



November 14, 2024

## **Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority**

This report is submitted by the Standard Plans Advisory Working Group (SPWG), Claire Heyison, Chair and Dock Winston, MD, Vice Chair. The Working Group's charge was to modify the standard benefit plan design for appropriate metal level tiers to continue to implement the recommendations of the Executive Board's Social Justice and Health Disparities Working Group.

### **Background**

For Plan Year 2026, the SPWG was tasked with continuing to implement the [recommendations](#) of the Social Justice and Health Disparities Working Group (SJHDWG) (as approved by the Board in its July 14, 2021 [Resolution](#)).

In the first year of implementation of the SJHDWG recommendations, the SPWG developed -- and the Board adopted -- the recommendation to eliminate cost-sharing for certain services, medications, and diabetic supplies for people with Type 2 diabetes [SPWG [Report](#) of March 7, 2022; Board [Resolution](#) adopted March 9, 2022].<sup>1</sup> A resolution also was adopted to make standard plans available in the small group market. In the second year of implementation, the Board adopted the resolution to reduce cost-sharing for pediatric mental health services [SPWG [Report](#) of March 6, 2023; Board [Resolution](#) adopted March 8, 2023]. In the third year, the Board adopted the resolution to eliminate cost-sharing for cardiovascular and cerebrovascular disease [SPWG [Report](#) of November 2, 2023; Board [Resolution](#) adopted November 8, 2023]. The relevant recommendation is as follows:

- Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and copayment, for medical care, prescription drugs, supplies and related services that prevent and manage diseases and health conditions that disproportionately affect patients of color in the District.
- HBX Standard Plan Working Group to review and develop for consideration a Value Based Insurance Design to support adherence for patients with chronic conditions. The Social

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<sup>1</sup> This recommendation builds on the \$0 cost-sharing for insulin and diabetic supplies implemented in individual market plans in Plan Year 2022 [SPWG [Report](#) of February 5, 2021; Board [Resolution](#) adopted February 10, 2021].

Justice and Health Disparities Working Group recommends the following prioritization of conditions to be assessed for AV and premium impact by the HBX Standard Plans Working Group: (1) for the adult population-- diabetes, cardiovascular disease, cerebrovascular disease, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus; and (2) for pediatric population-- mental and behavioral health services.

- Waiver of cost-sharing is only for the underlying condition and does not include comorbidities. Additionally, cost-sharing may be waived for HSA compatible, high deductible health plans only to the extent permitted by federal law. Insurance plan design changes are limited to AV standards approved under federal law.
- Health plans are encouraged to evaluate impact of design changes on enrolled population and provide periodic updates on trends to DCHBX. Furthermore, health plans are encouraged to expand their current health equity support and pilot programs to include patients for whom there will be no cost-sharing for treatment of certain specific conditions. Because product design changes will require provider education, DCHBX shall include in their budget funding for provider education in consultation with the health plans.
- New insurance design should apply to standard plans in the individual marketplace. DCHBX must also develop new standard plan design, which must include this new insurance design, for the small group marketplace to be offered for plan year 2023. SJHDWG [Report](#), pp. 35-36.

In this fourth year of implementation of the social justice recommendations, the SPWG was charged with making recommendations to modify the standard plan designs to reduce cost-sharing in standard plans for services and prescription drugs needed by people living with Human Immunodeficiency Virus (HIV) starting in Plan Year 2026. [The SPWG also briefly considered a scenario to reduce cost sharing for adult mental health services but decided to defer the discussion until next year. See the discussion at the end of this report.]

The working group's documents can be found on the [SPWG page](#) on the HBX website.

### **HIV in the District of Columbia**

In the District of Columbia, approximately 1.8% of the population is living with HIV (12,000 people), ranking D.C. as the state with the highest HIV prevalence in the United States. Most people living with HIV in the District are Black (71%) or Latino (8%), Black men, Latino men, and Black women are disproportionately affected: 4% of Black men, 2.2 percent of Latino men, and 1.7% of Black women in D.C. are living with HIV ([DC Health](#)). Since the epidemic's beginning, Black people in the U.S. have been [disproportionately affected](#) by HIV, and that disparity has deepened [over time](#). There also is [a growing Latino HIV crisis](#). Although the estimated number of new HIV infections per year decreased by 19% between 2010 and 2022, there was a 12% increase among Latino people.

Many factors may account for these disparities. The [National HIV/AIDS Strategy](#) (2022-2025) recognizes racism as a serious public health threat that affects HIV outcomes and disparities. Barriers to HIV prevention and treatment include stigma, mental health issues, health care access barriers, housing instability, language barriers, and other structural determinants of health.

Looking across the care [continuum](#), Black people face disparities related to linkage to care and viral suppression. At the end of 2022, 64% of Black people with HIV were linked to care and 53% were virally suppressed. In comparison, 70% of White people with HIV were linked to care and 63% were virally suppressed ([KFF](#)). Of the population living with HIV in D.C, 66% are virally suppressed, with similar gaps for Black people ([DC Health](#)).

Eliminating discrimination based on preexisting conditions is one of the central features of the Affordable Care Act (ACA). Before the ACA, insurers in the nongroup market regularly charged high premiums to people with chronic conditions or denied them coverage entirely. Since the launch of DC Health Link, thousands of people with HIV have been enrolled in qualified health plans in the individual and small group markets. During the working group meetings, carriers reported that people with HIV account for less than 1 percent of their enrolled populations.

### **An HIV Treatment Scenario**

HIV requires lifelong treatment and is treated with an expensive and disease-specific class of medications. HBX contracted with the Whitman Walker Institute (WWI) to develop a treatment scenario for HIV – a set of medical care services and prescription drugs that are commonly used by people living with HIV. These services would be provided at reduced copayments or no copayment in standard plans in the individual and small group markets.

In developing the scenario for reduced copayments, WWI relied on clinical guidelines for the management of HIV, interviews with medical providers, and analysis of data from their internal electronic health records system. They identified a core set of services utilized during a year including office visits for evaluation and management and necessary laboratory tests. Treatment of HIV requires regular labs to assess viral load, for example. [See tables 2 and 3 below for a list of the services and laboratory tests].

The standard plan copays for office visits are as follows. For the equity design, these copays would be eliminated for the selected services for people with an HIV diagnosis.

