

Exchange plans varied widely in their provider search functionality and their classification of provider types. For instance, some plans required a search by specific profession (such as licensed clinical social worker, psychologist, counselor, or psychiatrist) while others grouped all behavioral health providers under one broad search term and still others exclude psychiatrists from that broad category to be searched separately. Some plans indicate which providers are accepting new patients, while other plans do not. The study method was not designed to assess the accuracy of the information in the provider directory, although some plans had a good deal of duplication in the listings. All of this variation can make it difficult for a consumer unfamiliar with the behavioral health provider landscape to compare plans or even to find the best provider to address specific behavioral health needs.

There was no discernable difference in provider networks between Bronze and Silver metal level plans.

Service Cost Sharing

For the patient share of service costs, plans use copayments (a constant dollar amount per type and unit of services) or coinsurance (constant percentage which varies in price based on cost of the service), or both. For instance, all plans that provide some coverage for out-of-network specialist services, use coinsurance ranging from 20% to 75% while the plans might employ copayments for in-network services – for an average of $46. The average in-network coinsurance is 40%. For plans that use copayments for in-network services, the average copayment for specialist services is $40. Not all plans cover any out-of-network providers, and the cost sharing can be quite high for those that do, it is important that consumers investigate provider participation in plan networks before choosing coverage.

Conclusion

The study raised several issues, including whether plans should standardize their provider search functions. Also, consumers should watch developments around non-preferred generic tiers and should not assume that all generics will be on the lowest cost, or first, tier. It does appear that use of a high cost, fourth tier for newer, branded drug coverage is more common in some markets than others, so further research may be needed to learn more about those markets and their dynamics to see if those trends are more or less prevalent than this data suggests and what the trend means for access to new therapies. Regardless of specific markets, this study highlights the need for consumers/patients to be well informed about their plan choices – provider participation, out-of-network coverage and cost sharing, and drug coverage in particular.

Behavioral Prescription Drug and Services Coverage: A Snapshot of Exchange Plans

Background

Breakaway Policy Strategies (Breakaway) was commissioned by Mental Health America (MHA) to analyze coverage of, and access to, services, treatments, and providers needed by people who have behavioral health care needs. This work was supported by Takeda Pharmaceuticals U.S.A., Inc. (TPUSA) and Lundbeck U.S.

This report provides study results in two parts. The first part is a review of prescription drug coverage for a variety of behavioral health conditions. The second part is a review of services, cost sharing, and network composition that affect people with behavioral health care needs, relative to other medical service needs

There are many components of health plan coverage that impact patient access to care. Whether a service or treatment is covered is a baseline access measure. However, patient access is also contingent upon whether a service is on a tier (preferred or non-preferred), the amount of patient cost sharing at the point of service, and whether the service must be specifically authorized by the plan. All of these aspects were researched in this study.

Methodology

The Breakaway study included 72 Exchange health plans in nine states selected by Mental Health America (MHA) in the summer of 2014. In each state, we examined two Silver and two Bronze metal level plans from the most populous region of each state, including HMO, PPO plans. EPO and POS style plans were used where there were not four HMO and four PPO plans. Mental Health America chose these metal levels because they are the most popular among Exchange customers. In February 2014, the Department of Health and Human Services (HHS) released an Exchange enrollment report covering the period of October 1, 2013 to February 1, 2014, which showed that 62 percent of individuals who selected an Exchange plan chose a Silver plan, and 19% chose Bronze—compared to 12 percent and 7 percent choosing Gold and Platinum plans, respectively.

For the prescription drug part of the analysis, all nine states were included: Arizona, California, Colorado, Illinois, Maryland, Montana, New Jersey, New York, and Texas. For the services, network, and cost sharing analysis, Breakaway used only five of the nine states: Arizona, Illinois, Montana, New Jersey, and Texas. Unlike the other states, these five do not operate their own State-based Exchanges but have instead opted for a Federally-facilitated Exchange (FFE). These five FFE states had more complete information about networks and services than the State-operated Exchange states during the period of study, which was after the 2014 open-enrollment period. So, while FFE states were used for the service benefits analysis, all states were used for the prescription drug/formulary analysis.

It is important to note that sometimes plan benefit information was not consistent depending on where the information was accessed. For instance, information linked from healthcare.gov might be different from plan information found elsewhere, in terms of cost-sharing details. When conflicts occurred, the data collected were from the information accessed through healthcare.gov.

Coverage rates are simple averages, not weighted for enrollment or other factors.

Part I: Prescription Drug Benefits

Coverage

Breakaway reviewed 72 Exchange market Silver and Bronze level plans for this study: four plans in each of nine states[1], including a mix of HMO, PPO, POS and EPO plan types. The 25 pharmaceutical products Breakaway reviewed included treatments for a range of behavioral health conditions. The products were predominantly generics, but there were nine branded products in the study (Figure 1).

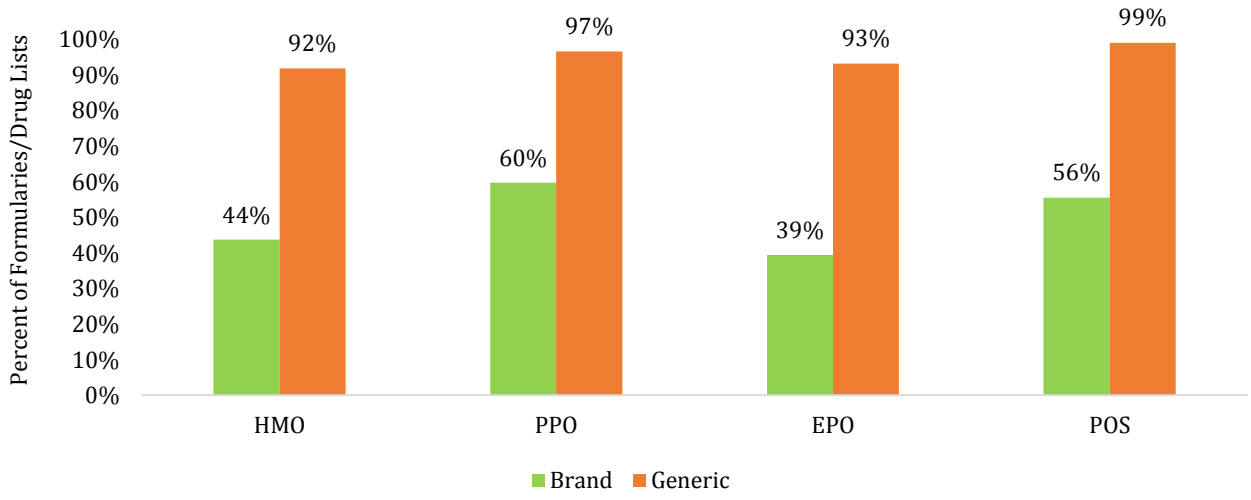
Figure 1: 25 Products Included in the Analysis
Branded products denoted in bold font.

Abilify	Depakote	Lamictal	**Pristiq**	Seroquel
Brintellix	Efexor	**Latuda**	Prozac	Tegetrol
Celexa	**Fetzima**	Lexapro	Risperdal	**Viibryd**
Clozaril	Geodon	Lithane	**Saphris**	Zoloft
Cymbalta	**Invega**	Paxil	**Savella**	Zyprexa

Coverage by Plan Type

Averaging coverage of all generic drugs and all brand products by type of health plan, it is clear that all plans provide greater coverage of generics than brands and that PPO plans cover both brands and generics at slightly higher rates than other plan types (Figure 2).

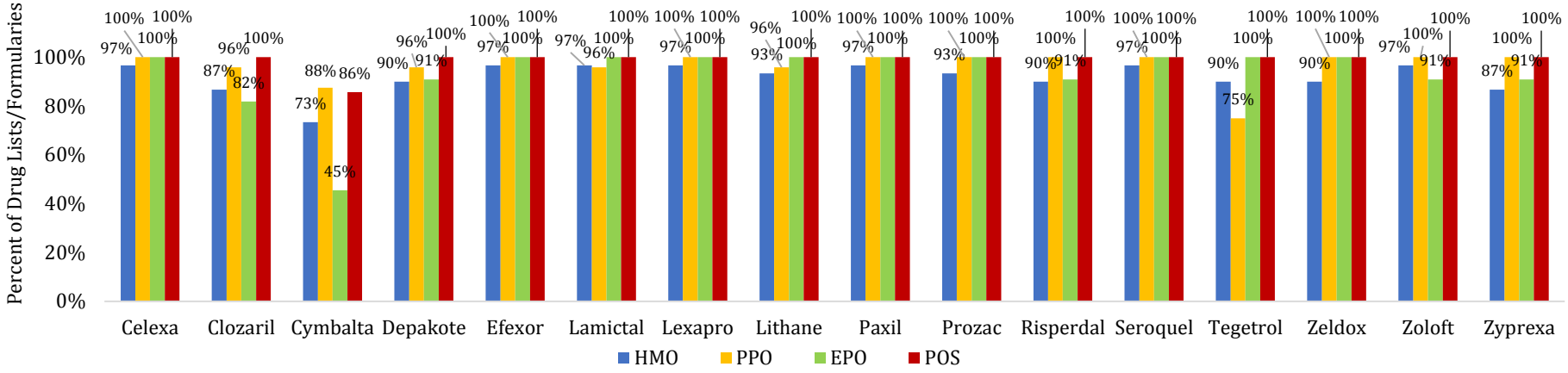
Figure 2. PPO Plans Have Better Coverage



[1] Arizona, California, Colorado, Illinois, Maryland, Montana, New Jersey, New York, and Texas.

In more detail, there were 30 HMO model plans in the Breakaway study, across all nine states. Coverage of generics was generally robust, with the possible exception of Cymbalta and Tegetrol (Figure 3). Even though coverage of generics was generally robust across all plans, HMOs are more restrictive in terms of drug coverage; none of the 16 generic drugs was covered by 100 percent of the HMOs. In contrast, 10 generic products were covered by 100 percent of the 24 PPO plans and 11 EPO plans. Among the POS plans, 15 generic products were covered by 100 percent of the seven plans.

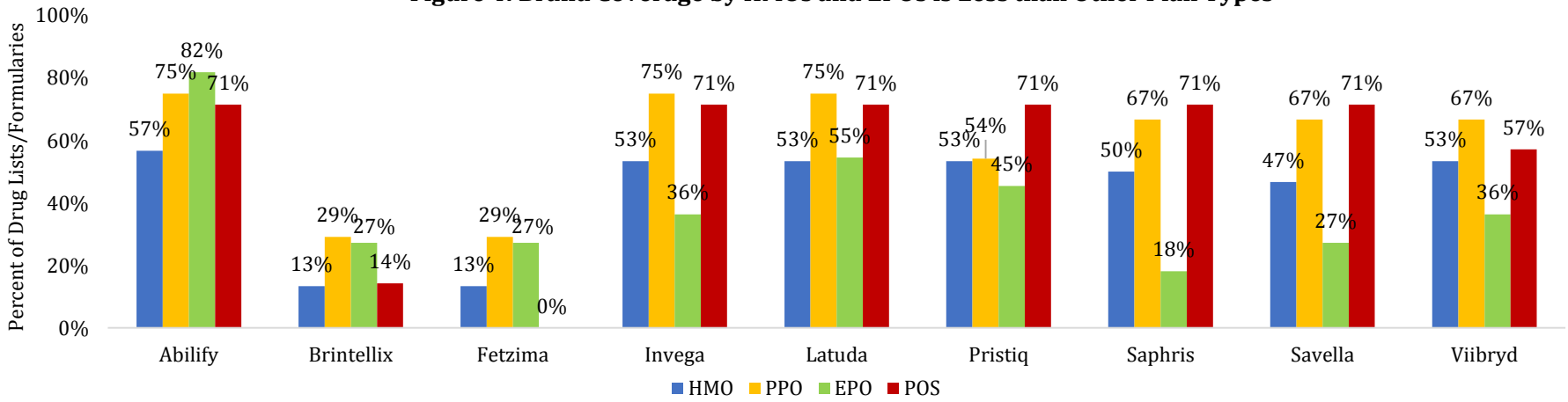
Figure 3: PPO and POS Have Slightly Better Average Coverage of Generics



Coverage of Specific Drugs by Plan Type

The nine branded products were often not covered in a majority of plans (Figure 4). None of the POS plans covered Fetzima, and 70 percent to 80 percent of the other plan types also did not cover Fetzima. Abilify, Latuda, and Invega had better coverage among all types of plans, relative to the other six branded products.

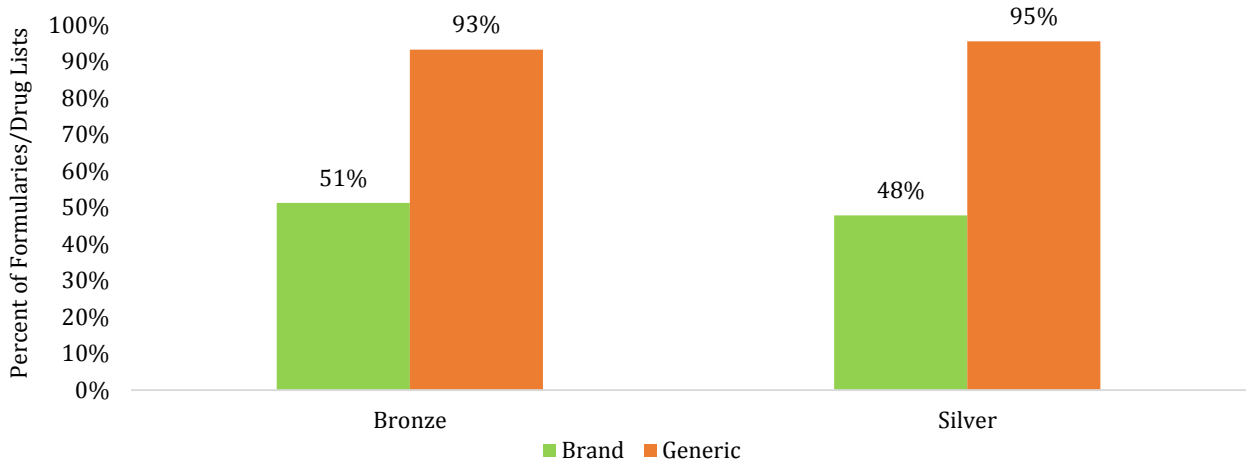
Figure 4: Brand Coverage by HMOs and EPOs is Less than Other Plan Types



Coverage by Metal Level

As Figure 5 shows, rates of brand or generic coverage are similar for Bronze plans and for Silver plans. Figure 6 shows in more detail the same concept – that coverage of generics is better than coverage of brands and that there is, in general, little difference in coverage of either brands or generics by metal level.

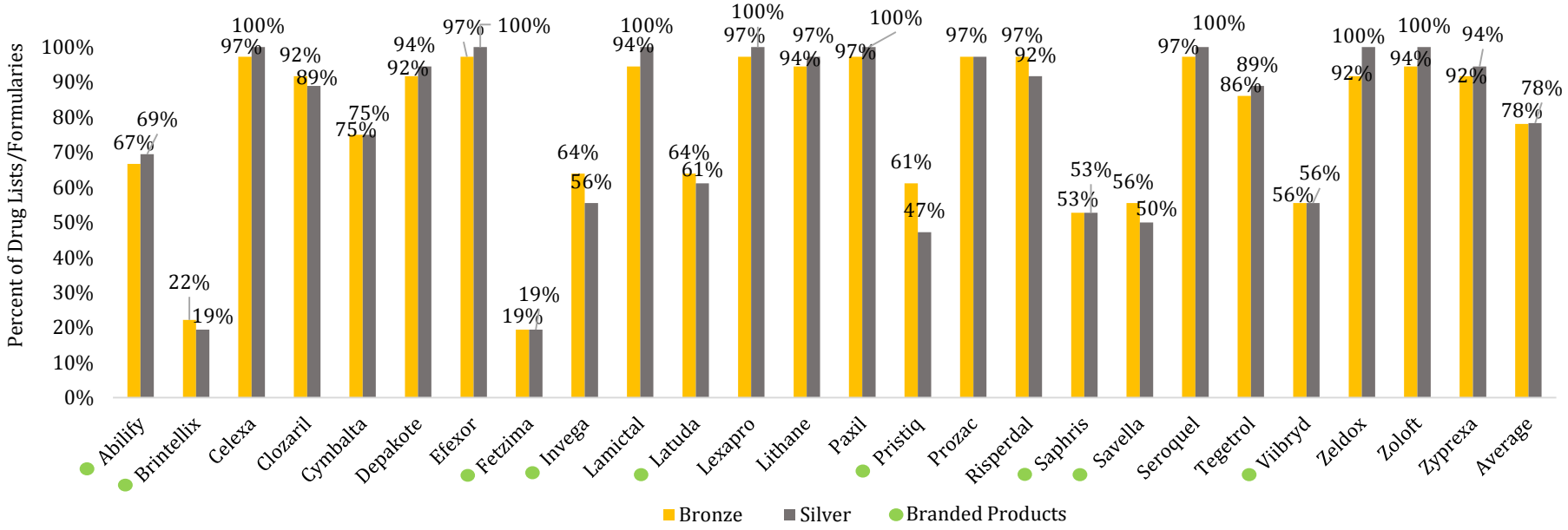
Figure 5. Coverage of Brands and Generics Do Not Vary Much by Metal Level



Coverage of Specific Drugs by Metal Level

When we examined individual drug coverage by metal tier level, we found that Brintellix and Fetzima are the least frequently covered (Figure 6). This is consistent with our findings by plan type. No product is covered by 100% of the 36 Bronze plans, but some drugs come close at 97 percent average coverage rates-- Celexa, Seroquel, Efexor, Lexapro, and Paxil. Several of the generic drugs are covered 100 percent of the time by Silver plans: Celexa, Efexor, Lamictal, Lexapro, Paxil, Seroquel, Zeldox and Zoloft. The only product for which there is a notable difference in coverage between plan levels is Pristiq, which is covered by 61 percent of Bronze plans and 47 percent of Silver.

Figure 6: Drug Coverage Does Not Vary Significantly by Metal Level



Coverage by State

Figure 7 shows again that generics have better coverage when analyzed by state. Illinois and Arizona have better coverage of brand products; Colorado plans cover few brand products. California has the least robust coverage of generics among the states. Figure 8 shows that average coverage in California and Colorado across all plans and metal tiers is lower than in other states.

