November 9, 2022

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), Dr. Leighton Ku, Chair, and Ms. Jodi Kwarciany, 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 2024, 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].[1] A resolution also was adopted to make standard plans available in the small group market. The relevant recommendation is as follows:

> Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and co-payment, 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 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. For example, for an enrollee with diabetes, heart disease treatment would continue to have cost-sharing. 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.

[1] This recommendation built 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].

- 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 Final Report, pp. 35-36.

In this second year of implementation of the social justice recommendations, the Working Group was charged with making recommendations to modify the standard plan designs (for plan year 2024, in both IVL and SHOP) to eliminate cost sharing for pediatric mental health services. As background, Standard Plans approved for plan year 2023 have the following cost-sharing for mental health office visits and prescription medications:

Standard Plan Mental and Behavioral Health Office Visits Copay for Plan Year 2023

METAL LEVEL	COPAY
Platinum	$20
Gold	$25
Silver	$40
Bronze Copay Plan	$45

RX Copays for 2023 PY Standard Plans

METAL LEVEL	COPAY Generic	COPAY Preferred	COPAY Non-Preferred	COPAY Specialty
Platinum	$5	*$15*	$25	$100
Gold	$15	*$50*	$70	$150
Silver	$15	*$50*	$70	$150
Bronze Copay Plan	$25	*$75*	$100	$150

Since the SJHDWG report did not specify the mental health conditions or ages to which the $0 cost sharing design should apply, much of the SPWG discussion focused on how to define "pediatric mental health services" for the purpose of revising the standard plan benefit designs. Over the course of 9 meetings in the fall of 2022, the SPWG considered treatment scenarios for pediatric mental health for selected common conditions affecting minority pediatric populations, focusing on racial, ethnic, and gender minority youth, based on prevalence in the District.

All of the working group's documents, including meeting notes for the 9 meetings held in the fall of 2022, can be found on the SPWG page on the HBX website.

Discussion

To provide some initial direction for this work, HBX staff consulted with experts at Children's National Hospital, the largest provider of child and adolescent mental and behavioral health services in the District of Columbia, to identify mental and behavioral health conditions that disproportionately affect historically marginalized pediatric populations who both reside in the District and have private health insurance coverage. Additionally, HBX contracted with the Whitman-Walker Institute (WWI) to undertake the analysis necessary to produce clinical treatment scenarios conditions to inform the standard plan benefit design.

Treatment scenarios for 3 conditions

Initially, WWI developed treatment scenarios for three mental health conditions identified by the team at CNH as disproportionately affecting marginalized populations: anxiety, post-traumatic stress disorder, and gender dysphoria. WWI used several strategies to identify the health care services included in a typical course of treatment for each mental health condition, including analysis of publicly available data, review of clinical guidelines (such as those produced by the American Academy of Child and Adolescent Psychiatry), analysis of Electronic Medical Record utilization data, and qualitative interviews with behavioral and medical health providers.

Starting with a treatment scenario for anxiety, the team at WWI specified a scenario that included three service types and prescription medications. No cost sharing would be applied (for claims with any of the 11 ICD-10 codes in the primary, secondary or tertiary position) for:

1. Initial Visit/assessment: up to 1 visit (of the identified procedure codes)
2. Medication management: up to 2 visits (of the identified procedure codes)
3. Mental health therapy: up to 26 visits (of the identified procedure codes).

In addition, no cost sharing would apply to prescriptions for 5 classes of drugs: SSRIs, SNRIs, Cyclic Antidepressants, Anticonvulsants, Anxiolytics, and to one antihistamine commonly used in the treatment of anxiety in children, Hydroxyzine HCI.