<b>Standard Plan Copayments for Office Visits</b>				
Service Type	Metal AV			
	Platinum	Gold	Silver	Bronze Copay
Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$20	\$25	\$40	\$45

WWI also identified prescription drugs prescribed to people living with HIV including antiretrovirals (10 HIV drug classes listed below, which includes combination medications of drugs in 2 or more classes) and a select list of other drugs (antifungals, macrolide antibiotics, antimycobacterials, sulfonamide antibiotics and penicillin) that are often prescribed to patients living with HIV to treat or prevent opportunistic infections. [See WWI [report](#), pp. 5-6]

	<b>HIV Drug Classes</b>
1	Nucleoside Reverse Transcriptase Inhibitors
2	Non-Nucleoside Reverse Transcriptase Inhibitors
3	Protease Inhibitors
4	Fusion Inhibitors
5	CCR5 Antagonists
6	Integrase Strand Transfer Inhibitor
7	Attachment Inhibitors
8	Post-Attachment Inhibitors
9	Capsid Inhibitors Class
10	Pharmacokinetic Enhancers

The most frequently prescribed antiretroviral (ARV) drugs (among people with HIV receiving services at Whitman Walker Health, a federally qualified health clinic in the District of Columbia) include the following (mostly brand) medications.

<b>Frequently Prescribed Antiretroviral Drugs</b>	
<b>HIV Drug</b>	<b>HIV Drug Class</b>
Truvada	Nucleoside reverse transcriptase inhibitors (NRTIs)
Biktarvy	Nucleoside reverse transcriptase inhibitors (NRTIs)
Descovy	Nucleoside reverse transcriptase inhibitors (NRTIs)
Genvoya	Nucleoside reverse transcriptase inhibitors (NRTIs)
Tivicay	Integrase Inhibitors
Triumeq	Nucleoside reverse transcriptase inhibitors (NRTIs)
Emtricitabine-Tenofovir DF	Nucleoside reverse transcriptase inhibitors (NRTIs)
Norvir	Protease inhibitors
Prezcobix	Protease inhibitors
Prezista	Protease inhibitors

The formulary tiering of the HIV drugs varies across plans. A standard plan enrollee’s out-of-pocket costs for HIV drugs depends on the formulary placement of their prescribed drugs and their plan metal AV. HIV drugs could be placed on a non-preferred brand tier, for example, have copays that range from \$25 in a Platinum plan to \$100 in a Bronze plan.

<b>Prescription Drugs Copays in Standard Plans by Drug Tier and Metal Level</b>				
<b>Tier</b>	<b>Platinum</b>	<b>Gold</b>	<b>Silver</b>	<b>Bronze Copay</b>
Generic	\$5	\$15	\$20	\$25
Preferred brand	\$15	\$50	\$50	\$75
Non-preferred Brand	\$25	\$70	\$70	\$100
Specialty	\$100	\$150	\$150	\$150

Assuming the following tier placement of some common HIV treatment regimens, the annual out-of-pocket costs for HIV drugs are significant, especially for people enrolled in a Bronze plan.

<b>Out-of-pocket costs for common HIV treatment regimens in standard plans</b>			
<b>Drug regimen</b>	<b>Tier placement</b>	<b>Standard plan copay per month for the regimen (range)</b>	<b>Annual cost (range across metal levels)</b>
<b>Biktarvy</b>	Non-preferred brand	\$25 (Platinum) - \$100 (Bronze copay)	\$300 - \$1,200
<b>Symzuta</b>	Non-preferred brand	\$25 (Platinum) - \$100 (Bronze copay)	\$300 - \$1,200
<b>Descovy and Prezcoibix</b>	Preferred brand, Non-preferred brand	\$40 (Platinum) - \$175 (Bronze copay)	\$480 - \$2,100
<b>Cabenuva</b>	Non-preferred brand	\$25 (Platinum) - \$100 (Bronze copay)	\$300 - \$1,200
<b>Biktarvy and Prezcoibix</b>	Non-preferred brand, Non-preferred brand	\$50 (Platinum) - \$200 (Bronze copay)	\$600 - \$2,400

**Refinement of the proposed HIV treatment scenario**

During their discussions, the SPWG agreed to some refinements to this initial scenario.

1. The group noted that the original scenario included diagnosis codes for people at risk of HIV. Since the working group’s charge was to lower cost sharing for people diagnosed with HIV, these diagnosis codes were removed from the scenario.
2. Carriers asked for the prescription drugs to be limited to HIV drug classes. They cited operational challenges to limiting the lower copay for the antibiotics (that are widely used by people with conditions other than HIV) to people with HIV only, explaining that a diagnosis code is not typically available on a prescription at the point of service. The group agreed to adopt this refinement.

3. A small number of CPT codes were added to the original scenario. These were codes that were inadvertently left off the original scenario (focused on adults) and were added to assure that reduced copay services are made available to people of all ages (including children and adolescents and older adults aged 65+).

### **Reducing or eliminating copayments for HIV drugs**

Beyond the initial refinements to scenario, much of the discussion about the HIV scenario focused on prescription drugs. Several working group members noted that many people with HIV – including with people with insurance through DC Health Link – are eligible for financial assistance with health insurance premiums and prescription drug copays through the Ryan White AIDS Drug Assistance Program (ADAP). Some stated that copays for these drugs should not be reduced; instead, enrollees should seek financial assistance from ADAP or from other sources such as manufacturer patient assistance programs.

HBX staff invited Amy Killelea from the Georgetown University Center on Health Insurance Reforms to provide an overview of ADAP, its services and funding, focusing on partial pay rebates that ADAP may receive [[Presentation slides](#)].

- Amy explained that ADAP is a state-administered program authorized by the Ryan White HIV/AIDS Program, Part B. ADAP's primary role is to provide FDA-approved medications to low-income individuals with HIV. ADAP operates at the health department level, providing medication access through procured discount medications and insurance assistance.
- The eligibility criteria for ADAP is defined by the Ryan White statute but can vary by state. In the District of Columbia, ADAP income eligibility is set at 500% of the federal poverty level. ADAP can pay client health insurance premiums and medication cost-sharing.
- ADAP covers a range of insurance plans, including employer plans, large self-funded plans, and Medicare, with marketplace plans being a smaller portion of the total enrollment.
- ADAP funding includes federal allocations, state contributions, and drug rebates. Drug rebates and program income are a significant part of ADAP's budget, allowing the program to sustain and increase services.
- ADAPs can only generate a partial pay rebate on a cost-sharing claim. Plan designs that offer \$0 cost sharing for HIV medications may mean significant hits to ADAP budgets

HBX staff also met with ADAP leadership at DC Health. They shared that there are currently 79 ADAP clients enrolled in a QHP via DC Health Link and that 80 to 120 clients are on QHP at any time. They also explained that eliminating copays for HIV drugs in standard plans could negatively affect ADAP's claims for partial pay rebates.