Figure 7. Product Coverage Varies Significantly Across States

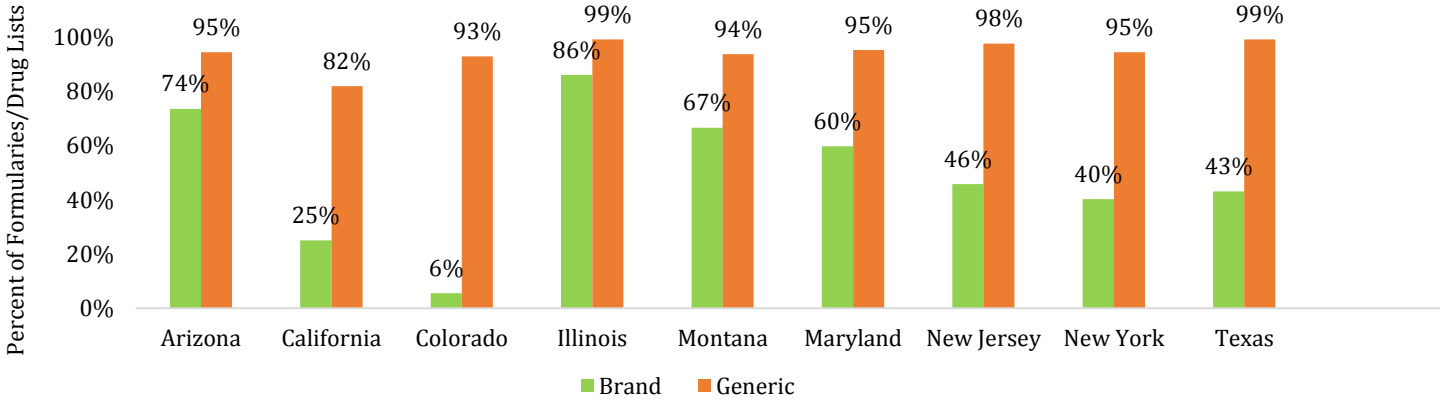


Figure 8: California and Colorado Plans Have Lower Average Coverage Rates of All 25 Behavioral Health Therapies

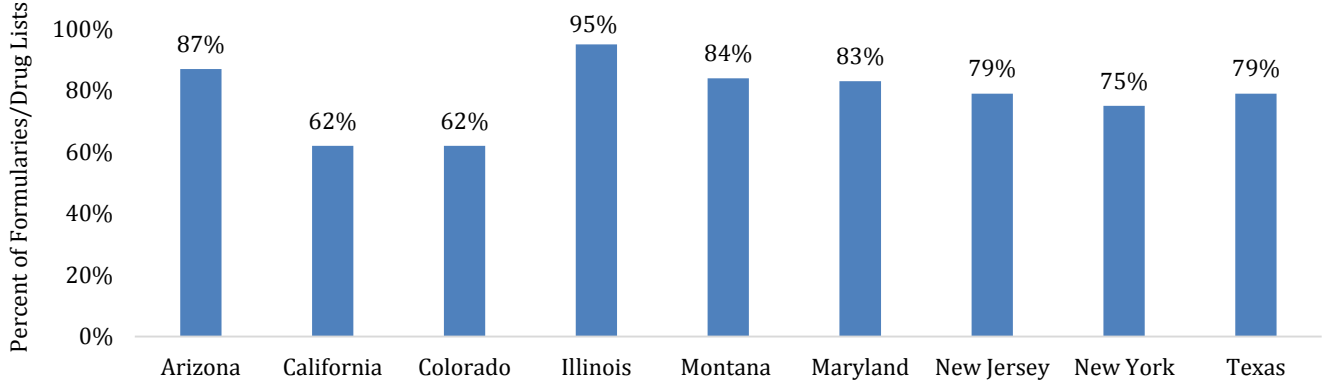
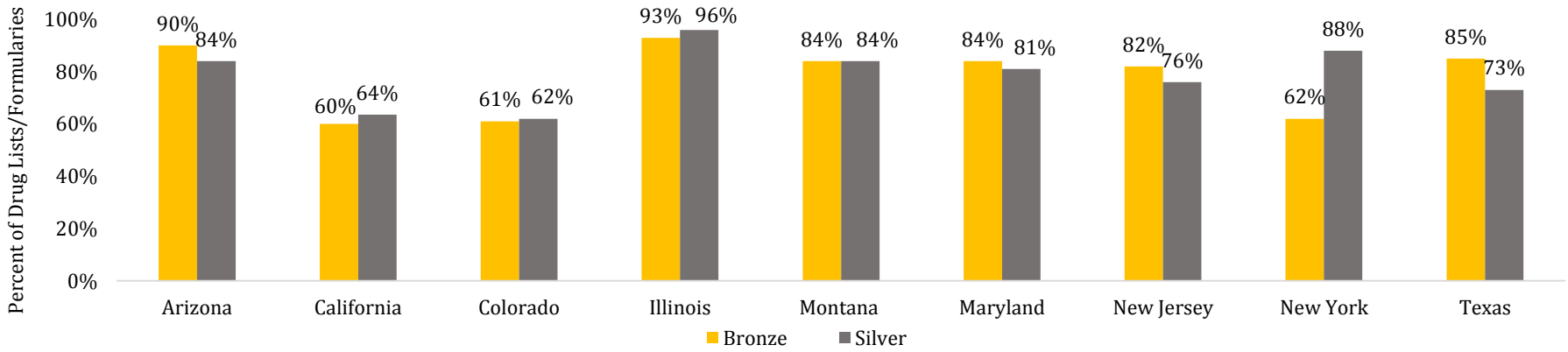


Figure 9 shows the average rate of coverage among all eight plans in each state studied, for all 25 behavioral health therapies, in slightly different terms than Figures 7 and 8. Each metal level average includes both brands and generics. Illinois has the highest average rate of coverage of the 25 products in both Bronze and Silver levels. California and Colorado have the lowest average rates of coverage of all the products in each metal level. Overall, coverage varies quite a bit by state, but within a state there is less variability in coverage between metal levels with the exception of New York and Texas. Though New York has an overall 75 percent average coverage rate for all therapies, coverage is considerably better on Silver plans (88 percent) than Bronze plans (62 percent).

Figure 9: Average Coverage Rates Vary More by State than by Metal Level



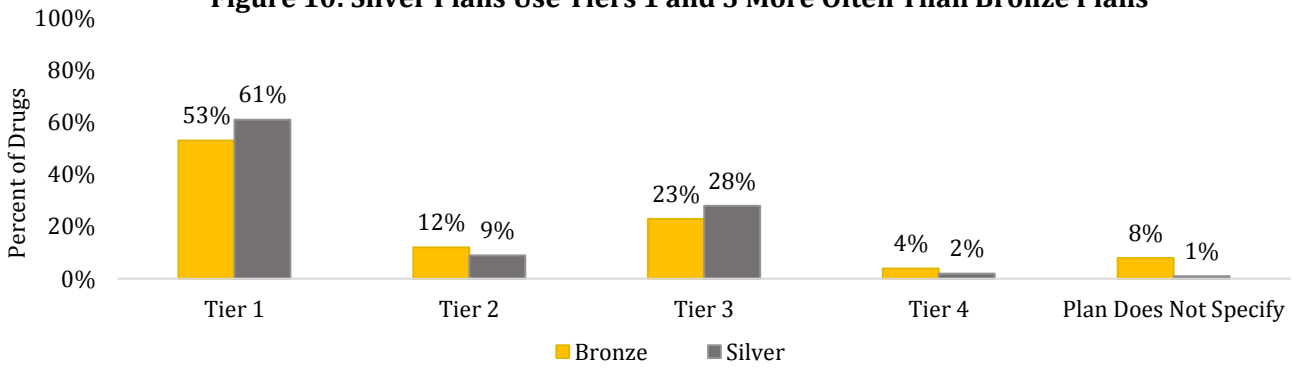
Tiering

A drug's placement on a particular tier is an important aspect of coverage beyond the simple fact of its inclusion on the formulary or drug list. In this study, 16 of the 25 products are generics, so it stands to reason that the preponderance of covered drugs across all plans are placed on Tier 1-- the generic, low cost-share tier. Silver plans place a greater number of products on Tier 1 than Bronze plans (61 percent versus 53 percent) (Figure 10). Tier 3 is either preferred brand or non-preferred brand, depending on whether a plan utilizes a four or five tier formulary structure. Tier 4 is seldom used among plans in this study. Tier four would have the highest cost sharing as either non-preferred brand or specialty tier, depending again on the formulary structure.

Tiering by Metal Level

By metal level, Silver plans make greater use of Tier 1 and Tier 3 than Bronze plans (Figure 10).

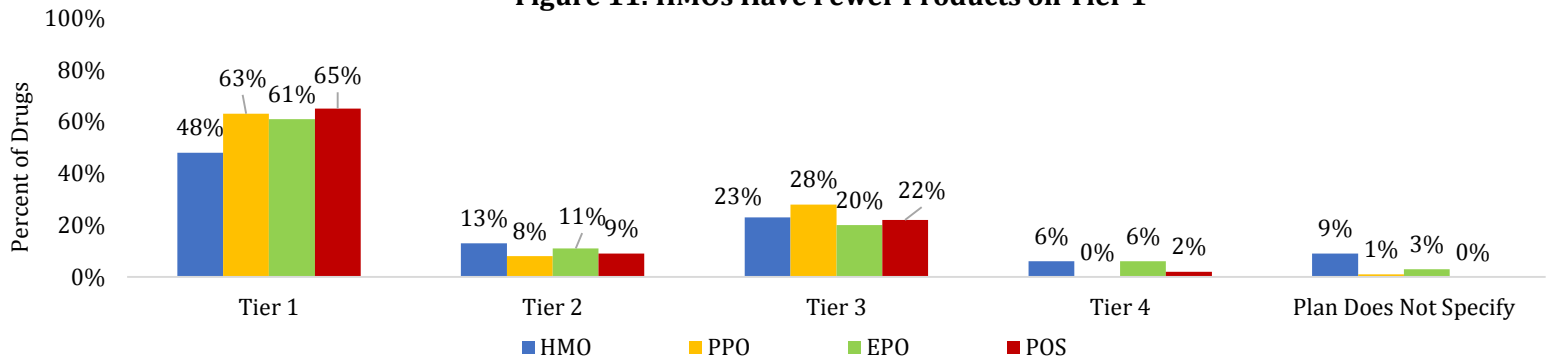
Figure 10: Silver Plans Use Tiers 1 and 3 More Often Than Bronze Plans



Tiering by Plan Type

HMOs appear to use the lowest cost-sharing tier, Tier 1, with the least frequency among all the plan types (Figure 11). PPOs appear to use Tier 3 at higher rates than other plan models.

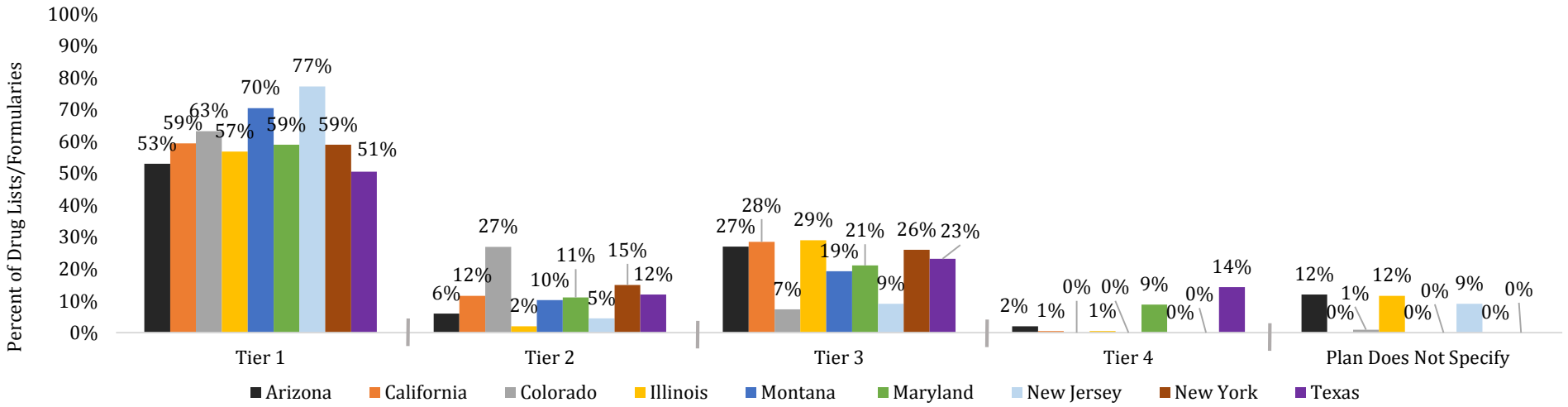
Figure 11: HMOs Have Fewer Products on Tier 1



Tiering by State

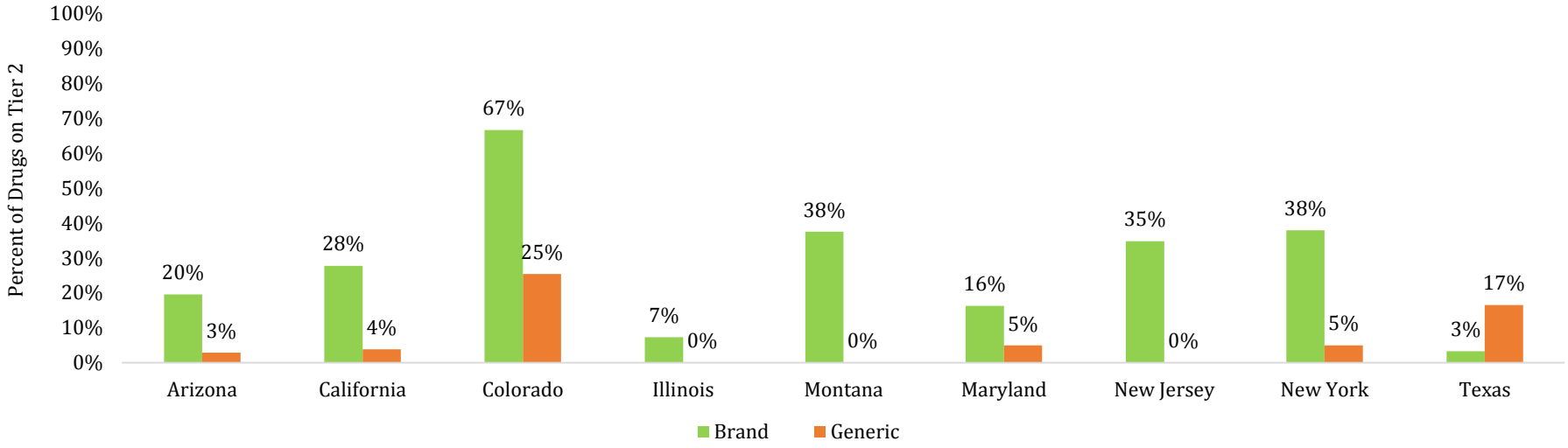
Texas plans, more than any other state, use Tier 4, and some of the Texas plans include a number of generic products on this tier (Figure 12). A minority of plans in Arizona and Illinois apply Tier 4 to just generic Cymbalta and no brands, while a minority of Arizona and California plans apply Tier 4 to generic Clozaril and no brands. New Jersey plans place all covered generics on Tier 1 and use Tiers 1, 2 and 3 for brand coverage. New York plans generally use Tier 1 for generics, with the exception of Cymbalta and Zyprexa, and Tiers 2 and 3 for brands; Montana is similar to New York with respect to use of Tiers. (Detailed data not shown.)

Figure 12: Texas Plans Use Tier 4 More than Plans in Other States



In general, Colorado and Texas stand out for coverage of generics on Tier 2 – even though such tiering is among a minority of the plans studied in each state (Figure 13). New Jersey, Montana and Illinois use Tier 2 exclusively for branded products.

Figure 13: Some Plans Use Tier 2 for Generics Which Results in Higher Cost Sharing Than Tier 1



Utilization Management (UM)

Utilization Management (UM) is an important part of the story regarding coverage and access to services and treatment. A service or treatment can be covered, subject to lower cost sharing, and still be subject to some type of UM that could inhibit access to the therapy. A patient may have to undergo prior authorization, step therapy, or have limits on the amount of the product that he or she can access at one time. This study reviewed UM overall among plans that covered a drug, and then reviewed the prevalence of specific types of UM: prior authorization, step therapy, and quantity limits.

There is no particularly clear relationship between coverage and UM, nor between tiering and UM across all products. There does, however, seem to be a relationship between branded coverage, branded tiering, and branded UM. Coverage of branded products is lower, tiering is higher, and UM is more common than among generics. For instance, Abilify is only covered about 20 percent of the time and is subject to UM about 71 percent of the time it is covered in the plans included in this research.

UM by Metal Level

As Figure 14 shows, Silver plans apply UM to brands more often than is applied by Bronze plans. The rate of UM applied to generics is similar between metal levels.