During SPWG meetings, members discussed the treatment scenario for anxiety (i.e., whether the scenario represented a "typical" course of treatment) and offered recommendations to:

- Revise the benefit design
    - For example, the original version of the treatment scenario for anxiety in children and adolescents specified visit limits for three distinct categories of service: initial visit/assessment, (2) medication management, (3) mental health follow-up visits. The SPWG discussed the purpose of these distinctions and operational considerations (such as determining whether a visit was a "new" visit or a "follow-up" visit) and identified a problem of overlap in the CPT codes across categories.

- Change [increase or decrease] the maximum number of mental health therapy visits included without cost sharing
    - The Work Group discussed the level of utilization of mental health therapy in a typical course of treatment for pediatric anxiety. Some argued that the typical frequency of

therapy is lower than 26 visits, and that a lower maximum should be considered. Others observed that current utilization might be lower than suggested by evidence-based treatment guidelines because of cost and other barriers. It was also noted that carriers' medical necessity processes should not change and that many children using services would not be expected to reach the $0 cost share therapy visit maximum.

- Revise the drug classes and/or specific prescription medications within classes
    - For example, although members agreed that SSRIs, SNRIs, and Cyclic Antidepressants are evidence-based treatments for anxiety in children, some members raised questions about the inclusion of Anticonvulsants, Anxiolytics, and Hydroxyzine HCl. Limitations on the drugs also were proposed. For example, some proposed allowing carriers some flexibility to determine the drugs within each class to be offered without cost sharing or to offer only generic drugs at no copay.

Throughout the course of meetings and discussions, the Working Group requested several analyses of the impact of the benefit designs on the Actuarial Value Calculation (AVC) by metal level. These analyses can be found on the SPWG webpage, including the initial AV analysis for the anxiety scenario.

Next, WWI also presented a treatment scenario for PTSD. The PTSD scenario, like the anxiety scenario, identified a typical course of treatment, with three service types:

1. Initial Visit/Assessment: up to 3 visits (any of the identified procedure codes)
2. Evaluation and management: up to 4 visits (any of the identified procedure codes)
3. Mental health therapy: up to 20 visits (any of the identified procedure codes).

Two additional prescription drug classes – antihypertensives (e.g., Prazosin) and beta blockers (e.g., Propranolol, HCl) -- were added to the list of drugs included in the anxiety scenario.

Unified treatment scenario

Subsequently, CNH presented a comprehensive analysis of the most prevalent mental health conditions among privately insured children of color in the District of Columbia seen at Children's National Hospital, and shared clinical treatment scenarios (which they developed independently) for 6 of these conditions.

The team at WWI reviewed the CNH scenarios, utilization data, and clinical guidelines, and presented a Unified Treatment Scenario for 6 conditions [32 ICD-10 diagnosis codes]: anxiety, depression, gender dysphoria, post-traumatic stress disorder, conduct disorders, and ADHD. Like the initial anxiety scenario, the Unified Treatment Scenario included visit limits for 3 visit types: (1) up to 2 visits for initial screening/assessment, (2) up to 4 visits for evaluation/monitoring, and (3) up to 20 visits for mental health therapy. It also included a set of prescription drug classes typically prescribed for the treatment of the 6 conditions, and lab work required as a part of that treatment. Specifically, this included prescription drugs which are hormone therapies and the related testing, imaging, and injection procedures for the treatment of gender dysphoria.

The list of prescription medications included in the Unified Treatment Scenario was developed based on analysis of the medications recommended for treatment and used in the treatment of anxiety, PTSD, depression, gender dysphoria, ADHD, and conduct disorders among children 18 years of age and under.