Based on the discussion, two options were under consideration:

- Option 1: \$5 copays for services and drugs.
  - A \$5 copay (instead of \$0) assures no impact on ADAP partial pay rebates.
  
- Option 2: \$5 copays for services only.
  - Prescription drugs removed from the scenario.
  - Presumes most people with HIV can seek financial assistance with copays from ADAP or manufacturer patient assistance programs.

Some working group members stated that we should not include prescription drugs but instead focus on increasing take up of ADAP and manufacturer copay assistance programs. Others felt that we should do what we can to increase uptake of ADAP; however, it is a safety net program (a payor of last resort) and should not stop the group from including prescription drugs in the \$5 treatment scenario.

### Actuarial Value Analysis

The Work Group considered preliminary analysis of the HIV treatment scenarios using the 2025 AV calculator (AVC). All the plans remained within the de minimis range even with the addition of the HIV equity design (Option 1, HIV with Rx, \$5 copay). However, the 2026 AVC substantially increased the metal AVs for the 2025 plan design. The metal AVs under the final 2026 AVC increased for all metal levels between 0.50% and 1.54% so that all standard plans are now outside of the de minimis range (as shown by the red text) even without reducing copays for services or prescription drugs for those with HIV.

Plan	2025 Final Plan Design		
	2025 Calculator	2026 Calculator	Additive Change
Platinum Plan	91.90%	92.40%	0.50%
Gold Plan	81.95%	82.95%	1.00%
Silver Plan	70.80%	72.32%	1.52%
Bronze Copay Plan	64.74%	66.28%	1.54%

## Impact of the HIV scenario

The impact of the HIV scenario to the metal level AV is small (ranging from 0% additive impact to 0.07%), but all plans are outside of the de minimis range under the final 2026 AV calculator.

HIV scenario with Rx – 2026 AVC					
HIV with Rx					
	2025 Final Plan Design	\$0 Copay for HIV services & RX		\$5 Copay for HIV services & RX	
Plan	2026 Calculator	2026 Metal AV	Additive Change	2026 Metal AV	Additive Change
Platinum Plan	92.40%	92.40%	0.00%	92.40%	0.00%
Gold Plan	82.95%	82.95%	0.00%	82.95%	0.00%
Silver Plan	72.32%	72.33%	0.01%	72.33%	0.01%
Bronze Copay Plan	66.28%	66.35%	0.07%	66.35%	0.07%

The HIV scenario without Rx shows no discernable change in Metal AV but is still outside the de minimis range for all plans under the final 2026 AV calculator.

HIV without Rx					
	2025 Final Plan Design	\$0 Copay for HIV services & no RX		\$5 Copay for HIV services & no RX	
Plan	2026 Calculator	2026 Metal AV	Additive Change	2026 Metal AV	Additive Change
Platinum Plan	92.40%	92.40%	0.00%	92.40%	0.00%
Gold Plan	82.95%	82.95%	0.00%	82.95%	0.00%
Silver Plan	72.32%	72.32%	0.00%	72.32%	0.00%
Bronze Copay Plan	66.28%	66.28%	0.00%	66.28%	0.00%

Since Working Group members were divided on whether to include or exclude prescription drugs, HBX staff added a third option in an attempt to find a consensus. Option 3 is a \$0 copay option with copays eliminated for the services and lab tests and generic drugs only (i.e., this HIV scenario excludes brand ARVs from the equity benefit design).

In addition, based on carriers' suggestion that potentially qualifying enrollees should seek assistance from ADAP and other patient assistance programs, language also was added to reflect this outreach commitment from carriers.

Options	Description	Copay for specified services and Rx		Other
		Services and Labs	Prescription drugs	
<b>Option 1</b>	HIV scenario with Rx	\$5 copay	\$5 copay for prescription drugs in all ARV drug classes; within each ARV drug class, the drugs selected for formulary coverage are at the carrier's discretion.	
<b>Option 2</b>	HIV scenario without Rx	\$5 copay	No Rx copay reduction for people with HIV diagnoses; standard plan copays for Rx apply.	<u>Outreach</u> : Carriers undertake outreach activities to inform enrollees about the availability of copay assistance programs such as the Ryan White/AIDS Drug Assistance programs and manufacturer copay assistance programs.
<b>Option 3</b>	HIV scenario with generic Rx only	\$0 copay	\$0 copay for generic prescription drugs in all ARV classes; within each drug class, the generic drugs selected for formulary coverage are at the carrier's discretion.	<u>Outreach</u> : Carriers undertake outreach activities to inform enrollees about the availability of copay assistance programs such as the Ryan White/AIDS Drug Assistance programs and manufacturer copay assistance programs.

### Cost offsets necessary for AVs to fall within the de minimis range

The consulting actuaries from Oliver Wyman produced alternative cost offsets to get the AVs within the de minimis range. The actuaries modified the standard plan cost sharing as needed at each metal level to get the 2025 plan designs within the de minimis range under the 2026 AV Calculator. Two types of offsets were considered: (1) one relied mostly on increases to the Maximum Out of Pocket (MOOP), (2) another approach increased copayments across a range of services (e.g., x-rays, therapies, generic drugs, emergency room). These options are shown in the table below.