Figure 14. Branded Products Subject to UM at Higher Rate than Generics

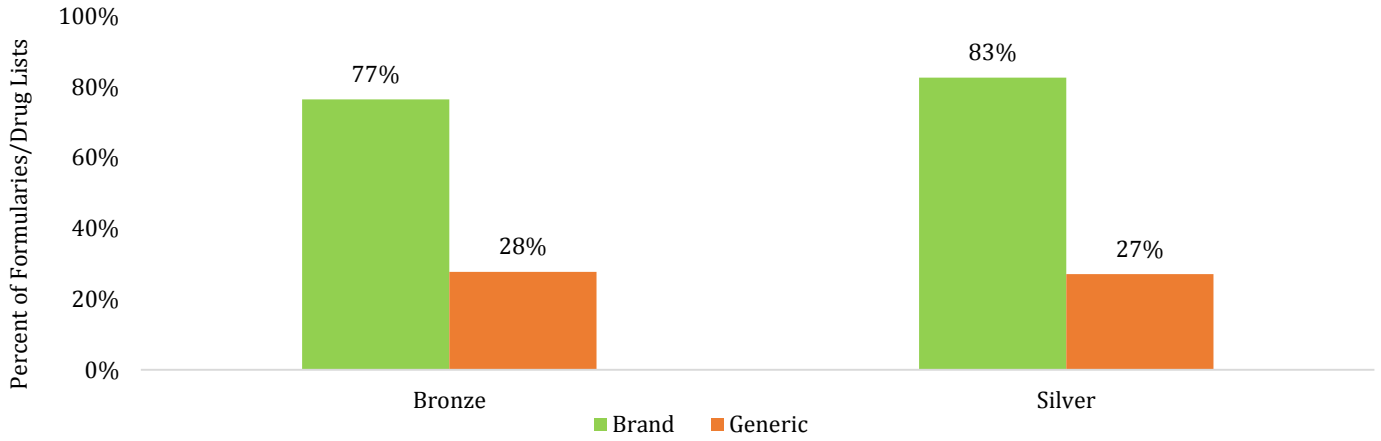
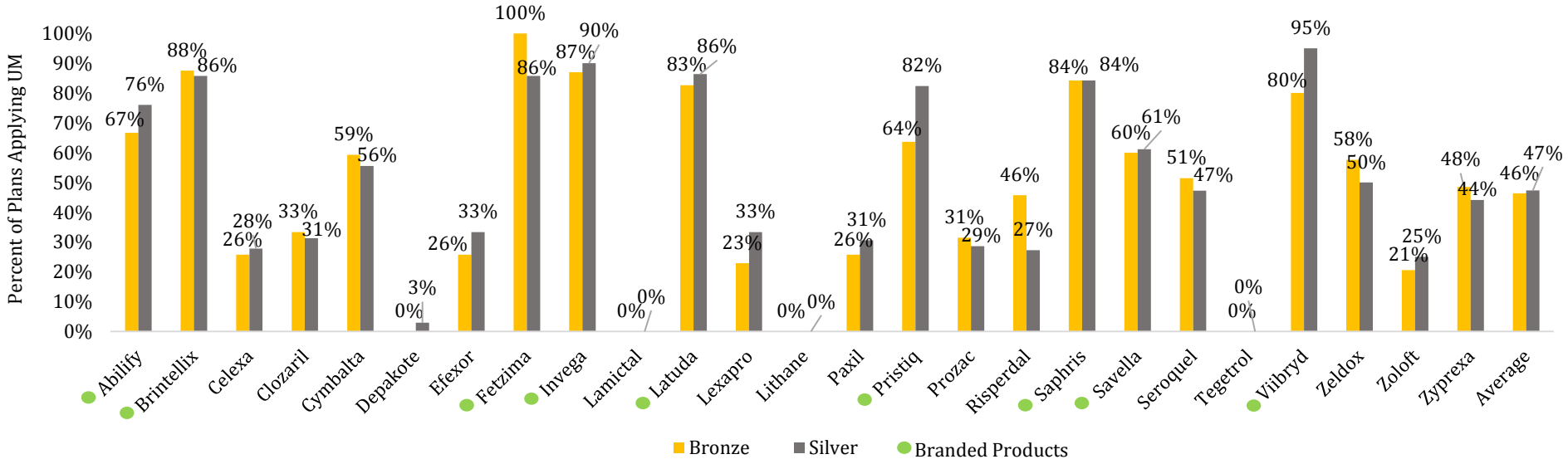


Figure 15 shows UM is applied by about half the plans to Cymbalta, Seroquel, and Zeldox while UM rates for the other generics are lower. Treatment of individual drugs is fairly consistent between metal levels (82 percent of Silver plans and 64 percent of Bronze plans apply UM) and Fetzima (86 percent for Silver and 100 percent for Bronze) and Viibryd (95 percent of Silver plans and 80 percent of Bronze plans).

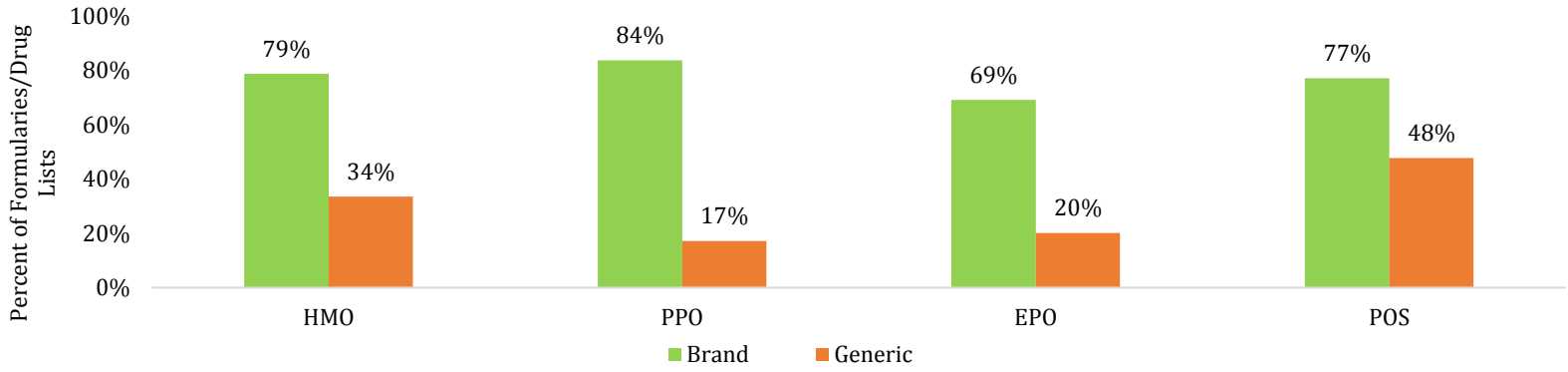
Figure 15: No Clear Pattern in UM Rates by Metal Level



UM by Plan Type

PPO plans applied general UM more frequently to brands than other plan types (Figure 16). POS plans apply UM to generics at almost a 50 percent rate.

Figure 16. PPOs Apply UM Most Often to Brands and Least Often to Generics



Figures 17, 18, 19, and 20 show more detail by plan type and UM application to specific drugs in this study. Among plan types there are a minority of plans that apply UM to all branded and generic products. Conversely, Depakote, Lamictal, Lithium, and Tegetrol have no UM applied in any of the plan types.

Figure 17: Utilization Management Rate Among HMO Plans

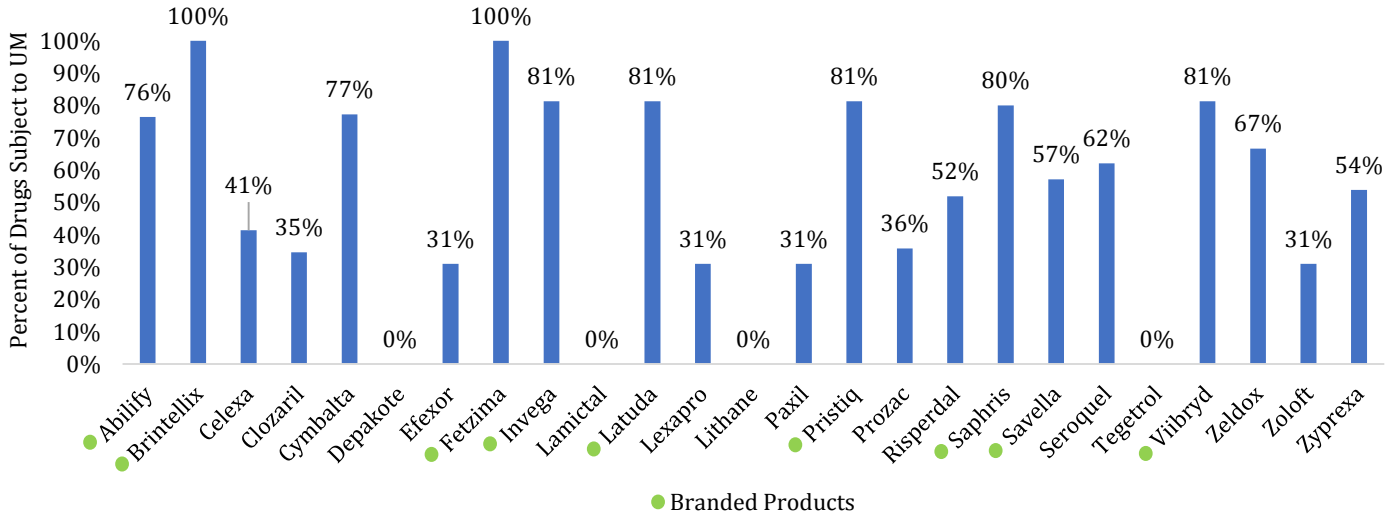


Figure 18: Utilization Management Rate Among PPO Plans

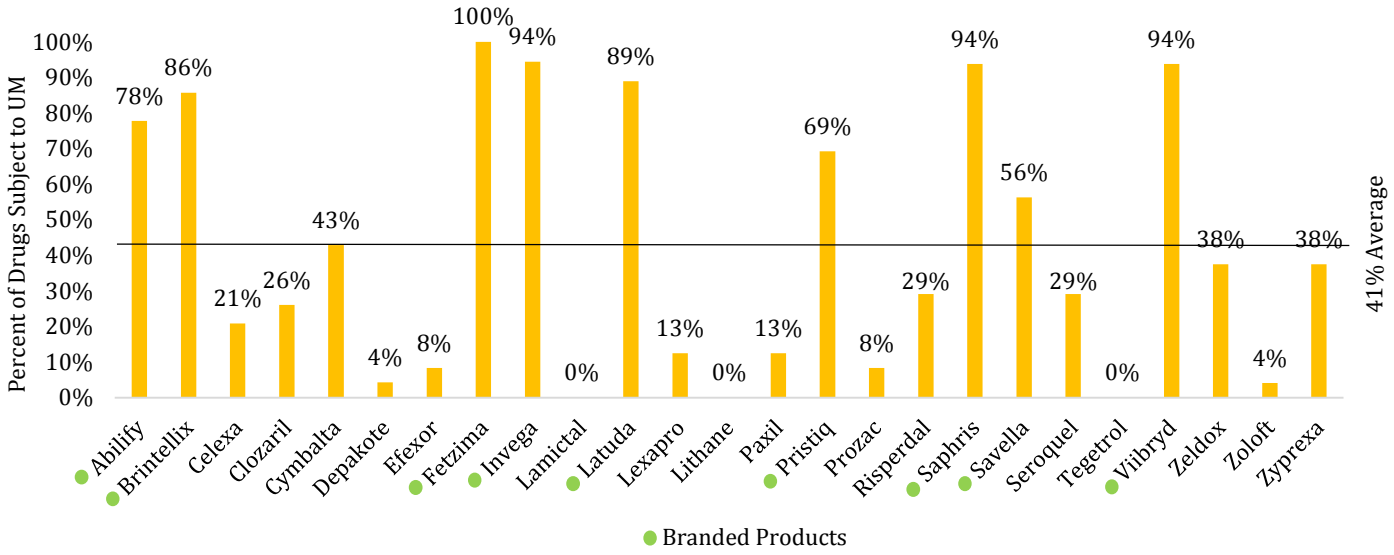
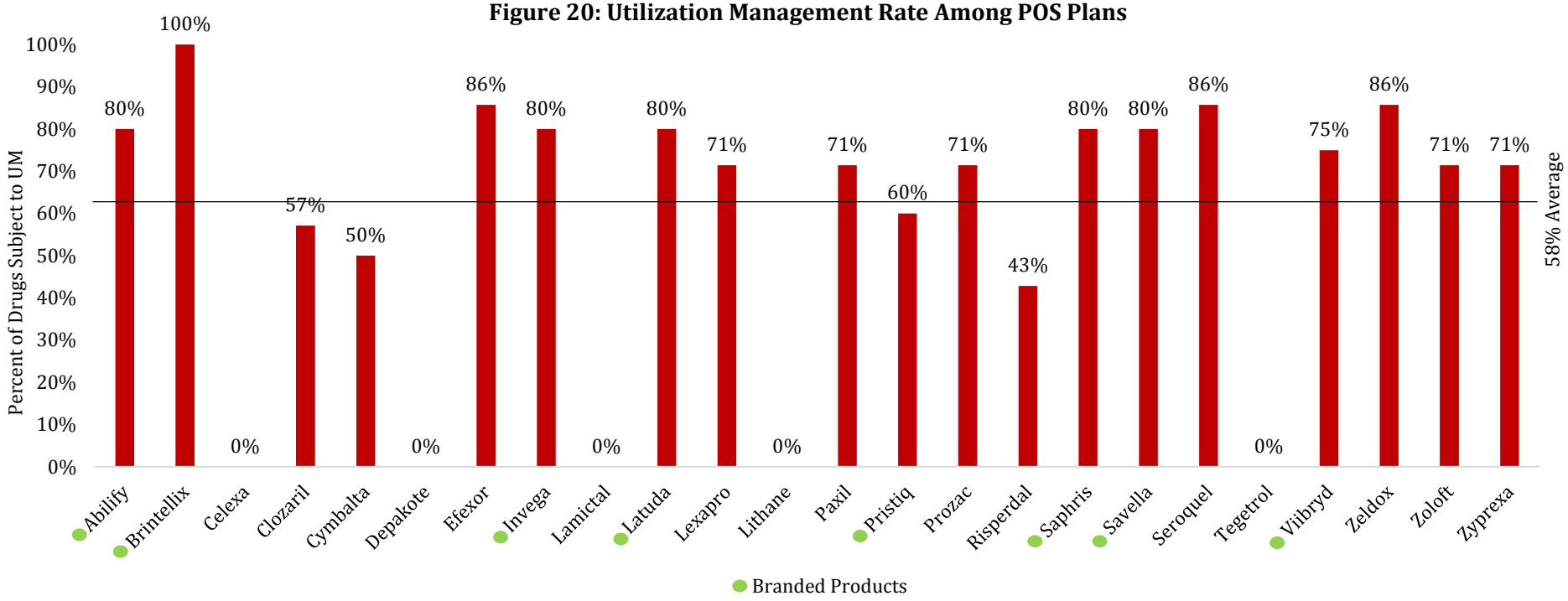


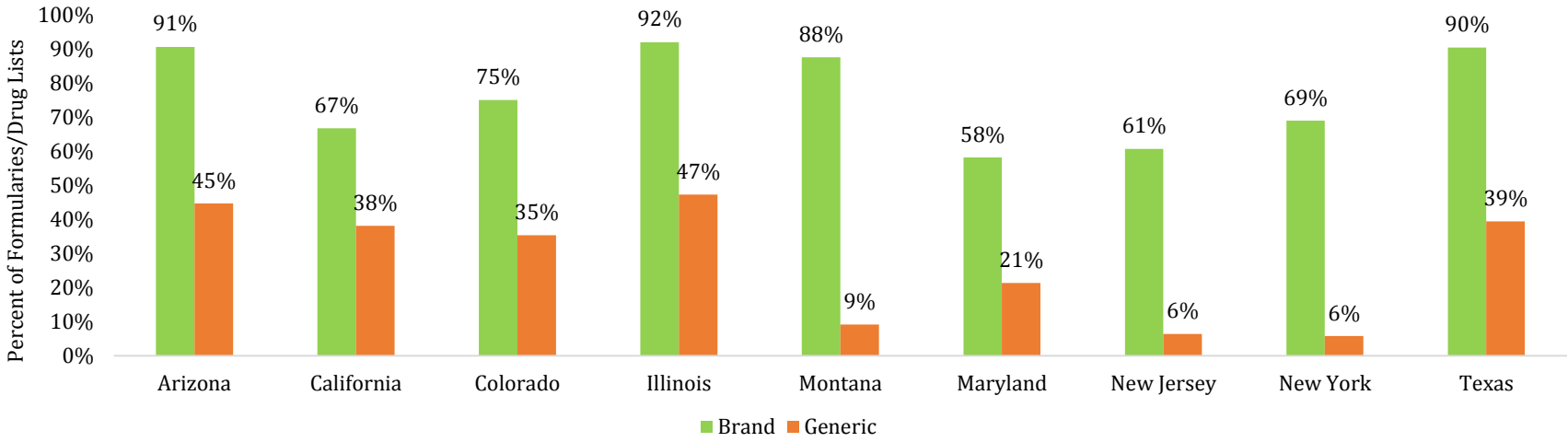
Figure 19: Utilization Management Rate Among EPO Plans

Figure 20: Utilization Management Rate Among POS Plans



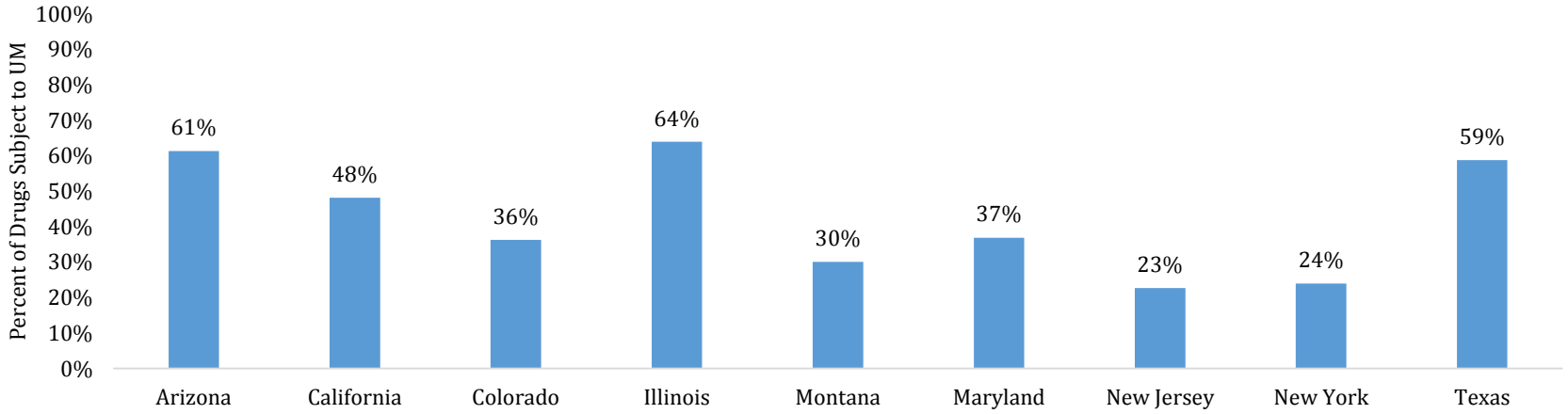
UM by State

Figure 21: Among States, UM of Branded Products is More Common



UM seems to be used with more frequency, and applicable to more products, in Arizona, California, Illinois, and Texas whether considered by brand/generic or in total (Figures 21 and 22). Remember that Illinois had the best average coverage rate of products across plans, and California had the worst (95 percent and 62 percent respectively).