Overarching Comments

The Working Group members were supportive of efforts to reduce racial and ethnic health disparities in pediatric mental health. Members agreed that there is a pediatric mental health crisis nationally and acknowledged the need to close racial and ethnic disparities in child and adolescent mental health. Working group members discussed whether this approach directly addresses the pediatric mental health crisis given the complexity of the problem. Specifically, some members questioned whether cost barriers are a primary cause of racial and ethnic treatment disparities among children with private insurance in the District. Working group members discussed that pediatric mental health treatment gaps are also attributable to provider shortages, the pandemic, stigma, and other structural factors including social determinants of health. Some questioned whether this policy would help individuals and families that are facing the highest cost sharing-related barriers to care. Other Working Group members countered that cost sharing is a barrier to access and that cost sharing reductions are appropriate to include as part of a larger set of strategies to meet growing needs and eliminate disparities. HBX staff noted that the enforcement of network adequacy standards rests with DISB. DISB has convened a workgroup to examine this issue. They issued proposed regulations to address network adequacy with local considerations in mind.

Some members questioned whether the proposal was permissible under the Plan Year 2023 Notice of Benefit and Payment Parameters Final Rule on EHB nondiscrimination policy, with one carrier arguing that differentiating cost sharing on the basis of age and chronic condition risks noncompliance with the rule. [See additional discussion of compliance beginning on Page 9].

Most of the workgroup discussion focused on the specifics of the $0 cost sharing design including the age limit, covered diagnoses, lowering instead of eliminating cost sharing, and the number and type of covered visits.

Age

Workgroup members noted that an age limit for a pediatric mental health benefit design can be set at various ages. A justification could be made for drawing a line age 18, 19, 20, or an older age. Some members made the case for setting the age at 21 or even older, such as 26, since young adults have relatively high unmet needs for mental health services, and many mental health conditions are first diagnosed in late adolescence or early adulthood. Some working group members raised concerns about having any age limit when mental health conditions affect people of all ages, treatment is medically necessary regardless of age, and there may be disparities at these ages as well, suggesting we should consider broadening to all mental health conditions at all ages but narrow where cost sharing is lowered to the silver and bronze level plans. One member also shared concerns that the design would drive member confusion, with the potential to disrupt care and surprise members when they fall outside the age-based criteria for lower cost sharing and must pay the standard cost share.

The group reviewed analysis of the impact on the metal-level AV of setting the maximum age to 19, 20 and 21. The impact of increasing the maximum age ranged from 0.01% to 0.04%, depending on the metal level and copay. Ultimately, however, the group decided to keep the maximum age at 18, and to "save" the AV impact to achieve other goals [as described below].

Diagnoses

The discussion in the SPWG began with a limited set of three diagnoses then expanded to the top ten conditions that Children's National Hospital identified as the most prevalent conditions affecting minority populations treated at Children's, based on data from their health system and patient population. Workgroup members observed that limiting the policy to selected conditions, without strong justification, could seem arbitrary and would exclude some children and adolescents with mental health treatment needs. The workgroup members suggested further expanding the covered diagnoses to include all mental and behavioral health services. [to include all ICD-10 codes in The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (F01-F99)]. This recommendation reflected both concerns about the perceived fairness or arbitrariness of excluding some mental health diagnoses, as well as operational challenges carriers might face if the standard plan design required them to set different cost sharing levels by primary diagnosis for mental health services.

The workgroup also discussed some of the challenges of consumer outreach and education and the potential for confusion, consumer complaints, and impact on providers to identifying certain conditions as primary over others. Working group members discussed how much easier it would be to provide education on this coverage if it included all mental health conditions. A working group member further reflected concern over lower cost sharing for any pediatric mental health condition when the cost sharing for other medical conditions all pose a challenge for enrollees and have disparities.

To address these operational and equity concerns, the group arrived at a consensus decision to expand the scenario to include all mental and behavioral health conditions, with the lower cost share applying only when the condition is the primary diagnosis.