Plan	Scenario	2026 Final AV Calculator
Platinum	Current 2025 Plan	92.40%
	Increase MOOP from \$2,100 to \$2,450 (+\$350)	91.81%
	Increase OP surgery copay from \$0 to \$50 and decrease OP facility fee from \$250 to \$200	91.68%
Gold	Current 2025 Plan	82.95%
	Increase MOOP from \$6,050 to \$7,050 (+\$1,000)	81.83%
	Increase X-Ray Copays \$5 + Increase PCP, MH/SA, Specialist, ST/OT/PT, Lab Copays \$10 + Increase ER, Imaging Copays \$50	81.82%
Silver	Current 2025 Plan	72.32%
	Increase MOOP from \$8,850 to \$9,200 (+\$350)	71.85%
	Increase Rx generic copay from \$20 to \$25 (+\$5)	71.82%
Bronze Copay	Current 2025 Plan	66.28%
	Increase MOOP from \$9,150 to \$10,150 (+\$1,000) + Increase Rx deductible from \$850 to \$1,050 (+\$200)	64.82%
	Increase Rx Deductible from \$850 to \$950 (+\$100) + Increase PCP, MH/SA Copays \$15 + Increase Specialist Copay \$10 + Increase Rx Generic Copay \$5	64.85%

HBX staff determined that increases to MOOP were likely to affect a smaller subset of enrollees and the group opted for the cost offsets that relied on increases to MOOP. As shown in the table below, there is almost no difference between the AVs across the various HIV design options under consideration. At the Bronze copay plan there is a difference of 0.07% between the AV for Option 1 (the HIV scenario including prescription drugs) and the AVs for Option 1 and 2 (which exclude all drugs or include only generics). The cost offsets are the same across the options.

Recommended Standard Plan Design 2026 – AV and cost offsets for 3 Options			
Plan	Scenario	Option 1	Options 2 and 3
Platinum	Current 2025 Plan	92.40%	92.40%
	Increase OP surgery copay from \$0 to \$50 and decrease OP facility fee from \$250 to \$200 <b>(no net change)</b>	91.68%	91.68%
Gold	Current 2025 Plan	82.95%	82.95%
	Increase MOOP from \$6,050 to \$6,950 <b>(+\$900)</b>	81.94%	81.94%
Silver	Current 2025 Plan	72.33%	72.32%
	Increase MOOP from \$8,850 to \$9,150 <b>(+\$300)</b>	71.93%	71.92%
Bronze Copay	Current 2025 Plan	66.35%	66.28%
	Increase MOOP from \$9,150 to \$10,150 <b>(+\$1,000)</b> + Increase Rx deductible from \$850 to \$1,000 <b>(+\$150)</b>	64.96%	64.88%

The AVs and cost offsets are shown in the recommended PY 2026 standard plan grid (see Table 1 below, starting on page 13).

### **Vote and discussion**

The group proceeded to a vote on option 3. Seven voting members were present at the final meeting, including representatives from each of the three carriers. Rather than taking an individual voice vote, members were asked to state whether they opposed recommending option 3. One insurance carrier, Kaiser Permanente, opposed option 3. The other SPWG members endorsed option 3 during the discussion. As a result, the recommended PY2026 standard plan design is a non-consensus recommendation for option 3.

#### *Discussion During the Final Vote Regarding Evaluation of Equity Based-Benefit Design*

During the final vote and discussion, all 3 insurance carriers stated that the implementation of the equity designs should be paused to allow for an evaluation of the approved designs – for Type 2 diabetes, pediatric mental health, and cardiovascular/cerebrovascular disease – to determine whether the equity designs are helping to reduce barriers to access and narrowing racial, ethnic, and other disparities.

- Nikki Blake (CareFirst): We have no objections to option 3, but we did want to be on the record to say that we encourage the working group to pause. We've had several value-based, equity-based insurance designs over the past several years. And we know it's a charge from the social justice health disparities working group, but we haven't as a work group done any evaluation or looked at any metrics for how these designs are performing. As others have mentioned, these have impacts to all our members. As we think about the cost of care going up, we want to ensure that, as we consider these designs in the future, they're making a difference in the populations that we wish to serve. In speaking with the data/research folks here, I know evaluation takes time and diabetes VBID is only one we would begin to see anything from. Also, we would appreciate evaluation to function with a working group and so people can bounce ideas off each other and ensure data is being collected in a uniform way.
- Allison Mangiaracino (Kaiser Permanente): I want to express our support for further study before moving forward with any additional cost sharing changes based on chronic condition. We think it's important to establish an evidence basis for this approach. I think it's important, when this evaluation is conducted, that we use the same methodology across carriers. I would encourage working with an outside researcher. I think University of Michigan VBID Center, would have some ideas on how to do this, due to sample sizes in the small population, I think it would need to be a study conducted in a way that we would contribute data but would use the same methodology across carriers, as opposed to us conducting our own review of the data. I think that would be the appropriate way to tackle this.

- Keith Blecher (United HealthCare): I would echo the previous comments made around maybe taking a step back and taking a look to ensure that we're achieving the overall intention of the working group.
- The Chair asked if someone could provide some background on evaluation of equity-based benefit design. Purvee Kempf, Deputy Executive Director of HBX provided some background on the evaluation efforts: When the Board approved the social justice working group recommendations, we had a conversation about the importance of evaluation, but there was no agreement on the specifics. There was language in the Board Resolution that health plans are encouraged to evaluate impact of design changes on enrolled population. Then, at beginning of this year, we did engage consultants, a clinician and a researcher, to begin more technical conversations with the carriers to see what data could be collected and what kind of evaluation is possible. Those conversations with the carriers in some cases are still ongoing but it has been hard. We're also trying to see if there may be another research pathway that we can work on.
- Cheryl Fish-Parcham (Families USA): I support looking at the impact that these designs have, and I support option three, but I also want to make sure that we do move forward with looking at mental health for adults and substance use care as we had resolved earlier to do. I would like the report to reflect that we seek input on a clinical scenario and cost sharing and other barriers from the D.C. Behavioral Health Association or comparable nonprofit, and from the D.C. Department of Behavioral Health, and from a provider who specializes in substance use treatment.

### *Discussion of an adult mental health equity benefit*

At the start of the working group meetings in September of this year, HBX staff asked Whitman Walker Institute (WWI) to develop two treatment scenarios: one for HIV and one for adult mental health services. The adult mental health scenario would align with the benefit design adopted for pediatric mental services implemented for Plan Year 2024. A recommended treatment scenario was presented to the working group and can be found in the [report](#) on adult mental health prepared by WWI.

The workgroup initially considered whether to pursue both conditions for PY2026, but the group decided to defer discussion of adult mental health until after the release of the 2026 AV calculator. Preliminary AV analysis (using the 2025 AV calculator) of a benefit design that included adult mental health scenario at \$5 copay (to align with the pediatric mental health benefit design) revealed that it would be challenging to address adult mental health in addition to HIV due to the impact on the AC. An analysis of the adult mental health scenario using the 2026 AV calculator is shown in the table below. All plans fall well outside of the de minimis range under the final 2026 AV calculator without any changes. The additive change of adding Adult Mental Health scenario by plan ranges from 0.25% for the Platinum plan to 1.33% for the Bronze Copay plan. [These additive changes are similar to the results from the 2025 AV calculator].