Figure 22: States with High Rates of Coverage Have High Rates of UM

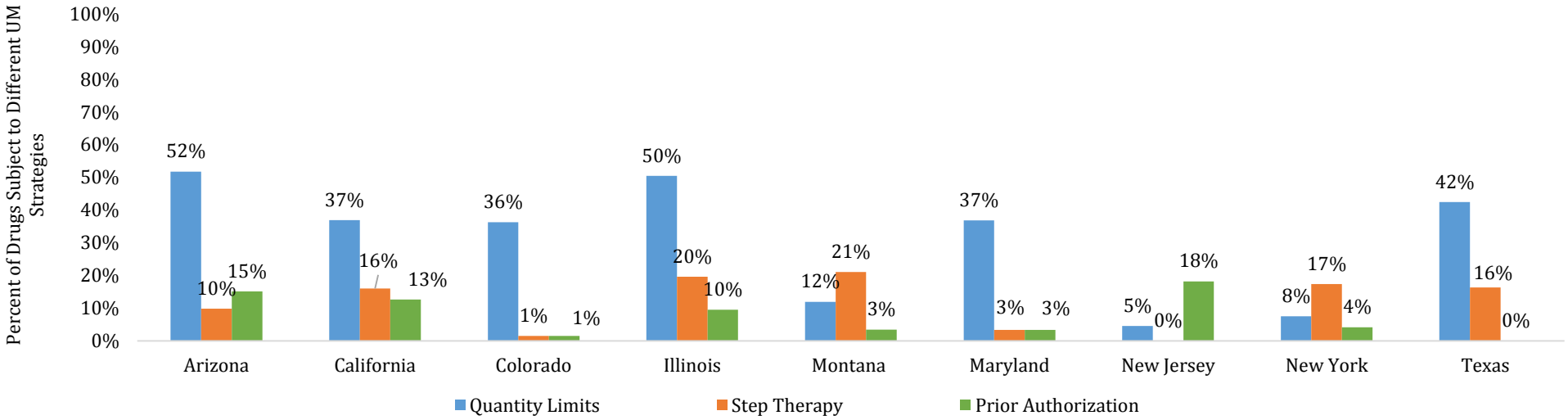


Step Therapy, Quantity Limits, and Prior Authorization

Type of UM by State

As Figure 23 shows, prior authorization and step therapy are not used with any great degree of frequency when viewed across states or by plan type. Quantity limits (QL) are often applied to the products in this study. Figure 23 shows that QL is the most prevalent form of UM in each state.

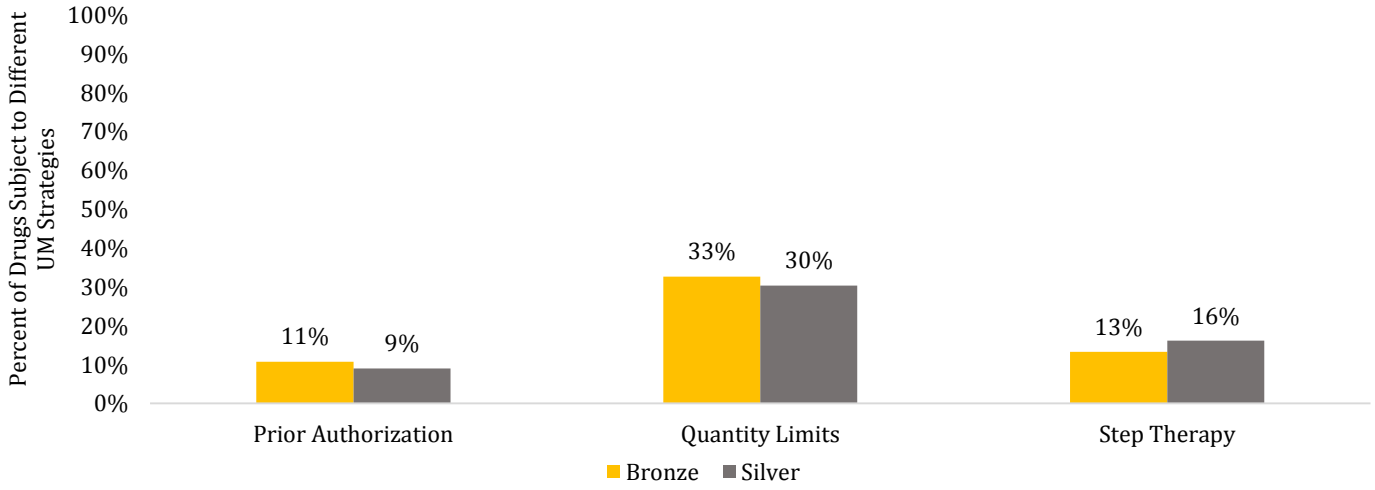
Figure 23: Quantity Limits is Most Common UM Among Majority of States



Type of UM by Metal Level

Figure 24 shows quantity limits are the most prevalent type of UM regardless of metal level, and the rate of UM is similar regardless of whether the plan is a Bronze or Silver plan.

Figure 24: Metal Level Not a Big Factor in Plan Use of Different Types of UM



Cost Sharing

Separate Drug-Only Deductibles

Four of the nine states (Arizona, California, Illinois, and Maryland)[2] have plans with separate, drug-only deductibles (Figure 25). California (with the worst average rate of coverage of the 25 products) has the lowest average deductible, while Illinois (with the best average rate of coverage of the 25 products) has the highest drug-only deductible. There is also a considerable differentiation in deductible by metal level in these particular plans (Figure 26).

Drug-Only Deductibles Vary Widely By State and Metal Level

Figure 25: Average Rx-Only Deductible Across States

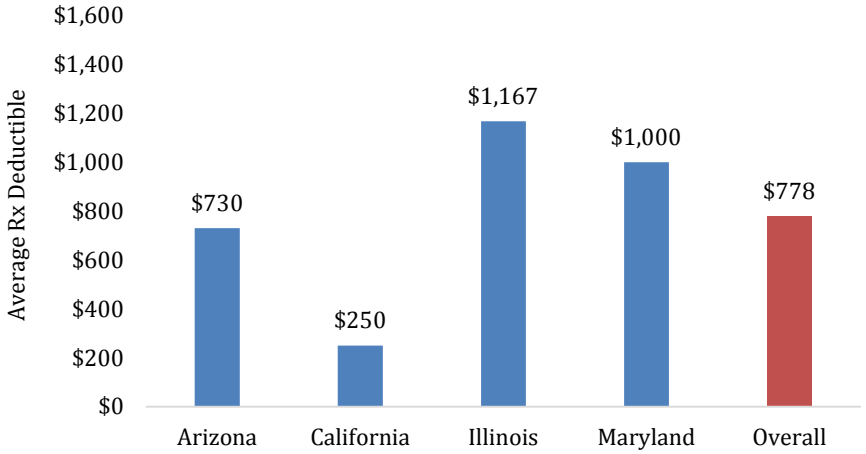
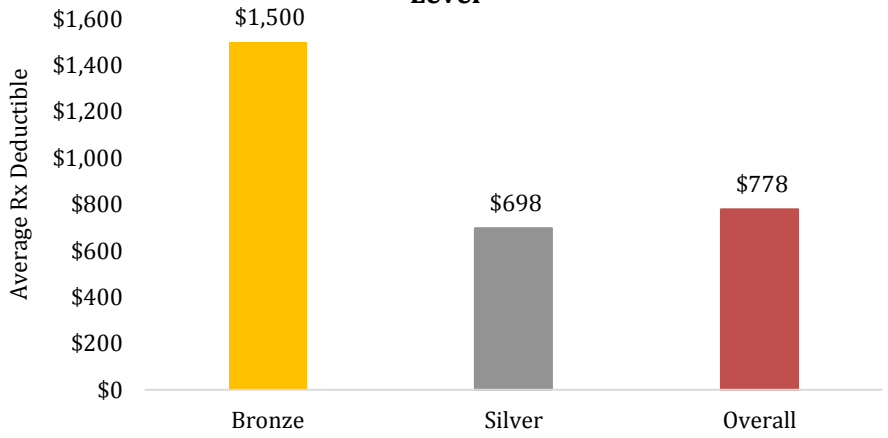


Figure 26: Average Rx-Only Deductible by Metal Level



[2] Two of the eight plans in Maryland, three of the eight plans each in Arizona and Illinois, and four of eight plans in California utilized a prescription-only deductible.

Copays Before and After Deductible by Metal Level

Looking at all the plans that include drugs in the deductible and apply copays before and/or after the deductible is met, there is a substantial difference between metal levels in copay amounts, both before and after the beneficiary meets his or her deductible (Figures 27 and 28).

Drug Cost Sharing Varies Widely by Metal Level

Figure 27: Average Drug Copay Before Deductible is Met

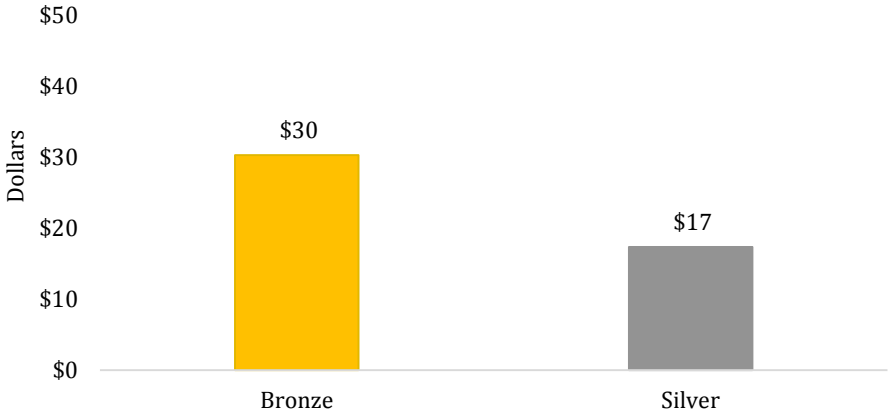
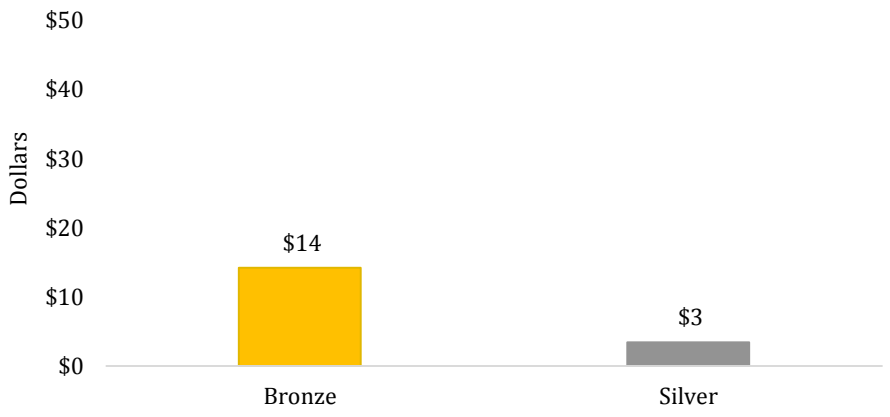


Figure 28: Average Drug Copay After Deductible is Met



Copays by Generic/Brand

Figures 29 and 30 show that metal levels may not matter very much when it comes to patient out-of-pocket costs or cost sharing, either before or after the deductible. Silver brand average copayments before deductible are almost double the Bronze averages among plans in this study, while average Silver copays are about 30 percent less than average Bronze copays after the deductible is met.

Figure 29: Average Copays Before Deductible Vary by Metal Level

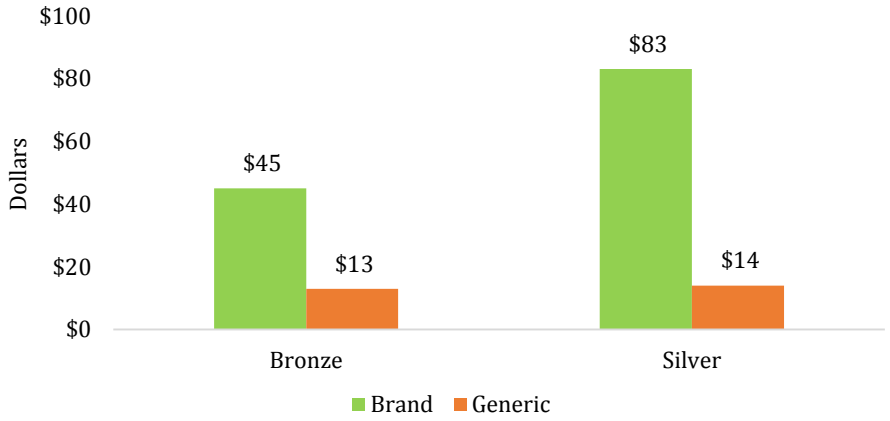
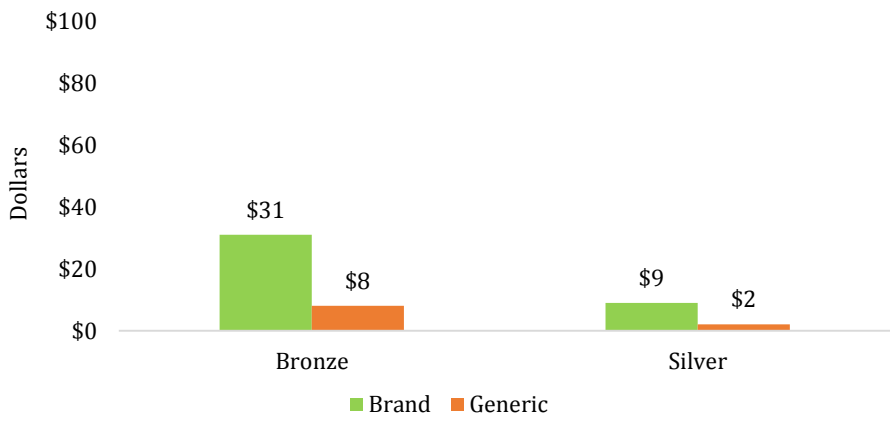


Figure 30: Average Copays After Deductible Vary by Metal Level



Copays Before and After Deductible by Plan Type

Figures 31 and 32 show again that the type of plan will affect consumer out-of-pocket costs and also varies by whether the drug is branded or generic. PPOs in this study had much higher average copay amounts for branded products than other plan types, either before or after the deductible was met.

Figure 31: Average Copays Before Deductible Vary by Plan Type*

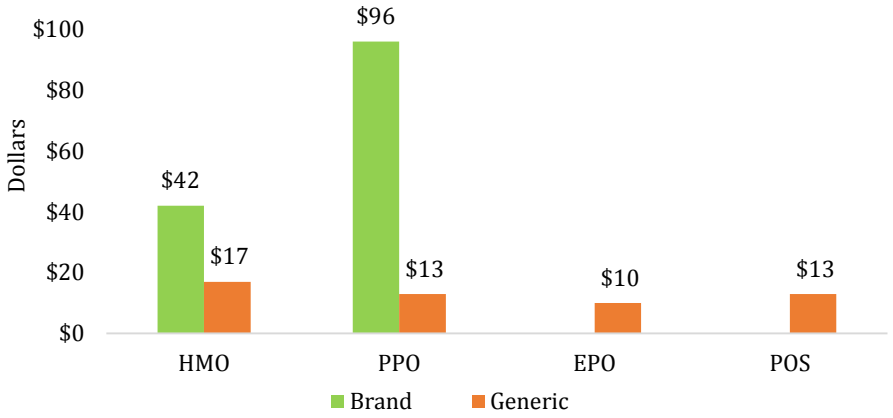
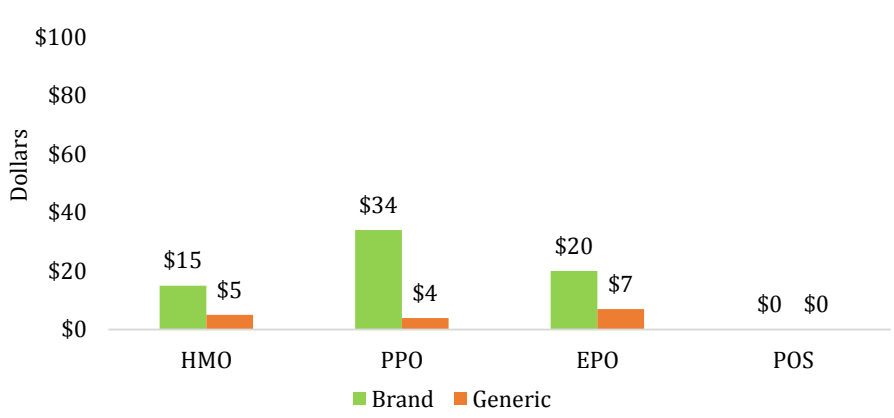


Figure 32: Average Copays After Deductible Vary by Plan Type

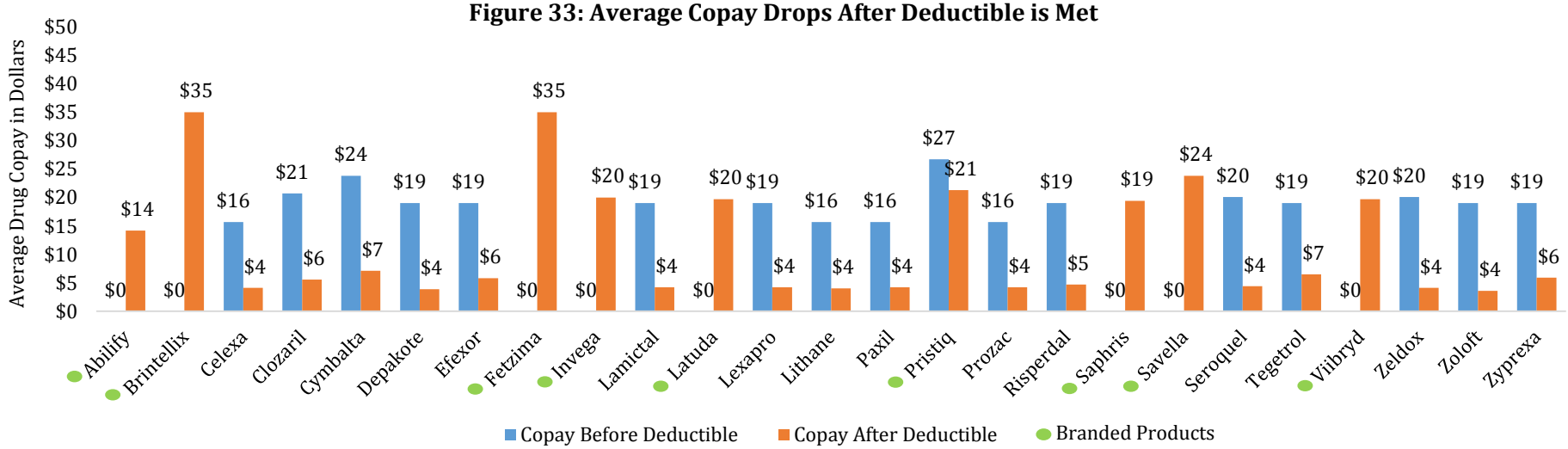


**Note: EPO and POS plans did not utilize a copay before a deductible for branded products*

Average Pre- and Post-Deductible Copayments—All plan types, all therapies, and all metal levels

Figure 33 provides detail on each drug in the study and the average copay before and after deductible is met at a highly aggregated level – all plans, all states, and all metal levels.

Figure 33: Average Copay Drops After Deductible is Met



**Note: $0 - No copay applied before deductible for these branded products.*
Pristiq was the only branded product to have a copay applied before deductible.

Coinsurance Before and After Deductibles

Patient cost sharing in the form of coinsurance is a set percentage (20%, for example) of the consumer drug price at the pharmacy counter. For all plans in this study that apply coinsurance before a deductible is met, the patient drug coinsurance is 100%.

Coinsurance by Metal Level

For plans that apply coinsurance after the deductible is met, there is a substantial variation in cost sharing among the metal levels—coinsurance after meeting the deductible is twice as high in Bronze plans than in Silver plans

Coinsurance by Metal Level/Brand and Generic

Figure 35 explains the results in Figure 34. The difference in average coinsurance between Bronze and Silver is a result of much lower generic coinsurance among Silver plans.

Figure 34: Average Drug Coinsurance After Deductible is Met is Twice as High in Bronze Plans

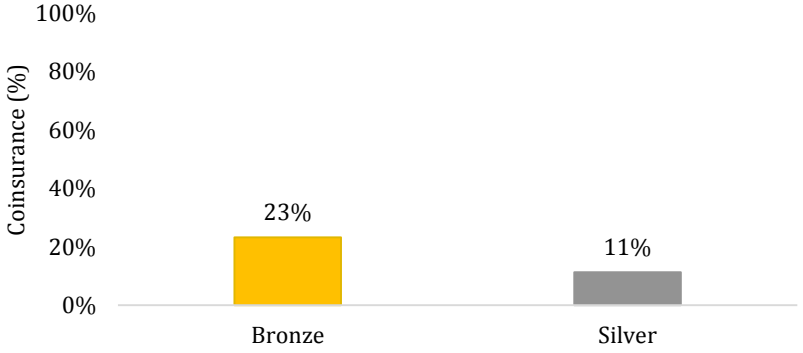


Figure 35: The Big Difference in Average Coinsurance After Deductible is in Silver Plan Generics

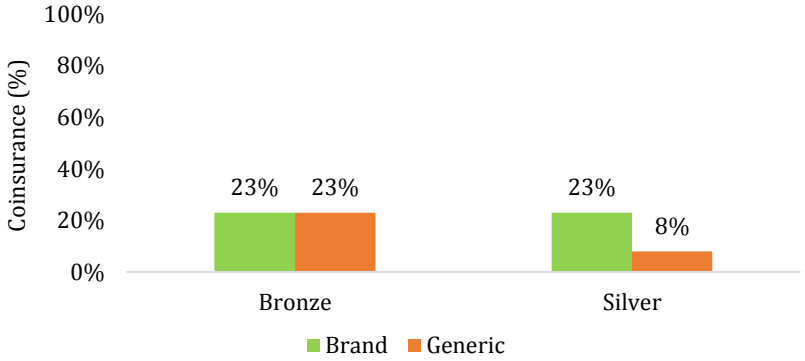
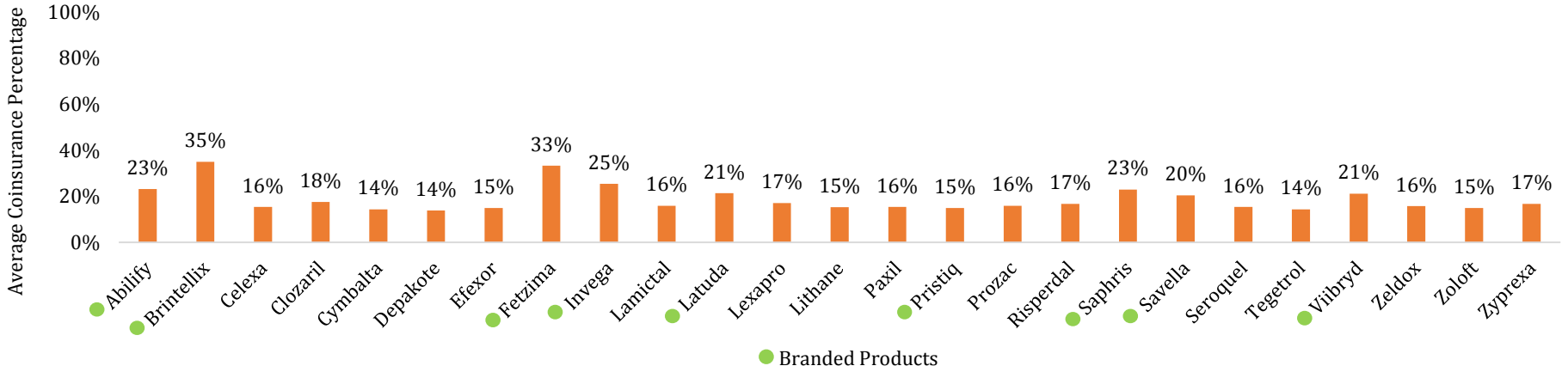


Figure 36 provides more detail on the average coinsurance rates for each product in the study – all plans that apply coinsurance, in all states, in both metal levels – after the deductible is met by the consumer. Even though the rates of coinsurance are clustered, the actual dollar amount of the patient payment may vary quite a bit depending on the drug and its price.

Figure 36: Average Coinsurance After Deductible is Met, All Plans and Products



Coinsurance by Plan Type and Brand/Generic

Figure 37 shows average coinsurance after the deductible is met by plan type – highlighting that PPOs and EPOs have higher consumer costs.

Figure 37: Coinsurance After a Deductible is Higher in EPOs

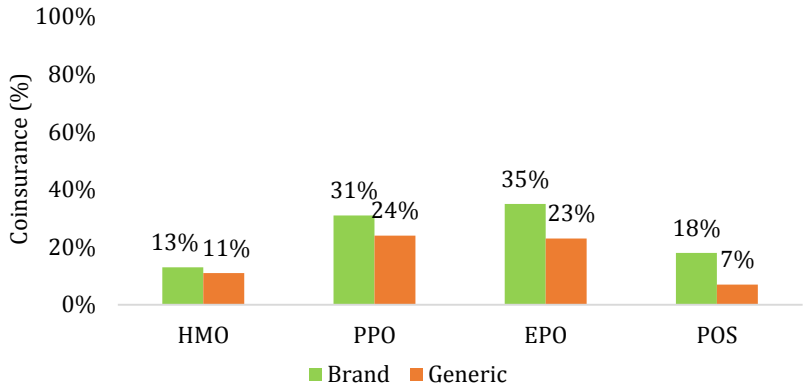
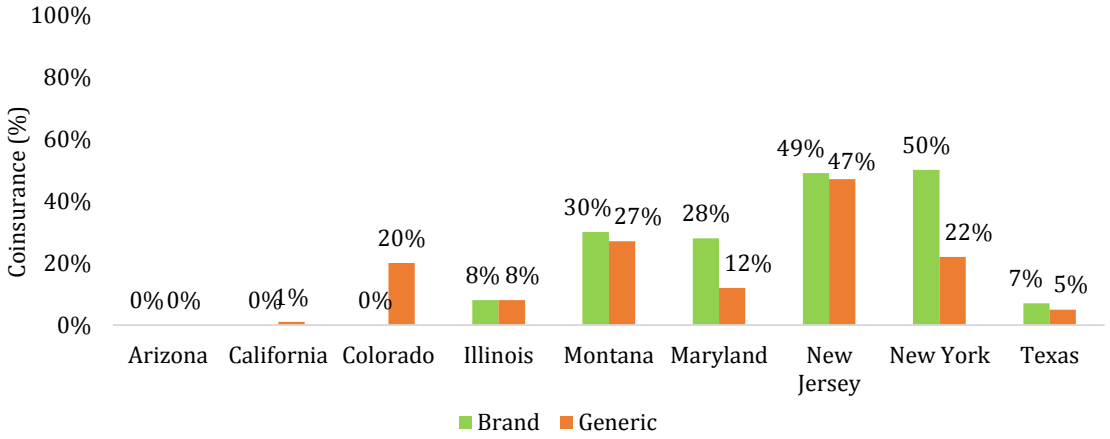


Figure 38 shows very variable coinsurance rates after the deductible by state and by whether the drug is generic or not.

Figure 38: Average Coinsurance After Deductible Varies by State



Part II: Service Coverage, Cost Sharing, and Provider Networks

Medical Necessity

In general, plans cover 'medically necessary' services in the various categories of essential health benefits (EHB) which are specified in the Affordable Care Act.[3] All twenty plans in this part of the study (four plans in each of five states) defined medical necessity by referencing the ACA Uniform Glossary of Health Coverage and Medical Terms, published by the Department of Health and Human Services and the Department of Labor. That document defines 'medically necessary' as:

> *Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.*

This is a broad definition. While clearly many services of import to people with behavioral health care needs will be consistently covered, others may fall into a grey area in relation to the concept of "standards of medicine," as not all behavioral health services are purely clinical in nature. The meaning and interpretation of the definition will likely be refined over time through further government guidance and possibly judicial decisions.

Provider Network Participation

The research focused on counts of in-network behavioral health providers who are accepting new patients. Plans had a variety of ways of organizing their search function, some of which were easier to use than others. Comments on the provider search functions of each of the plans are included in the Appendix. Four of the 20 plans in this part of the study did not have the capability to indicate providers accepting new patients. Note that the data collection did not verify the accuracy of the provider listings, so Breakaway results reflect any problems with the search functionality or accuracy of the search results.

In general, plans include a variety of behavioral health professionals – such as licensed clinical social workers and mental health counselors. Some plans provided a full panoply of behavioral health providers under one broad search term while other plans required searches by specialty. Six of the 20 plans have fewer than ten behavioral health providers in network (Table 1); this result may reflect a difficulty with the search function rather than an accurate provider count. It is important to remember that all plans in this study were approved by State or Federal regulators as having adequate provider networks. Also note that a count of behavioral health providers does not account for issues related to access – time, distance, ability to pay.

Benefits and Cost Sharing

The public plan documents showed that benefit design and cost sharing were equivalent for all types of services, which plans generally divided into physical health and mental health/substance abuse treatment, delivered in inpatient, outpatient, and specialty care settings. Perhaps over time there will be no need to distinguish behavioral health as a separate benefit category, given the current parity laws that are driving changes in coverage.

Of note, eight of the plans require prior primary care authorization to access a specialist. All plan documents were silent as to whether there was any type of behavioral health provider that was considered "primary care" (i.e., non-specialist). Therefore, the results reflect the presumption that all behavioral health providers are considered specialists. This has implications for cost sharing where patients pay more out-of-pocket for specialist services. By law,

[3] The EHBs include the following items and services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services.

patients have no out-of-pocket costs for preventive services rated A or B by the US Preventive Services Task Force (USPSTF). Currently, there are a very limited number of behavioral health preventive services rated A or B and thus available to patients at no cost. These services are:

- alcohol misuse screening for adults (over age 18); and
- depression screening for adults ONLY when there are adequate supports for diagnosis, treatment, and follow-up; otherwise the service is not recommended.

Conclusion

This study – a review of publicly available plan documents -- should only be considered a preliminary look at services and coverage important to people with behavioral health care needs. It therefore should not be used to assess actual patient access to services in a real world situation. In general, there is more diversity of coverage in formularies than in other benefits and services to treat behavioral health. The diversity in approach represents different market strategies among plans. There is a significant differentiation in coverage and cost sharing strategies among plan types and some state-level coverage characteristics.

The drug coverage information raises some interesting issues.

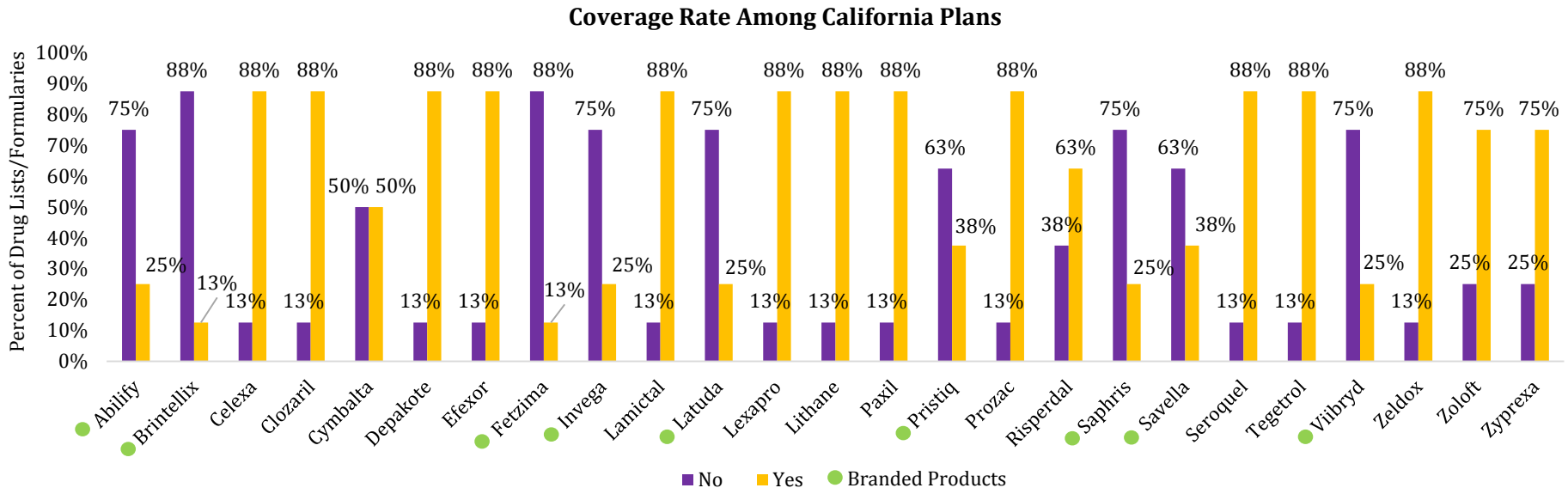
- Should more research be conducted to determine if there is a trend to move generic behavioral health drugs to non-preferred formulary tiers and thus, subject them to higher cost sharing?
- Should there be more work done to examine how drug coverage/market access affects incentives for research and development? This study shows that all branded (newer) products are not covered on a consistent basis in different markets. How does that affect access to improved treatments? Are there real patient impacts to the trend in drug coverage?

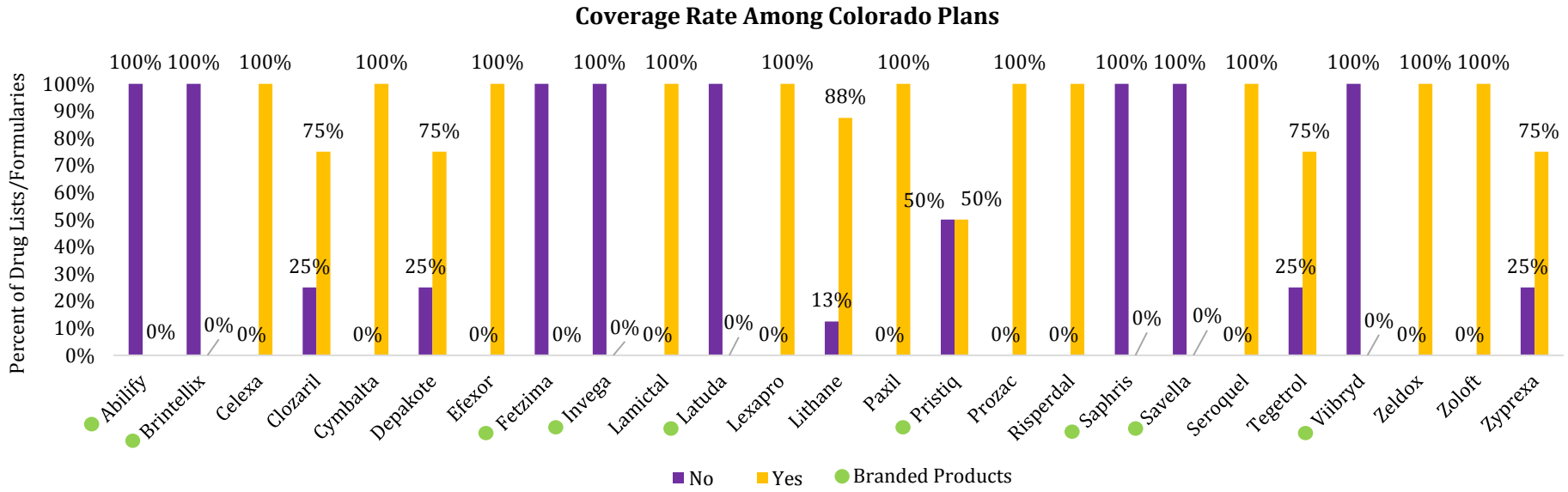
The service coverage information also raises a number of interesting issues.