Adult Mental Health Plan	2025 Final Plan Design	\$5 Copay for Adult MH Scenario	
	2026 Calculator	2026 Metal AV	Additive Change
Platinum Plan	92.40%	92.65%	0.25%
Gold Plan	82.95%	83.45%	0.50%
Silver Plan	72.32%	73.32%	1.00%
Bronze Copay Plan	66.28%	67.61%	1.33%

Because of the sizable increase in the AVs for the current 2025 design moving to the 2026 AVC and the additive impact of the adult mental health treatment scenario, the group decided to defer the discussion of adult mental health until we reconvene to make recommendations for the PY2027 standard plan design. The group needs more time to review the mental health scenario and understand the options and potential consequences of adopting the benefit design. We will also seek additional input from experts and clinicians.

### Recommendation

The plan year 2026 standard plan design is as follows in the grid below. (Table 1)

The 2026 benefit design includes the previously approved equity designs for Type 2 Diabetes, Pediatric Mental Health, and Cardiovascular/Cerebrovascular Disease, and adds the equity benefit design for people with HIV: no copay for selected services, laboratory tests, and generic antiretroviral medications in HIV drug classes. The HIV diagnosis codes, treatment codes (CPT codes), and drug classes are listed in tables 2-4 below.

As in past years, HBX acknowledges that the implementation of the equity design in standard plan design assumes: (1) Implementation Flexibility: HBX made assurances to work collaboratively with carriers as they develop these plans should they encounter additional operational challenges, and (2) Compliance with Federal and State Laws. The policy is premised on compliance with applicable federal and state laws. HBX will work with carriers to ensure compliance.

**Table 1. Recommendation: DC Health Benefit Exchange, Standard Plans, PY2026**

Recommendation: DC Health Benefit Exchange, Standard Plans, PY2026		Platinum		Gold		Silver		Bronze Copay	
Actuarial Value		91.68%		81.94%		71.92%		64.88%	
Individual Overall Deductible		\$0		\$500		\$5,200		\$8,350	
<b>Other Individual Deductibles for Specific Services</b>									
Medical		\$0		\$500		\$4,850		\$7,500	
Prescription Drugs		\$0		\$0		\$350		\$1,000	
Dental		\$0		\$0		\$0		\$0	
Individual Out-of-Pocket Maximum		\$2,100		\$6,950		\$9,150		\$10,150	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health Care Provider's Office or Clinic visit*	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$20		\$25		\$40		\$45	
	Specialist visit	\$40		\$50		\$80		\$105	
	Preventive care/screening/immunization	\$0		\$0		\$0		\$0	
Tests	Laboratory tests**	\$20		\$30		\$60		\$55	X
	X-rays and diagnostic imaging	\$40		\$50		\$80		\$80	X
	Imaging (CT/PET scans, MRIs)	\$150		\$250		\$400		\$500	X
Drugs to treat Illness or Condition***	Generic	\$5		\$15		\$20		\$25	
	Preferred brand	\$15		\$50		\$50	X	\$75	X
	Non-preferred Brand	\$25		\$70		\$70	X	\$100	X
	Specialty	\$100		\$150		\$150	X	\$150	X
Outpatient Surgery	Facility fee (e.g. hospital room)	\$200		\$375		20%	X	40%	X
	Physician/Surgeon fee	\$50		\$125		20%	X	40%	X

Recommendation: DC Health Benefit Exchange, Standard Plans, PY2026		Platinum		Gold		Silver		Bronze Copay		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	\$75		\$75		20%	X	40%	X	
Need Immediate Attention	Emergency room services (waived if admitted)	\$150		\$300		\$400	X	40%	X	
	Emergency medical transportation	\$150		\$300		\$400	X	40%	X	
	Urgent Care	\$40		\$60		\$90		\$100		
Hospital Stay	Facility fee (e.g. hospital room)	\$250 per day up to 5 days		\$600 per day up to 5 days	X	20%	X	40%	X	
	Physician/surgeon fee	\$0		\$0	X	20%	X	40%	X	
Mental/Behavioral Health	M/B office visits	\$20		\$25		\$40		\$45		
	M/B outpatient services	\$20		\$25		\$0		\$0		
	M/B inpatient services	Hospital	\$250 per day up to 5 days		\$600 per day up to 5 days	X	20%	X	40%	X
		Professional	\$0		\$0	X	20%	X	40%	X
Substance Abuse needs	Substance abuse disorder office visits	\$20		\$25		\$40		\$45		
	Substance abuse disorder outpatient services	\$20		\$25		\$0		\$0		
	Substance abuse disorder inpatient services	Hospital	\$250 per day up to 5 days		\$600 per day up to 5 days	X	20%	X	40%	X
		Professional	\$0		\$0	X	20%	X	40%	X
Pregnancy	Prenatal care and preconception services	\$0		\$0		\$0		\$0		
	Delivery and all inpatient services	Hospital	\$250 per day up to 5 days		\$600 per day up to 5 days	X	20%	X	40%	X
		Professional	\$0		\$0	X	20%	X	40%	X

Recommendation: DC Health Benefit Exchange, Standard Plans, PY2026			Platinum		Gold		Silver		Bronze Copay	
Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Help recovering or other special health needs	Home health care		\$20		\$30		\$50		\$50	X
	Outpatient rehabilitation services		\$20		\$30		\$65		\$50	X
	Outpatient habilitation services		\$20		\$30		\$65		\$50	X
	Skilled nursing care		\$150 per day up to 5 days		\$300 per day up to 5 days		20%	X	40%	X
	Durable medical equipment		10%		20%		20%		40%	X
	Hospice services		\$0		\$0		\$0		40%	X
Child eye care	Eye exam		\$0		\$0		\$0		\$50	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		\$0		\$0		\$0		\$0	
Child Dental Diagnostic and Preventive	Oral Exam		\$0		\$0		\$0		\$0	
	Preventive – cleaning		\$0		\$0		\$0		\$0	
	Preventive-x-ray		\$0		\$0		\$0		\$0	
	Sealants per tooth		\$0		\$0		\$0		\$0	
	Topical fluoride application		\$0		\$0		\$0		\$0	
	Space Maintainers – Fixed		\$0		\$0		\$0		\$0	

Recommendation: DC Health Benefit Exchange, Standard Plans, PY2026			Platinum		Gold		Silver		Bronze Copay	
Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Child Dental Basic Services	Amalgam Fill – 1 surface		\$25		\$25		\$25		\$41	
Child Dental Major Services	Root canal – molar		\$300		\$300		\$300		\$512	
	Gingivectomy per Quad		\$150		\$150		\$150		\$279	
	Extraction – single tooth exposed root		\$65		\$65		\$65		\$69	
	Extraction – complete bony		\$160		\$160		\$160		\$241	
	Porcelain with Metal Crown		\$300		\$300		\$300		\$523	
Child Orthodontics	Medically necessary orthodontics		\$1,000		\$1,000		\$1,000		\$3,422	

\*PCP visits dilated retinal exam (1x per year), diabetic foot exam (1x per year), and nutritional counseling visits (unlimited) with a primary diagnosis of Type 2 diabetes are provided with no cost-sharing.

\*\*For a person with a primary diagnosis of Type 2 diabetes, the following lab services are provided with no cost-sharing:

- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)

\*\*\* A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, select drug classes, select agents within the drug class and a select list of hypertensive medications within the drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.

\*\*\*\*Copay may not apply in a staff model HMO setting

\*\*\*\*\* Treatment of mental health conditions for children 18 and under will be provided with \$5 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

\*\*\*\*\*Treatment of cardiovascular and cerebrovascular disease will be provided with \$0 cost-sharing as reflected in the Appendix of the Whitman Walker report on "Evaluating Coverage Needs for Cardiovascular and Cerebrovascular Disease Among Communities of Color in the District of Columbia."

**Treatment for people living with HIV provided at \$0 cost sharing for services, laboratory tests, and generic prescription drugs as reflected in the HIV treatment scenario.**

## **HIV Treatment Scenario**

Starting in PY 2026, the services and laboratory tests listed in Table 2 are provided with no copay for claims submitted by any provider for a person with HIV as reflected by a diagnosis code on the claim (diagnosis codes listed in Table 4). Generic prescription drugs in the HIV drug classes listed in Table 3 are provided with no cost sharing. Carriers maintain the flexibility to determine which drugs are on formulary.

**Table 2. Recommendation: HIV Services covered with no copay**

CPT Code	DESCRIPTION	Service Type	Primary Diagnosis	Age	Annual Service Limit, if any, for reduced cost share	Member Cost Share
98960	Nonphysician education/counseling one on one- 30 mins	Primary care	HIV	No age restriction	None	\$0
99202	Evaluation and management of new patient (15-29 mins)	Primary care	HIV	No age restriction	None	\$0
99203	Evaluation and management of new patient (30-44 mins)	Primary care	HIV	No age restriction	None	\$0
99204	Evaluation and management of new patient (45-59 mins)	Primary care	HIV	No age restriction	None	\$0
99205	Evaluation and management of new patient (60-74 mins)	Primary care	HIV	No age restriction	None	\$0
99211	Established patient visit, physician not required	Primary care	HIV	No age restriction	None	\$0
99212	Established patient visit (10-19 mins)	Primary care	HIV	No age restriction	None	\$0
99213	Established patient visit (20-29 mins)	Primary care	HIV	No age restriction	None	\$0
99214	Established patient visit (30-39 mins)	Primary care	HIV	No age restriction	None	\$0
99215	Established patient visit (40-54 mins)	Primary care	HIV	No age restriction	None	\$0
99242	Consultation with new or established patient (at least 20 mins)	Primary care	HIV	No age restriction	None	\$0
99243	Consultation with new or established patient (at least 30 mins)	Primary care	HIV	No age restriction	None	\$0
99244	Consultation with new or established patient (at least 40 mins)	Primary care	HIV	No age restriction	None	\$0
99245	Consultation with new or established patient (at least 55 mins)	Primary care	HIV	No age restriction	None	\$0
99381	Initial comprehensive preventive medicine service evaluation and management < 1 year of age (new patient)	Primary care	HIV	No age restriction	None	\$0
99382	Initial comprehensive preventive medicine service evaluation and management 1-4 years of age (new patient)	Primary care	HIV	No age restriction	None	\$0
99383	Initial comprehensive preventive medicine service evaluation and management 5-11 years of age (new patient)	Primary care	HIV	No age restriction	None	\$0
99384	Initial comprehensive preventive medicine service evaluation and management 12-17 years of age (new patient)	Primary care	HIV	No age restriction	None	\$0
99385	Initial comprehensive preventive medicine service evaluation and management 18–39 years of age (new patient)	Primary care	HIV	No age restriction	None	\$0
99386	Initial comprehensive preventive medicine service evaluation and management 40–64 years of age (new patient)	Primary care	HIV	No age restriction	None	\$0
99387	Initial comprehensive preventive medicine service evaluation and management 65+ years of age (new patient)	Primary care	HIV	No age restriction	None	\$0
99391	Periodic comprehensive preventive medicine reevaluation and management < 1 year of age (established patient)	Primary care	HIV	No age restriction	None	\$0
99392	Periodic comprehensive preventive medicine reevaluation and management 1–4 years of age (established patient)	Primary care	HIV	No age restriction	None	\$0
99393	Periodic comprehensive preventive medicine reevaluation and management 5–11 years of age (established patient)	Primary care	HIV	No age restriction	None	\$0
99394	Periodic comprehensive preventive medicine reevaluation and management 12–17 years of age (established patient)	Primary care	HIV	No age restriction	None	\$0
99395	Periodic comprehensive preventive medicine reevaluation and management 18–39 years of age (established patient)	Primary care	HIV	No age restriction	None	\$0