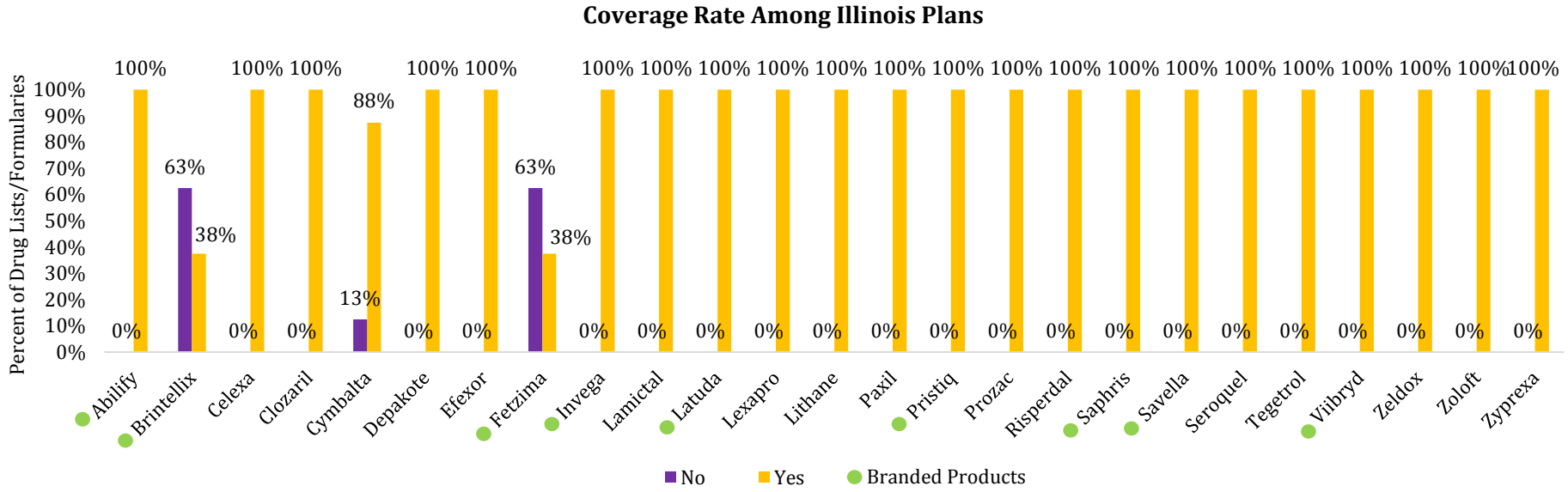
- Can plans standardize their provider search functions, make them consistently more user-friendly, and enhance those functions so that they explain the role/scope of license for each provider type?
- Is there an opportunity to assess other behavioral health services for potential first dollar coverage, and possibly start to consider some key clinical preventive services as primary care rather than specialty?
- Will the definition of "medical necessity" become more refined and more granular over time, which may benefit people with behavioral health care needs?
- Should there be a level of behavioral health services considered to be 'primary' care and thus subject to lower cost sharing than specialty care – similar to how gynecologic care is often treated?

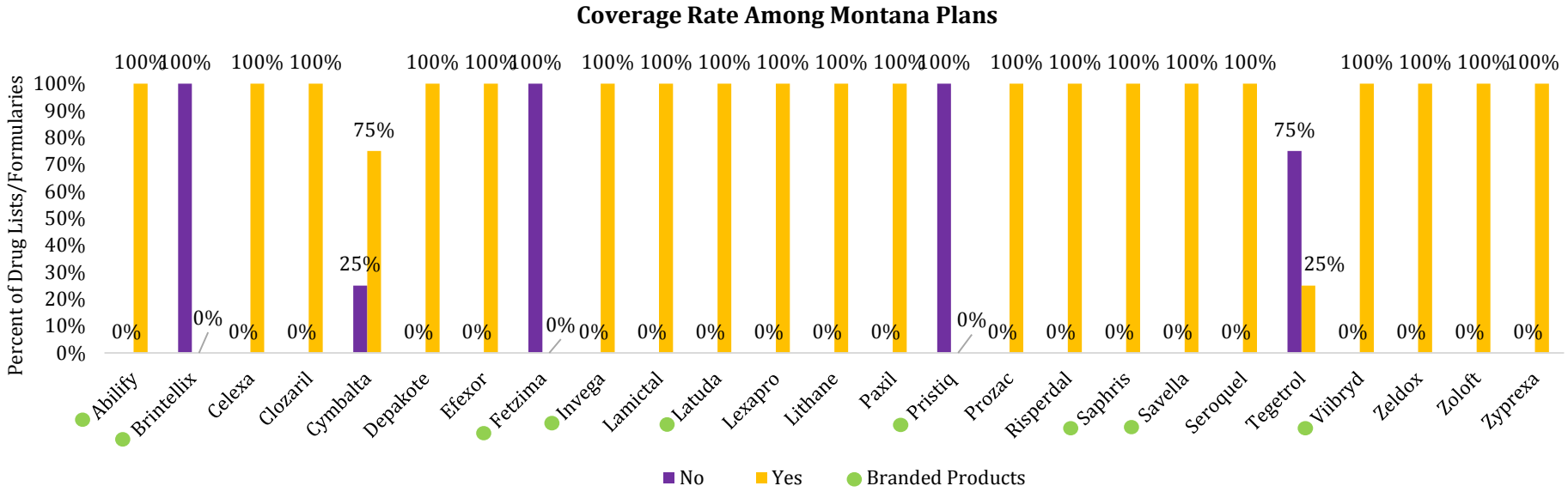
These are questions that should be researched and debated into the future as treatment protocols improve and as the insurance market evolves. All these issues will be of increasing importance in the future, and the discussion should start soon. In the meantime, consumers need to research their Exchange plan choices carefully before selecting a plan, and pay attention to drug coverage and cost sharing, in-network coverage and out-of-network cost sharing. These are critical aspects of coverage.

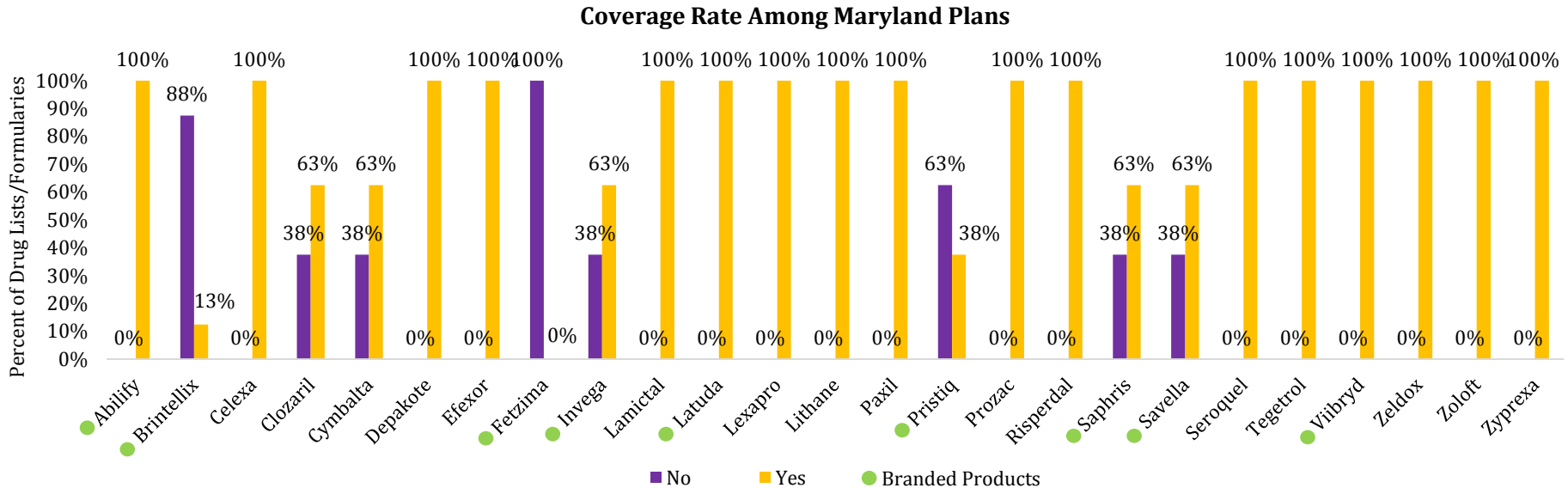
Appendix I: Coverage Rates of Each Product by State

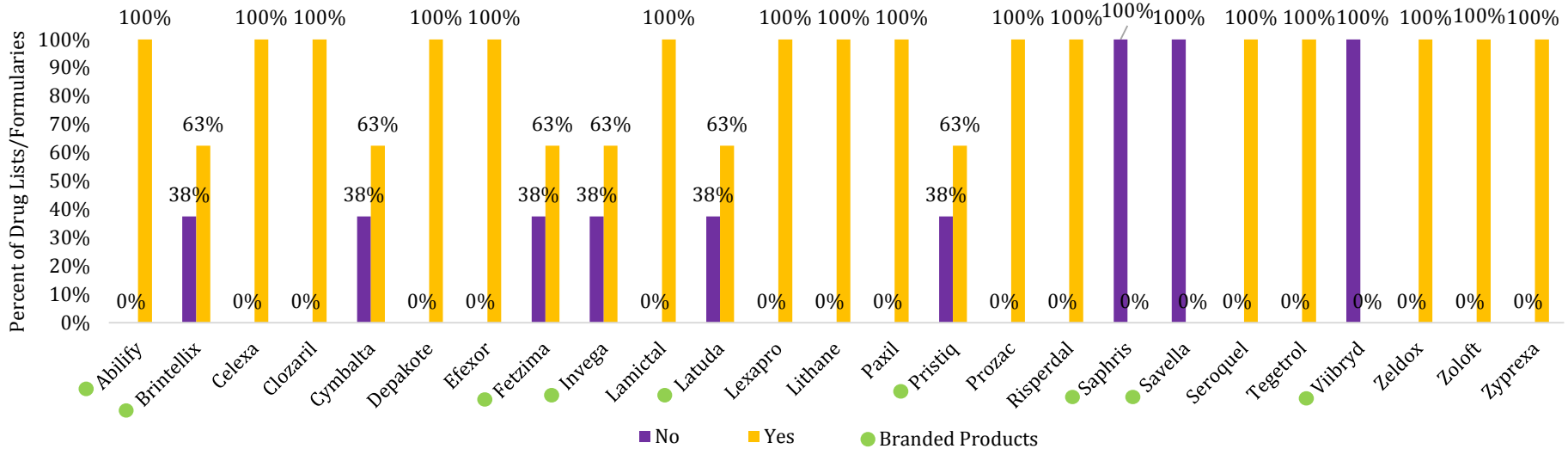


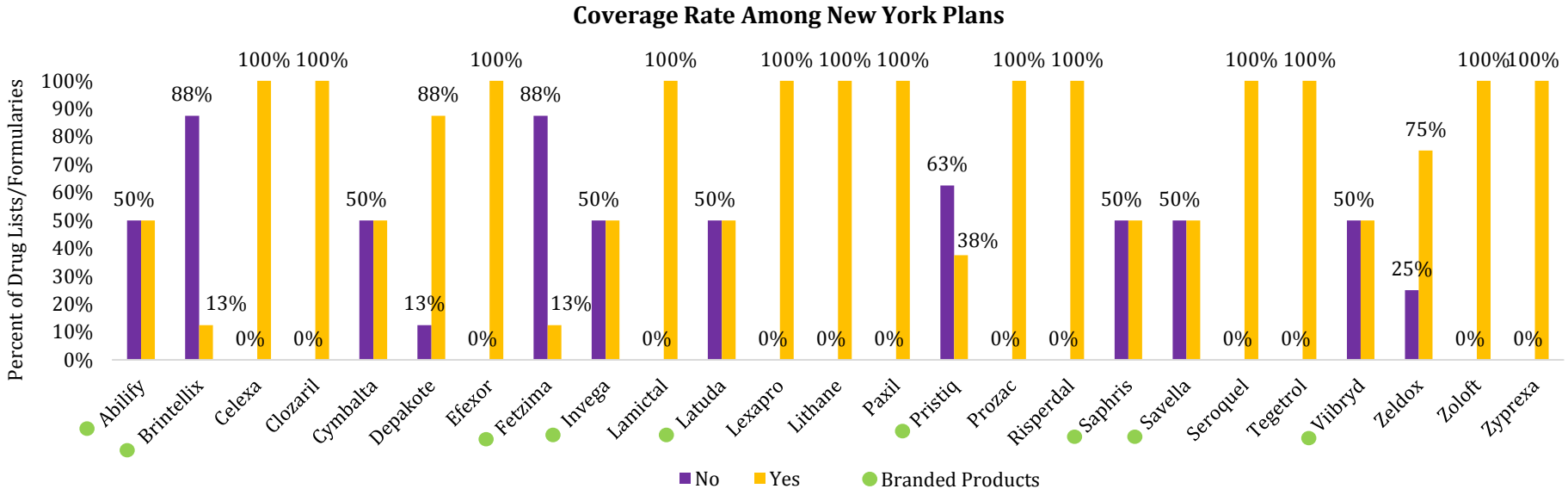


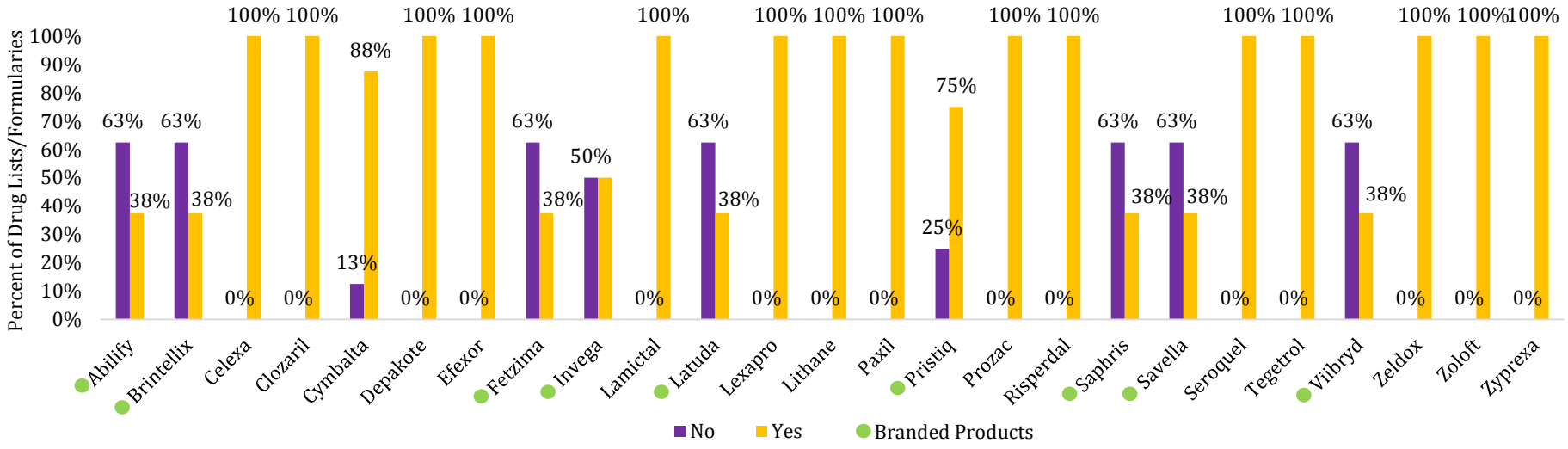

Coverage Rate Among Illinois Plans
Percent of Drug Lists/Formularies
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100% 63% 38% 100% 100% 88% 13% 100% 100% 63% 38% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%
0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%
Abilify
Brintellix
Celexa
Clozaril
Cymbalta
Depakote
Efexor
Fetzima
Invega
Lamictal
Latuda
Lexapro
Lithane
Paxil
Pristiq
Prozac
Risperdal
Saphris
Savella
Seroquel
Tegetrol
Viibryd
Zeldox
Zoloft
Zyprexa
No
Yes
Branded Products


Coverage Rate Among Montana Plans
Percent of Drug Lists/Formularies
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100% 100% 100% 100% 100% 75% 25% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 75% 25% 100% 100% 100% 100%
0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%
Abilify
Brintellix
Celexa
Clozaril
Cymbalta
Depakote
Efexor
Fetzima
Invega
Lamictal
Latuda
Lexapro
Lithane
Paxil
Pristiq
Prozac
Risperdal
Saphris
Savella
Seroquel
Tegetrol
Viibryd
Zeldox
Zoloft
Zyprexa
No
Yes
Branded Products


Coverage Rate Among Maryland Plans
Percent of Drug Lists/Formularies
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100% 88% 13% 100% 0% 63% 38% 63% 38% 100% 0% 100% 100% 0% 63% 38% 100% 100% 100% 100% 100% 63% 38% 100% 100% 100% 100% 100% 63% 38% 100% 100% 63% 38% 63% 38% 100% 100% 100% 100% 100% 100%
Abilify
Brintellix
Celexa
Clozaril
Cymbalta
Depakote
Efexor
Fetzima
Invega
Lamictal
Latuda
Lexapro
Lithane
Paxil
Pristiq
Prozac
Risperdal
Saphris
Savella
Seroquel
Tegetrol
Viibryd
Zeldox
Zoloft
Zyprexa
No
Yes
Branded Products


Coverage Rate Among New Jersey Plans
Percent of Drug Lists/Formularies
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100% 63% 38% 100% 100% 0% 0% 63% 38% 100% 100% 0% 63% 38% 63% 38% 100% 0% 100% 100% 100% 63% 38% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%
Abilify
Brintellix
Celexa
Clozaril
Cymbalta
Depakote
Efexor
Fetzima
Invega
Lamictal
Latuda
Lexapro
Lithane
Paxil
Pristiq
Prozac
Risperdal
Saphris
Savella
Seroquel
Tegetrol
Viibryd
Zeldox
Zoloft
Zyprexa
No
Yes
Branded Products


Coverage Rate Among New York Plans
Percent of Drug Lists/Formularies
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
50% 88% 13% 100% 100% 50% 88% 13% 100% 88% 13% 50% 100% 50% 100% 100% 100% 63% 38% 100% 100% 50% 50% 100% 100% 50% 25% 100% 100% 100%
Abilify
Brintellix
Celexa
Clozaril
Cymbalta
Depakote
Efexor
Fetzima
Invega
Lamictal
Latuda
Lexapro
Lithane
Paxil
Pristiq
Prozac
Risperdal
Saphris
Savella
Seroquel
Tegetrol
Viibryd
Zeldox
Zoloft
Zyprexa
No
Yes
Branded Products


Coverage Rate Among Texas Plans
Percent of Drug Lists/Formularies
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
63% 38% 63% 38% 100% 100% 0% 0% 88% 13% 100% 100% 0% 0% 63% 38% 50% 100% 0% 63% 38% 100% 100% 0% 0% 100% 100% 0% 0% 75% 25% 100% 100% 0% 0% 63% 38% 63% 38% 100% 100% 0% 0% 63% 38% 100% 100% 100% 0% 0%
Abilify
Brintellix
Celexa
Clozaril
Cymbalta
Depakote
Efexor
Fetzima
Invega
Lamictal
Latuda
Lexapro
Lithane
Paxil
Pristiq
Prozac
Risperdal
Saphris
Savella
Seroquel
Tegetrol
Viibryd
Zeldox
Zoloft
Zyprexa
No
Yes
Branded Products

Appendix II: Mental Health Services By State, Metal Level and Plan

Arizona							
Plan	**Metal Level and Type**	**Designates Accepting New Patients**	**Overall Number Mental Health Providers[4]**	**Psychiatrists**	**Oncologist**	**Comments on Provider Search Function**	**Notes**
Humana Connect	Silver HMO	yes	589	299 284 accepting new	25 25 accepting new	Search by specialty. Can search just mental health--all providers are listed, can filter by specialty	Mental Health Includes: Licensed Clinical Social Worker, Psychiatry, Licensed Mental Health Counselor, Psychology, Licensed Family and Marriage Therapist, Psychiatry & Neurology, Mental Health Hosptial, Psychiatry-Addiction, Preventive Medicine-Undersea and Hyperbaric, Psychology-Psychotherapy
BCBS Everyday Health Alliance 4000	Silver PPO	no	7	4	0	Links to a list, separated by county, then by specialty. *looked only at Maricopa County	Specifically listed: Licensed Clinical Social Worker, Psychiatry Child and Adolescent, Psychiatry Adult
Humana Connect 6300/6300	Bronze HMO	yes	592	166 (all accepting new)	290 289 accepting new	Search by specialty. Can search just mental health--all providers are listed, can filter by specialty	Mental Health Includes: Licensed Clinical Social Worker, Psychiatry, Licensed Mental Health Counselor, Psychology, Licensed Family and Marriage Therapist, Psychiatry & Neurology, Mental Health Hosptial, Psychiatry-Addiction, Preventive Medicine-Undersea and Hyperbaric, Psychology-Psychotherapy
BCBS Everyday Health Alliance 6000	Bronze PPO	no	7	4	0	Links to a list, separated by county, then by specialty. *looked only at Maricopa County	Specifically listed: Licensed Clinical Social Worker, Psychiatry Child and Adolescent, Psychiatry Adult

[4] Note: provider counts include providers that may practice in multiple locations

Arizona						
Plan	**Metal Level and Type**	**Definition of Medical Necessity**	**What is Excluded from the Deductible?**	**Deductible for Specific Services?**	**What is not included in the Out-of-Pocket Limit?**	**Referral to see a Specialist?**
Humana Connect	Silver HMO	Refers to Uniform Glossary	Premiums, balance-billed charges, and health care this plan does not cover	Prescription Drug Coverage	Premiums, balance-billed charges, items not covered, penalties	Yes
BCBS Everyday Health Alliance 4000	Silver PPO	Refers to Uniform Glossary	No exclusions	None	Premiums, precertification charges, balance-bills, and costs for items not covered	No
Humana Connect 6300/6300	Bronze HMO	Refers to Uniform Glossary	Premiums, balance-billed charges, and health care this plan does not cover	None	Premiums, balance-billed charges, items not covered, penalties	Yes
BCBS Everyday Health Alliance 6000	Bronze PPO	Refers to Uniform Glossary	No exclusions	None	Premiums, precertification charges, balance-bills, and costs for items not covered	No

Arizona				
Plan	**Metal Level and Type**	**Cost sharing for Primary Care (presumes does not include mental health providers)**	**Cost sharing for Specialist**	**Limitations and Exceptions**
Humana Connect	Silver HMO	In-Network: $25 per visit	In-Network: $35 per visit	None
		Out-of-Network: not covered	Out-of-Network: not covered	
BCBS Everyday Health Alliance 4000	Silver PPO	In-Network: $30/provider/day	In-Network: $60/provider/day	Limit of 1 routine vision exam/calendar year at PCP copay. Specialist copay for most chiropractic services. Plan excludes services by acupuncturists, naturopaths & homeopaths
		Out-of-Network: 50% & balance bill	Out-of-Network: 50% & balance bill	
Humana Connect 6300/6300	Bronze HMO	In-Network: no charge	In-Network: no charge	None
		Out-of-Network: not covered	Out-of-Network: not covered	
BCBS Everyday Health Alliance 6000	Bronze PPO	In-Network: $40 copay/provider/day	In-Network: $80 copay/provider/day	Limit of 1 routine vision exam/calendar year at PCP copay. Specialist copay for most chiropractic services. Plan excludes services by acupuncturists, naturopaths & homeopaths
		Out-of-Network: 50% & balance bill	Out-of-Network: 50% & balance bill	

Arizona							
Plan	**Metal Level and Type**	**Hospital Stay Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Inpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Inpatient Cost Sharing**	**Limitations and Exceptions**
Humana Connect	Silver HMO	In-Network: 20% facility and 20% physician/surgeon fee	None	In-Network: 20%	None	In-Network: 20%	None
		Out-of-Network: not covered		Out-of-Network: not covered		Out-of-Network: not covered	
BCBS Everyday Health Alliance 4000	Silver PPO	In-Network: 20% hospital and physician/surgeon fee	Precertification requires. $500 charge if no precertification for out-of-network stay. Additional $1,000 access fee for all bariatric surgeries	In-Network: 20%	Precertification required. $500 charge if no precertification for out-of-network facility stay	In-Network: 20%	Precertification required. $500 charge if no precertification for out-of-network facility stay
		Out-of-Network: 50% & balance bill facility fee and physician/surgeon fee		Out-of-Network: 50% & balance bill		Out-of-Network: 50% & balance bill	
Humana Connect 6300/6300	Bronze HMO	In-Network: no charge	None	In-Network: no charge	None	In-Network: no charge	None
		Out-of-Network: not covered		Out-of-Network: not covered		Out-of-Network: not covered	
BCBS Everyday Health Alliance 6000	Bronze PPO	In-Network: 20% hospital and physician/surgeon fee	Precertification requires. $500 charge if no precertification for out-of-network stay. Additional $1,000 access fee for all bariatric surgeries	In-Network: office visit copay or 20%	Precertification required. $500 charge if no precertification for out-of-network facility stay	In-Network: 20%	Precertification required. $500 charge if no precertification for out-of-network facility stay
		Out-of-Network: 50% & balance bill facility fee and physician/surgeon fee		Out-of-Network: 50% & balance bill		Out-of-Network: 50% & balance bill	

Arizona							
Plan	**Metal Level and Type**	**Outpatient Surgery Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Outpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Outpatient Cost Sharing**	**Limitations and Exceptions**
Humana Connect	Silver HMO	In-Network: 20% facility fee and 20% physician/surgeon fee Out-of-Network: not covered	None	In-Network: 20% Out-of-Network: not covered	None	In-Network: 20% Out-of-Network: not covered	None
BCBS Everyday Health Alliance 4000	Silver PPO	In-Network: 20% facility fee and physician/surgeon fee Out-of-Network: 50% & balance bill	Additional $1,000 access fee for all bariatric surgeries	In-Network: office visit copay or 20% Out-of-Network: 50% & balance bill	Cost share varies based on place of service and provider's network status & type	In-Network: Office visit copay or 20% Out-of-Network: 50% & balance bill	Cost sharing varies based on place of service and provider's network status & type. Precertification required. $500 charge if no precertification for out-of-network facility stay
Humana Connect 6300/6300	Bronze HMO	In-Network: no charge facility fee and physician/surgeon fee Out-of-Network: not covered	None	In-network: no charge Out-of-Network: not covered	None	In-Network: no charge Out-of-Network: not covered	None
BCBS Everyday Health Alliance 6000	Bronze PPO	In-Network: 20% facility fee and physician/surgeon fee Out-of-Network: 50% & balance bill	Additional $1,000 access fee for all bariatric surgeries	In-Network: office visit copay or 20% Out-of-Network: 50% & balance bill	Cost share varies based on place of service and provider's network status & type	In-Network: Office visit copay or 20% Out-of-Network: 50% & balance bill	Cost share varies based on place of service and provider's network status & type

Illinois							
Plan	**Metal Level and Type**	**Designates Accepting New Patients**	**Overall Number Mental Health Providers[5]**	**Psychiatrists**	**Oncologist**	**Comments on Provider Search Function**	**Notes**
Blue Choice Silver PPO 003	Silver PPO	Yes	0	558 (all accepting new)	95 (all accepting new)	May search by type, specialty, provider name or location (drop down menu of specialty). Very confusing to search. For example, a search of "Behavioral Health" or "Mental Health/Dependency" turned up nothing	
Humana Connect Silver 4600/6300	Silver HMO	Yes	1346 (all accepting new)	246 (all accepting new)	397 (395 accepting new	Search by specialty. Can search just mental health--all providers are listed, can filter by specialty	Mental Health Provider includes: Licensed Clinical Social Worker, Licensed Mental Health Counselor, Psychology, Psychiatry, Psychairty & Neurology, Psychiatry-clinical, Child and Adolescent Psychiatry, Licensed Family and Marriage Therapist, Mental Health Hospital, Pediatrics-psychology
Blue PPO Bronze 006	Bronze PPO	Yes	0	2, 071 (all accepting new)	255 (all accepting new)	May search by type, specialty, provider name or location (drop down menu of specialty). Very confusing to search. For example, a search of "Behavioral Health" or "Mental Health/Dependency" turned up nothing	
Humana Connect Bronze 6300/6300	Bronze HMO	Yes	1346 (all accepting new)	616 (592 accepting new)	397 (395 accepting new	Search by specialty. Can search just mental health--all providers are listed, can filter by specialty	Mental Health Provider includes: Licensed Clinical Social Worker, Licensed Mental Health Counselor, Psychology, Psychiatry, Psychairty & Neurology, Psychiatry-clinical, Child and Adolescent Psychiatry, Licensed Family and Marriage Therapist, Mental Health Hospital, Pediatrics-psychology

[5] Note: provider counts include providers that may practice in multiple locations.

Illinois						
Plan	**Metal Level and Type**	**Definition of Medical Necessity**	**What is Excluded from the Deductible?**	**Deductible for Specific Services?**	**What is not included in the Out-of-Pocket Limit?**	**Referral to see a Specialist?**
Blue Choice Silver PPO 003	Silver PPO	Refers to Uniform Glossary	Does not apply to preventative care and certain copays	Yes. Per occurrence; $250 participating/ $350 non-participating inpatient admission and $200 participating/$300 non-participating outpatient surgery. There are no other specific deductibles	Premiums, balance-billed charges, and not covered items	No
Humana Connect Silver 4600/6300	Silver HMO	Refers to Uniform Glossary	Does not apply to preventative care and prescription drugs. Coinsurance and copayments do not count toward deductible	Yes. Prescription drug coverage	Premiums, balance-billed charges, items not covered, penalties	Yes
Blue PPO Bronze 006	Bronze PPO	Refers to Uniform Glossary	Does not apply to preventative care	No	Premiums, balance-billed charges, and not covered items	No
Humana Connect Bronze 6300/6300	Bronze HMO	Refers to Uniform Glossary	Does not apply to preventative care and prescription drugs. Coinsurance and copayments do not count toward deductible	No	Premiums, balance-billed charges, items not covered, penalties	Yes

Illinois				
Plan	**Metal Level and Type**	**Cost Sharing for Primary Care (presumes does not include mental health providers)**	**Cost Sharing for Specialist**	**Limitations and Exceptions**
Blue Choice Silver PPO 003	Silver PPO	In-Network: $30 per visit	In-Network: $50 per visit	Primary care: no benefits will be provided for services which are not, in the reasonable judgment of BCBS, medically necessary
		Out-of-Network: 20%	Out-of-Network: 20%	
Humana Connect Silver 4600/6300	Silver HMO	In-Network: $25 per visit	In-Network: $35 per visit	None
		Out-of-Network: not covered	Out-of-Network: not covered	
Blue PPO Bronze 006	Bronze PPO	In-Network: No Charge	In Network: No Charge	Primary care: no benefits will be provided for services which are not, in the reasonable judgment of BCBS, medically necessary
		Out-of-Network: 20%	Out-of-Network: 20%	
Humana Connect Bronze 6300/6300	Bronze HMO	In-Network: no charge	In-Network: no charge	None
		Out-of-Network: not covered	Out-of-Network: not covered	

Illinois							
Plan	**Metal Level and Type**	**Hospital Stay Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Inpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Inpatient Cost Sharing**	**Limitations and Exceptions**
Blue Choice Silver PPO 003	Silver PPO	In-Network: No charge facility and physician/surgeon fee	$250 participating/$350 non-participating (per occurrence deductible may apply)	In-Network: no charge	$250 participating/$350 non-participating (per occurrence deductible may apply)	In-Network: no charge	$250 participating/$350 non-participating (per occurrence deductible may apply)
		Out-of-Network: 20%		Out-of-Network: 20%		Out-of-Network: 20%	
Humana Connect Silver 4600/6300	Silver HMO	In-Network: 20% and facility and physician/surgeon fee	Facility fee: preauthorization may be required, penalty will be 50% or $500, whichever is less	In-Network: 20%	Preauthorization may be required, penalty will be 50% or $500, whichever is less	In-Network: 20%	Preauthorization may be required, penalty will be 50% or $500, whichever is less
Blue PPO Bronze 006	Bronze PPO	In-Network: No charge facility and physician/surgeon fee	None	In-Network: no charge	None	In-Network: no charge	None
		Out-of-Network: 20%		Out-of-Network: 20%		Out-of-Network: 20%	
Humana Connect Bronze 6300/6300	Bronze HMO	In-Network: No charge facility and physician/surgeon fee	Facility fee: preauthorization may be required, penalty will be 50% or $500, whichever is less	In-Network: no charge	Preauthorization may be required, penalty will be 50% or $500, whichever is less	In-Network: no charge	Preauthorization may be required, penalty will be 50% or $500, whichever is less
		Out-of-Network: not covered		Out-of-Network: not covered		Out-of-Network: not covered	

Illinois							
Plan	**Metal Level and Type**	**Outpatient Surgery Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Outpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Outpatient Cost Sharing**	**Limitations and Exceptions**
Blue Choice Silver PPO 003	Silver PPO	In-Network: No charge facility and physician/surgeon fee Out-of-Network: 20%	$200 participating/$300 non-participating outpatient surgery (per occurrence deductible may apply)	In-Network: $30 per visit Out-of-Network: 20%	$200 participating/$300 non-participating outpatient surgery (per occurrence deductible may apply)	In Network: $30 per visit Out-of-Network: 20%	$200 participating/$300 non-participating outpatient surgery (per occurrence deductible may apply)
Humana Connect Silver 4600/6300	Silver HMO	In-Network: 20% and facility and physician/surgeon fee Out-of-Network: not covered	Facility fee: preauthorization may be required, penalty will be 50% or $500, whichever is less	In-Network: 20% Out-of-Network: not covered	None	In-Network: 20% Out-of-Network: not covered	None
Blue PPO Bronze 006	Bronze PPO	In-Network: No charge facility and physician/surgeon fee Out-of-Network: 20%	None	In-Network: no charge Out-of-Network: 20%	None	In-Network: no charge Out-of-Network: 20%	None
Humana Connect Bronze 6300/6300	Bronze HMO	In-Network: No charge facility and physician/surgeon fee Out-of-Network: not covered	Facility fee: preauthorization may be required, penalty will be 50% or $500, whichever is less	In-Network: no charge Out-of-Network: not covered	None	In-Network: no charge Out-of-Network: not covered	None

Montana							
Plan	**Metal Level and Type**	**Designates Accepting New Patients**	**Overall Number Mental Health Providers[6]**	**Psychiatrists**	**Oncologists**	**Comments on Provider Search Function**	**Notes**
PacificSource: SmartHealth Value Silver 3000	Silver PPO	Yes	190 (all accepting new)	26 (all accepting new)	5	Consumer can search by location and specialty, then narrow down once inside the specialty	Providers are tiered
Connected Care Silver: Montana Health Cooperative	Silver POS	Yes	4	0	77	Consumer can search by location, all providers are shown. Then, can narrow by specialty by choosing from a list. Can also search for specialty	
Access Care Bronze	Bronze PPO	No	5	7	30	Consumer can search by location, all providers are shown. Then, can narrow by specialty by choosing from a list. Can also search for specialty	This plan does not label specialties consistently
SmartHealth Value Bronze 3000	Bronze PPO	Yes	189 (all accepting new)	26 (all accepting new)	5	Consumer can search by location and specialty, then narrow down once inside the specialty	Providers are tiered

[6] Note: provider numbers to not take into account those providers that practice in multiple locations