**Table 2. Recommendation: HIV Services covered with no copay**

CPT Code	DESCRIPTION	Service Type	Primary Diagnosis	Age	Annual Service Limit, if any, for reduced cost share	Member Cost Share
99396	Periodic comprehensive preventive medicine reevaluation and management 40–64 years of age (established patient)	Primary care	HIV	No age restriction	None	\$0
99397	Periodic comprehensive preventive medicine reevaluation and management 65+ years of age (established patient)	Primary care	HIV	No age restriction	None	\$0
99401	15 min counseling session	Primary care	HIV	No age restriction	None	\$0
99402	30 min counseling session	Primary care	HIV	No age restriction	None	\$0
99403	45 min counseling session	Primary care	HIV	No age restriction	None	\$0
99404	60 min counseling session	Primary care	HIV	No age restriction	None	\$0
99441	Evaluation and management via telephone (5-10 mins)	Primary care	HIV	No age restriction	None	\$0
99442	Evaluation and management via telephone (11-20 mins)	Primary care	HIV	No age restriction	None	\$0
99443	Evaluation and management via telephone (21-30 mins)	Primary care	HIV	No age restriction	None	\$0
36415	Collection of venous blood by venipuncture	Laboratory tests	HIV	No age restriction	None	\$0
36416	Collection of blood by finger prick	Laboratory tests	HIV	No age restriction	None	\$0
80053	Comprehensive Metabolic Panel	Laboratory tests	HIV	No age restriction	None	\$0
80061	Lipid Panel	Laboratory tests	HIV	No age restriction	None	\$0
85004	Blood count automated differential white blood cell (WBC) count	Laboratory tests	HIV	No age restriction	None	\$0
85032	Manual cell count (erythrocyte, leukocyte, or platelet) each	Laboratory tests	HIV	No age restriction	None	\$0
85049	Platelet, automated	Laboratory tests	HIV	No age restriction	None	\$0
87536	Test viral load	Laboratory tests	HIV	No age restriction	None	\$0
0219U	Sentosa® SQ HIV–1 Genotyping Assay by Vela Diagnostics USA Inc	Laboratory tests	HIV	No age restriction	None	\$0
80081	obstetric panel, including HIV-1 antigens and antibodies for HIV-1 and HIV-2	Laboratory tests	HIV	No age restriction	None	\$0
86359	test to measure the number of T cells, typically in a blood specimen	Laboratory tests	HIV	No age restriction	None	\$0
86360	test to measure CD4 and CD8 cells	Laboratory tests	HIV	No age restriction	None	\$0

**Table 2. Recommendation: HIV Services covered with no copay**

CPT Code	DESCRIPTION	Service Type	Primary Diagnosis	Age	Annual Service Limit, if any, for reduced cost share	Member Cost Share
86361	absolute CD4 cell count test	Laboratory tests	HIV	No age restriction	None	\$0
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g, Western Blot)	Laboratory tests	HIV	No age restriction	None	\$0
86701	Antibody; HIV-1	Laboratory tests	HIV	No age restriction	None	\$0
86702	Antibody; HIV-2	Laboratory tests	HIV	No age restriction	None	\$0
86703	Antibody; HIV-1 and HIV-2, single assay	Laboratory tests	HIV	No age restriction	None	\$0
87389	test to screen for human immunodeficiency virus, called HIV	Laboratory tests	HIV	No age restriction	None	\$0
87390	test to detect antigens of the human immunodeficiency virus 1, called HIV 1, using an immunoassay technique, such as EIA.	Laboratory tests	HIV	No age restriction	None	\$0
87391	test to detect antigens of the human immunodeficiency virus 2, called HIV 2, using an immunoassay technique, such as EIA.	Laboratory tests	HIV	No age restriction	None	\$0
87534	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique	Laboratory tests	HIV	No age restriction	None	\$0
87535	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique	Laboratory tests	HIV	No age restriction	None	\$0
87538	tests a patient's specimen to provide a definitive diagnosis of HIV-2 by amplified probe technique.	Laboratory tests	HIV	No age restriction	None	\$0
87806	tests to identify the presence of HIV type 1 or type 2 strain in the patient's blood.	Laboratory tests	HIV	No age restriction	None	\$0
87901	technical lab test to analyze the patient specimen, typically serum, for the reverse transcriptase and protease regions of the specific genotype of the virus causing the patient's HIV 1 infection.	Laboratory tests	HIV	No age restriction	None	\$0
87903	technical lab test to analyze the nucleic acids from a sample of tissue from an HIV 1 positive patient to determine drug resistance through culture analysis for up to the first 10 drugs tested.	Laboratory tests	HIV	No age restriction	None	\$0
87904	technical lab test to analyze the nucleic acids from a sample of tissue from an HIV 1-positive patient to determine drug resistance through culture analysis.	Laboratory tests	HIV	No age restriction	None	\$0
87906	technical lab test to analyze the genotype of an HIV 1 virus by nucleic acid for regions other than the reverse transcriptase and protease regions, for example, the integrase gene or fusion gene.	Laboratory tests	HIV	No age restriction	None	\$0
87900	Resistance test (HIV genotype)	Laboratory tests	HIV	No age restriction	None	\$0
81381	HLA B*5701 (Abacavir hypersensitivity test)	Laboratory tests	HIV	No age restriction	None	\$0

**Table 3. Recommendation: HIV Prescription Drugs covered with no copay: generic drugs in HIV drug classes**

<b>Condition</b>	<b>MEDICATION CLASS/GROUP</b>	<b>Rx Coverage Design Type</b>	<b>Age Limit</b>	<b>Member Cost Share</b>
HIV	Nucleoside Reverse Transcriptase Inhibitors	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	Non-Nucleoside Reverse Transcriptase Inhibitors	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	Protease Inhibitors	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	Fusion Inhibitors	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	CCR5 Antagonists	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	Integrase Strand Transfer Inhibitor	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	Attachment Inhibitors	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	Post-Attachment Inhibitors	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	Capsid Inhibitors	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0
HIV	Pharmacokinetic Enhancers	Class (Carrier flexibility to select drugs for formulary coverage)	None	\$0

**Table 4. Recommendation: HIV diagnosis codes**

<b>ICD-10 Code</b>	<b>Code Description</b>
B20	HIV disease
B97.35	HIV, type 2
O98.71	HIV complicated pregnancy (non-billable code)
O98.711	HIV complicating pregnancy, 1st trimester
O98.712	HIV complicating pregnancy, 2nd trimester
O98.713	HIV complicating pregnancy, 3rd trimester
O98.719	HIV complicating pregnancy, unspecified trimester
O90.72	HIV complicating childbirth
O98.73	HIV complicating the puerperium
Z21	Asymptomatic human immunodeficiency virus HIV infection status

## SPWG Members, Consultants, Technical Advisors, and Staff

HBX is grateful for the engagement of all who participated in these working group meetings. A special note of thanks to the consultants who provided expert analysis and insights to support the group's discussions: Mary Adomshick and Peter Scharl of Oliver Wyman and Lienna Feleke-Eshete of the Whitman Walker Institute.