Montana						
Plan	**Metal Level and Type**	**Definition of Medical Necessity**	**What is Excluded from the Deductible?**	**Deductible for Specific Services?**	**What is not included in the Out-of-Pocket Limit?**	**Referral to see a Specialist?**
PacificSource: SmartHealth Value Silver 3000	Silver PPO	Refers to Uniform Glossary	Does not apply to certain participating provider services like preventive care or pediatric vision. Also does not apply to non-participating provider services such as well baby/child care, routine mammograms, and pediatric vision exam	No	Premiums, balance-billed charges, and health care this plan does not cover	No
Connected Care Silver: Montana Health Cooperative	Silver POS	Refers to Uniform Glossary	Does not apply to preventative care, pediatric vision or copayments	No	Premiums, balance-billed charges, and health care this plan does not cover	No
Access Care Bronze	Bronze PPO	Refers to Uniform Glossary	Does not apply to preventative care, pediatric vision or copayments	No	Premiums, balance-billed charges, and health care this plan does not cover	No
PacificSource: SmartHealth Value Bronze 3000	Bronze PPO	Refers to Uniform Glossary	Does not apply to certain participating provider services like preventive care or pediatric vision. Also does not apply to non-participating provider services such as well baby/child care, routine mammograms, and pediatric vision exam	No	Premiums, balance-billed charges, and health care this plan does not cover	No

Montana				
Plan	**Metal Level and Type**	**Cost Sharing for Primary Care (presumes does not include mental health providers)**	**Cost Sharing for Specialist**	**Limitations and Exceptions**
PacificSource: SmartHealth Value Silver 3000	Silver PPO	In-Network: no charge Out-of-Network: 25%	In-Network: no charge Out-of-Network: 25%	None
Connected Care Silver: Montana Health Cooperative	Silver POS	In-Network: $35/visit Out-of-Network: 60% coinsurance	In-Network: $60/visit after deductible Out-of-Network: 60% coinsurance	None
Access Care Bronze	Bronze PPO	In-Network: 50% Out-of-Network: 70%	In-Network: 50% Out-of-Network: 70%	None
PacificSource: SmartHealth Value Bronze 3000	Bronze PPO	In-Network: 50% Out-of-Network: 75%	In-Network: 50% Out-of-Network: 75%	None

Montana							
Plan	**Metal Level and Type**	**Hospital Stay Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Inpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Inpatient Cost Sharing**	**Limitations and Exceptions**
PacificSource: SmartHealth Value Silver 3000	Silver PPO	In-Network: no charge	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Pre-authorization required for some inpatient services.	In-Network: no charge	Pre-authorization required	In-Network: no charge	Pre-authorization required
		Out-of-Network: 25%		Out-of-Network: 25%		Out-of-Network: 25%	
Connected Care Silver: Montana Health Cooperative	Silver POS	In-Network: 40%	None	In-Network: 40%	None	In-Network: 40%	None
		Out-of-Network: 60%		Out-of-Network: 60%		Out-of-Network: 60%	
PacificSource: SmartHealth Value Bronze 3000	Bronze PPO	In-Network: 50%	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Pre-authorization required for some inpatient services.	In-Network: 50%	Pre-authorization required	In-Network: 50%	Pre-authorization required
		Out-of-Network: 75%		Out-of-Network: 75%		Out-of-Network: 75%	
Access Care Bronze	Bronze PPO	In-Network: 50%	None	In-Network: 50%	None	In-Network: 50%	None
		Out-of-Network: 70%		Out-of-Network: 70%		Out-of-Network: 70%	

Montana							
Plan	**Metal Level and Type**	**Outpatient Surgery Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Outpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Outpatient Cost Sharing**	**Limitations and Exceptions**
PacificSource: SmartHealth Value Silver 3000	Silver PPO	In-Network: no charge	Pre-authorization required	In-Network: no charge	None	In-Network: no charge	None
		Out-of-Network: 25%		Out-of-Network: 25%		Out-of-Network: 25%	
Connected Care Silver: Montana Health Cooperative	Silver POS	In-Network: 40%	None	In-Network: $60/visit after deductible	None	In-Network: $60/visit after deductible	None
		Out-of-Network: 60%		Out-of-Network: 60%		Out-of-Network: 60%	
Access Care Bronze	Bronze PPO	In-Network: 50%	None	In-Network: 50%	None	In-Network: 50%	None
		Out-of-Network: 70%		Out-of-Network: 70%		Out-of-Network: 70%	
PacificSource: SmartHealth Value Bronze 3000	Bronze PPO	In-Network: 50%	Pre-authorization required	In-Network: 50%	None	In-Network: 50%	None
		Out-of-Network: 75%		Out-of-Network: 75%		Out-of-Network: 75%	

New Jersey							
Plan	**Metal Level and Type**	**Designates Accepting New Patients**	**Overall Number Mental Health Providers[7]**	**Psychiatrists**	**Oncologist**	**Comments on Provider Search Function**	**Notes**
Horizon Advance EPO Silver	Silver EPO	Yes	35	12	16	First, search by provider name, zip code, specialty, or plan. One may then search multiple specialties at once and further filter results by gender, languages spoken, and distance from any location.	
AmeriHealth Tier 1 Advantage Silver EPO H.S.A.	Silver EPO	Yes	22	30	36	First, select a region and then search by provider type. The types of providers in the drop-down box are not exhaustive which makes finding the correct specialty confusing. The next page provides a search by provider name, location, and specialty .One may then filter results by gender, languages spoken, and distance from any location.	
AmeriHealth Tier 1 Advantage Bronze EPO H.S.A.	Bronze EPO	Yes	22	30	36	First, select a region and then search by provider type. The types of providers in the drop-down box are not exhaustive which makes finding the correct specialty confusing. The next page provides a search by provider name, location, and specialty .One may then filter results by gender, languages spoken, and distance from any location.	
Horizon Advantage EPO Bronze	Bronze EPO	Yes	45	15	30	First, search by provider name, zip code, specialty, or plan. One may then search multiple specialties at once and further filter results by gender, languages spoken, and distance from any location.	

[7] Note: provider counts include providers that may practice in multiple locations

New Jersey						
Plan	**Metal Level and Type**	**Definition of Medical Necessity**	**What is Excluded from the Deductible?**	**Deductible for Specific Services?**	**What is not included in the Out-of-Pocket Limit?**	**Referral to see a Specialist?**
Horizon Advance EPO Silver	Silver EPO	Refers to Uniform Glossary	**Tier 1** hospital and out-of-office services ($1500 individual/$3000 family) **Tier 2** hosptials ($2500 individual/$5000 family)	No	Premiums, balance-billed charges, and health care this plan does not cover	Yes
AmeriHealth Tier 1 Advantage Silver EPO H.S.A.	Silver EPO	Refers to Uniform Glossary	"Deductible may not apply to all services"	No	Premiums, balance-billed charges, and health care this plan does not cover	No
AmeriHealth Tier 1 Advantage – Bronze EPO H.S.A.	Bronze EPO	Refers to Uniform Glossary	"Deductible may not apply to all services"	No	Premiums, balance-billed charges, and health care this plan does not cover	No
Horizon Advantage EPO Bronze	Bronze EPO	Refers to Uniform Glossary	"Does not apply to preventive care"	No	Premiums, balance-billed charges, and health care this plan does not cover	No

New Jersey				
Plan	**Metal Level and Type**	**Cost Sharing for Primary Care (presumes does not include mental health providers)**	**Cost Sharing for Specialist**	**Limitations and Exceptions**
Horizon Advance EPO Silver	Silver EPO	In-Network: $30 after deductible	In-Network: 30% after deductible	None
		Out-of-Network: Not Covered	Out-of-Network: Not Covered	
AmeriHealth Tier 1 Advantage Silver EPO H.S.A.	Silver EPO	In-Network: $50 after deductible for Tier 1 and Tier 2	In-Network: $75 after deductible for Tier 1 and Tier 2	None
		Out-of-Network: No information	Out-of-Network: No information	
AmeriHealth Tier 1 Advantage Bronze EPO H.S.A.	Bronze EPO	In-Network: $50 after deductible for Tier 1 and Tier 2	In-Network: $75 after deductible for Tier 1 and Tier 2	None
		Out-of-Network: No information	Out-of-Network: No information	
Horizon Advantage EPO Bronze	Bronze EPO	In-Network: $30 per visit after deductible	In-Network: 50% after deductible	None
		Out-of-Network: Not Covered	Out-of-Network: Not Covered	

New Jersey							
Plan	**Metal Level and Type**	**Hospital Stay Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Inpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Inpatient Cost Sharing**	**Limitations and Exceptions**
Horizon Advance EPO Silver	Silver EPO	In-Network: **Tier 1:** 30% after deductible **Tier 2**: 50% after deductible	Requires pre-approval	In-Network: **Tier 1:** 30% after deductible **Tier 2**: 50% after deductible	Requires pre-approval	In-Network: **Tier 1:** 30% after deductible **Tier 2**: 50% after deductible	Requires pre-approval
		Out-of-Network: Not Covered		Out-of-Network: Not Covered		Out-of-Network: Not Covered	
AmeriHealth Tier 1 Advantage Silver EPO H.S.A.	Silver EPO	In-Network: **Tier 1**: 10% after deductible **Tier 2**: 50% after deductible"	Precertification is required	In-Network: **Tier 1**: 10% after deductible **Tier 2**: 50% after deductible"	Precertification is required	In-Network: **Tier 1**: 10% after deductible **Tier 2**: 50% after deductible"	Precertification is required
		Out-of-Network: No information		Out-of-Network: No information		Out-of-Network: No information	
AmeriHealth Tier 1 Advantage Bronze EPO H.S.A.	Bronze EPO	In-Network: **Tier 1:** 20% after deductible **Tier 2:** 50% after deductible	Precertification is required	In-Network: **Tier 1:** 20% after deductible **Tier 2:** 50% after deductible	Precertification is required	In-Network: **Tier 1:** 20% after deductible **Tier 2:** 50% after deductible	Precertification is required
		Out-of-Network: No information		Out-of-Network: No information		Out-of-Network: No information	
Horizon Advantage EPO Bronze	Bronze EPO	In-Network: 50% after deductible	Requires pre-approval	In-Network: 50% after deductible	Requires pre-approval	In-Network: 50% after deductible	Requires pre-approval
		Out-of-Network: Not Covered		Out-of-Network: Not Covered		Out-of-Network: Not Covered	

New Jersey							
Plan	**Metal Level and Type**	**Outpatient Surgery Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Outpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Outpatient Cost Sharing**	**Limitations and Exceptions**
Horizon Advance EPO Silver	Silver EPO	In-Network: **Tier 1:** 30% after deductible **Tier 2**: 50% after deductible	None	In-Network: **Tier 1:** 30% after deductible **Tier 2**: 50% after deductible	None	In-Network: **Tier 1:** 30% after deductible **Tier 2**: 50% after deductible	None
		Out-of-Network: Not Covered		Out-of-Network: Not Covered		Out-of-Network: Not Covered	
AmeriHealth NJ Tier 1 Advantage – Silver EPO H.S.A.	Silver EPO	In-Network: **Tier 1**: 10% after deductible **Tier 2**: 50% after deductible"	Precertification may be required	In-Network: $75 after deductible	None	In-Network: $75 after deductible	None
		Out-of-Network: No information		Out-of-Network: No information		Out-of-Network: No information	
AmeriHealth NJ Tier 1 Advantage – Bronze EPO H.S.A.	Bronze EPO	In-Network: **Tier 1:** 20% after deductible **Tier 2:** 50% after deductible	Precertification may be required	In-Network: $75 after deductible	None	In-Network: $75 after deductible	None
		Out-of-Network: No information		Out-of-Network: No information		Out-of-Network: No information	
Horizon Advantage EPO Bronze	Bronze EPO	In-Network: 50% after deductible	None	In-Network: 50% after deductible **Office**: $30 copay for a PCP or 50% after deductible for Specialist visit	None	In-Network: 50% after deductible **Office:** $30 copay for a PCP or 50% after deductible for Specialist visit	None
		Out-of-Network: Not Covered		Out-of-Network: Not Covered		Out-of-Network: Not Covered	

Texas							
Plan	**Metal Level and Type**	**Designates Accepting New Patients**	**Overall Number Mental Health Providers[8]**	**Psychiatrists**	**Oncologists**	**Comments on Provider Search Function**	**Notes on Providers**
Molina Marketplace Silver Plan	Silver HMO	Yes	21	7	8	First search by address, county, or city. Then search by coverage type (plan name). One must select a provider type before selecting a specialty, searching by provider name, or by hospital, which makes finding the correct specialty a bit confusing. The website setup is also hard to read. The website has a click-through dictionary explaining each specialty.	
Blue Advantage Silver HMO 003	Silver HMO	Yes: Oncologists No: Psychiatrists	399	51	5	May first search by provider network or plan name. Then search by county, zip code, and city within a state. May filter by provider type or specialty. The list of specialties is exhaustive and relatively easy to navigate. May also search by providers names and languages spoken.	
Blue Advantage Bronze HMO 005	Bronze HMO	Yes	399	51	5	May first search by provider network or plan name. Then search by county, zip code, and city within a state. May filter by provider type or specialty. The list of specialties is exhaustive and relatively easy to navigate. May also search by providers names and languages spoken.	
Blue Advantage Bronze HMO 006	Bronze HMO	Yes	399	51	5	May first search by provider network or plan name. Then search by county, zip code, and city within a state. May filter by provider type or specialty. The list of specialties is exhaustive and relatively easy to navigate. May also search by providers names and languages spoken.	

[8] Note: provider counts include providers that may practice in multiple locations

Texas						
Plan	**Metal Level and Type**	**Definition of Medical Necessity**	**What is Excluded from the Deductible?**	**Deductible for Specific Services?**	**What is not included in the Out-of-Pocket Limit?**	**Referral to see a Specialist?**
Molina Marketplace Silver Plan	Silver HMO	Refers to Uniform Glossary	Zero deductible	No	Premiums, balance-billed charges, and health care this plan does not cover	No
Blue Advantage Silver HMO 003	Silver HMO	Refers to Uniform Glossary	"Doesn't apply to certain services that charge a copay, preventive care, and prescription drugs"	Yes. Per Occurrence: $250. In-Network Inpatient Admission. There are no other specific deductibles	Premiums, balance-billed charges, and health care this plan does not cover	Yes. All specialist visits require a written PCP referral unless it's for an OB/GYN or for emergency care
Blue Advantage Bronze HMO 005	Bronze HMO	Refers to Uniform Glossary	"Does not apply to certain preventive care"	No	Premiums, balance-billed charges, and health care this plan does not cover	Yes
Blue Advantage Bronze HMO 006	Bronze HMO	Refers to Uniform Glossary	"Does not apply to certain preventive care"	No	Premiums, balance-billed charges, and health care this plan does not cover	Yes

Texas				
Plan	**Metal Level and Type**	**Cost Sharing for Primary Care (presumes does not include mental health providers)**	**Cost Sharing for Specialist**	**Limitations and Exceptions**
Molina Marketplace Silver Plan	Silver HMO	In-Network: $30 per visit	In-Network:$75 per visit	Prior authorization may be required or services not covered
		Out-of-Network: Not Covered	Out-of-Network: Not Covered	
Blue Advantage Silver HMO 003	Silver HMO	In-Network: $30 per visit	In-Network: $50 per visit	None
		Out-of-Network: Not Covered	Out-of-Network: Not Covered	
Blue Advantage Bronze HMO 005	Bronze HMO	In-Network: 20%	In-Network: 20%	None
		Out-of-Network: Not Covered	Out-of-Network: Not Covered	
Blue Advantage Bronze HMO 006	Bronze HMO	In-Network: No Charge	In-Network: No Charge	None
		Out-of-Network: Not Covered	Out-of-Network: Not Covered	

Texas							
Plan	**Metal Level and Type**	**Hospital Stay Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Inpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Inpatient Cost Sharing**	**Limitations and Exceptions**
Molina Marketplace Silver Plan	Silver HMO	In-Network:40% Out-of-Network: Not Covered	Prior authorization may be required or services not covered	In-Network:40% Out-of-Network: Not Covered	Prior authorization may be required or services not covered	In-Network:40% Out-of-Network: Not Covered	Prior authorization may be required or services not covered
Blue Advantage Silver HMO 003	Silver HMO	In-Network: No Charge Out-of-Network: Not Covered	$250 In-Network Inpatient Per Occurrence Deductible	In-Network: No Charge Out-of-Network: Not Covered	$250 In-Network Inpatient Per Occurrence Deductible	In-Network: No Charge Out-of-Network: Not Covered	$250 In-Network Inpatient Per Occurrence Deductible
Blue Advantage Bronze HMO 005	Bronze HMO	In-Network: 20% Out-of-Network: Not Covered	None	In-Network: 20% Out-of-Network: Not Covered	None	In-Network: 20% Out-of-Network: Not covered	None
Blue Advantage Bronze HMO 006	Bronze HMO	In-Network: No Charge Out-of-Network: Not Covered	None	In-Network: No Charge Out-of-Network: Not Covered	None	In-Network: No Charge Out-of-Network: Not covered	None

Texas							
Plan	**Metal Level and Type**	**Outpatient Surgery Cost Sharing**	**Limitations and Exceptions**	**Mental/Behavioral Health Outpatient Cost Sharing**	**Limitations and Exceptions**	**Substance Use Outpatient Cost Sharing**	**Limitations and Exceptions**
Molina Marketplace Silver Plan	Silver HMO	In-Network: 40% Out-of-Network: Not Covered	Prior authorization may be required or services not covered	In-Network: $75 per visit Out-of-Network: Not Covered	Prior authorization is required for services by Other Practitioners (Other than PCP or Specialist Psychiatrist), or services not covered.	In Network: $75 per visit Out-of-Network: Not Covered	Prior authorization is required for services by Other Practitioners (Other than PCP or Specialist Psychiatrist), or services not covered.
Blue Advantage Silver HMO 003	Silver HMO	In-Network: Facility fee: $200 per visit; Physician/Surgeon fee: No Charge Out-of-Network: Not Covered	None	In-Network: $30 per visit Out-of-Network: Not Covered	None	In-Network: $30 per visit Out-of-Network: Not Covered	None
Blue Advantage Bronze HMO 005	Bronze HMO	In-Network: 20% Out-of-Network: Not Covered	None	In-Network: 20% Out-of-Network: Not Covered	None	In-Network: 20% Out-of-Network: Not Covered	None
Blue Advantage Bronze HMO 006	Bronze HMO	In-Network: No Charge Out-of-Network: Not Covered	None	In-Network: No Charge Out-of-Network: Not Covered	None	In-Network: No Charge Out-of-Network: Not Covered	None