<b>Name</b>	<b>Organization</b>
Claire Heyison	SPWG Chair
Dock Winston	SPWG Vice Chair
Keith Lake	America's Health Insurance Plans
Yulondra Barlow	CareFirst BlueCross BlueShield
Nikki Blake	CareFirst BlueCross BlueShield
Cory Bream	CareFirst BlueCross BlueShield
Jason Neimiller	CareFirst BlueCross BlueShield
Peter Orlaskey	CareFirst BlueCross BlueShield
Greg Sucher	CareFirst BlueCross BlueShield
Kelly Vayda	CareFirst BlueCross BlueShield
Cheryl Parcham	Families USA
Stephen Chuang	Kaiser Permanente
Ky Le	Kaiser Permanente
Allison Mangiaracino	Kaiser Permanente
Sam Ongwen	Kaiser Permanente
Kakia Prasad	Kaiser Permanente
Samantha Saad	Kaiser Permanente
Janice Davis	The Living Capital Group
Daniel Akier	UnitedHealthcare
Keith Blecher	UnitedHealthcare
Ryan Radcliff	UnitedHealthcare
Michelle Raymond	UnitedHealthcare
Andre Beard	HBX
Purvee Kempf	HBX
O'Brien	HBX
MaryBeth Senkewicz	HBX
Howard Liebers	DC-DISB
Mary Adomshick	Oliver Wyman
Peter Scharl	Oliver Wyman
Lienna Feleke-Eshete	Whitman-Walker Institute
Kellan Baker	Whitman-Walker Institute



November 14, 2024

**Addendum to the  
Recommendations of the Standard Plans Advisory Working Group  
to the District of Columbia Health Benefit Exchange Authority**

This addendum is attached to the report submitted by the Standard Plans Advisory Working Group (SPWG), Claire Heyison, Chair and Dock Winston, MD, Vice Chair to modify the standard benefit plan design for Plan Year 2026.

**Background**

The report to which this addendum is attached describes the SPWG's recommendations for the standard plan design for the Platinum, Gold, Silver, and Bronze copay plans for PY 2026 that includes a new equity design that eliminates copays for services and generic prescription drugs used by people with Human Immunodeficiency Virus (HIV).

HSA plans must have all costs, excluding preventive services, accumulate to a deductible before any change in cost sharing. As a result, there is no ability to reduce cost sharing for certain conditions (like HIV) since they all must accumulate to the deductible. For that reason, the equity designs do not apply to the Bronze HSA plan.

Nonetheless, the standard Bronze HSA plan must be updated. This addendum provides the SPWG recommendation for the Bronze HSA plan.

## Recommendation

The AV for the Bronze HSA 2025 plan is outside the de minimis range for 2026 (65.11%). The SPWG voted on a recommended offset – a \$100 increase in MOOP, raising the MOOP from \$7,200 to \$7,300—which brings the AV back within the de minimis range (64.96%). This is the only change to the current 2025 Bronze HSA design.

Plan	Scenario	2026 Final AV Calculator
Bronze HSA	Current 2025 Plan	65.11%
	Increase MOOP from \$7,200 to \$7,300 (+\$100)	64.96%

By an email vote, the SPWG reached consensus to recommend a \$100 increase in the Maximum Out of Pocket (MOOP) for the Bronze HSA plan for PY2026.

The recommended Bronze HSA standard plan is shown in the table below [see the next page].

## SPWG Voting Members

The SPWG voting members who approved this recommendation are:

Name	Organization
Claire Heyison	SPWG Chair
Dock Winston	SPWG Vice Chair
Nikki Blake	CareFirst BlueCross BlueShield
Cheryl Parcham	Families USA
Allison Mangiaracino	Kaiser Permanente
Keith Blecher	UnitedHealthcare
Janice Davis	The Living Capital Group

Recommendation: DC Health Benefit Exchange, Standard Plan, PY2026		Bronze HSA		
Actuarial Value		64.96% [ <del>64.00%</del> ]		
Individual Overall Deductible		\$6,350		
<b>Other Individual Deductibles for Specific Services</b>				
Medical		\$6,350		
Prescription Drugs		Integrated with Medical		
Dental		\$0		
Individual Out-of-Pocket Maximum		\$7,300 [ <del>\$7,200</del> ]		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health Care Provider's Office or Clinic visit*	Primary care visit or non-specialist practitioner visit to treat an injury or illness	20%	X	
	Specialist visit	20%	X	
	Preventive care/screening/immunization	\$0		
Tests	Laboratory tests**	20%	X	
	X-rays and diagnostic imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat Illness or Condition***	Generic	20%	X	
	Preferred brand	20%	X	
	Non-preferred Brand	20%	X	
	Specialty	20%	X	
Outpatient Surgery	Facility fee (e.g. hospital room)	20%	X	
	Physician/Surgeon fee	20%	X	
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X	
Need Immediate Attention	Emergency room services (waived if admitted)	20%	X	
	Emergency medical transportation	20%	X	
	Urgent Care	20%	X	
Hospital Stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental/Behavioral Health	M/B office visits	20%	X	
	M/B outpatient services	20%	X	
	M/B inpatient services	Hospital	20%	X
		Professional	20%	X
Substance Abuse needs	Substance abuse disorder office visits	20%	X	
	Substance abuse disorder outpatient services	20%	X	
	Substance abuse disorder inpatient services	Hospital	20%	X
		Professional	20%	X

Recommendation, DC Health Benefit Exchange, Standard Plan, PY2026		Bronze HSA		
Common Medical Event	Service Type	Member Cost Share		Deductible Applies
Pregnancy	Prenatal care and preconception services		\$0	X
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient rehabilitation services		20%	X
	Outpatient habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice services		20%	X
Child eye care	Eye exam		\$50	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		\$0	
Child Dental Diagnostic and Preventive	Oral Exam		\$0	
	Preventive – cleaning		\$0	
	Preventive- x-ray		\$0	
	Sealants per tooth		\$0	
	Topical fluoride application		\$0	
	Space Maintainers – Fixed		\$0	
Child Dental Basic Services	Amalgam Fill – 1 surface		\$41	
Child Dental Major Services	Root canal – molar		\$512	
	Gingivectomy per Quad		\$279	
	Extraction – single tooth exposed root		\$69	
	Extraction – complete bony		\$241	
	Porcelain with Metal Crown		\$523	
Child Orthodontics	Medically necessary orthodontics		\$3,422	