Chapter 5

Mental, Behavioral and Neurodevelopmental disorders (F01-F99)

Includes: disorders of psychological development

Excludes2: symptoms, signs and abnormal clinical laboratory findings, not elsewhere classified (R00-R99)

This chapter contains the following blocks:

F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30-F39	Mood [affective] disorders
F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities
F80-F89	Pervasive and specific developmental disorders
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

Number and type of covered visits

The Unified Treatment Scenario (like the initial anxiety and PTSD scenarios) included visit limits for 3 visit types: (1) initial screening/assessment/referral - up to 2 visits, (2) evaluation/monitoring - up to 4 visits, and (3) mental health therapy - up to 20 visits. A consensus was reached to collapse the three categories and apply the $0 cost sharing to a maximum number of visits across all visit types. Accordingly, the revised Unified scenario set an overall visit limit of 26 visits (for any of the identified

CPT codes). [Note: this overall visit limit is slightly lower than the aggregate visit limit in the anxiety scenario (27 visits) and the PTSD scenario (29 visits)]. Carriers noted that collapsing the scenario to a single service break would address operational concerns about how to count the $0 cost sharing visits and potentially increase cost sharing after the visit limit was reached during the year. Other workgroup members did not raise any objection to this proposed simplification.

Some workgroup members proposed reducing the visit limit so that it aligns more closely with the current utilization of these services. Others noted that current utilization may not align with evidence-based treatment recommendations and needs due to other barriers to care that might be impacting utilization. Visit limits at 12, 16, and 20, for example, were proposed.

However, another strand of the conversation focused on the operational challenges carriers would face counting these visits, determining when the visit limit for lower cost sharing was reached, and switching to the higher usual cost sharing for these services on additional visits. Some suggested eliminating the visit limit for mental health services for children with the selected conditions.

Like the decision to expand the covered diagnoses, the group arrived at a consensus decision to eliminate the cap on visits – largely due to concerns voiced by carriers about the operational challenges of "counting" visits and then switching to a higher copay level when a visit limit for reduced cost sharing is reached. Since utilization tends to fall below the limits under consideration and since carriers will continue to utilize their standard medical management processes, there were no significant concerns with eliminating the limit altogether. The AV analysis showed that eliminating the visit limit had a small effect. For example, in one of the options reviewed – a $10 copay for mental health visits and $0 copay for drugs and labs – raising the visit limit from 26 to unlimited visits increased the metal-level AV for the Gold, Silver, and Bronze plans by .01.

AV Analysis of visit limit options

$10 Copay for All Services (except drug/labs which remain at $0)

Plan	Current Metal AV	*Age 18, 26 Visits*	Age 18, Unlimited Visits
Platinum Plan 2023	89.89%	*89.92%*	89.92%
Gold Plan 2023	81.92%	*82.00%*	82.01%
Silver Plan 2023	71.95%	*72.11%*	72.12%
Bronze Copay Plan 2023	64.91%	*64.98%*	64.99%

Considerations related to cost sharing

Some workgroup members expressed concern about eliminating cost sharing for pediatric mental health services (even for a limited number of visits). One working group member noted that eliminating cost sharing for pediatric mental health services in DC Health Link standard plans could be expected to increase utilization by the privately insured, potentially exacerbating the provider access challenge

already faced by children and adolescents covered by Medicaid in the District, who are even more likely to be low-income children than those served by DC Health Link. It was noted that children served by DC Health Link in DC, MD or VA will not be poor because of Medicaid and CHIP income criteria (above 300% of poverty in DC and MD and 148% of poverty in Virginia). That is, expanding access for mental health services in DC Health Link might make it harder for poor minority children on Medicaid or CHIP to get access. On the other hand, experts at Children's National Hospital noted that there are many reasons that the proposed policy may not result in decreased access for children insured by Medicaid, including other policies being implemented to address the behavioral health crisis and that there are often differences in patient insurance status at various care sites throughout the city.

Some carriers who were concerned about the $0 cost sharing observed that the proposed benefit design changes are likely to have pricing impacts resulting from the increase to the actuarial value of the plans. The standard plans are more expensive than some other DC Health Link plans, and carriers expressed concern that the PY 2024 changes would add upward pressure on premiums for standard plans and potentially drive the populations we hope to benefit from being able to purchase the plan. Although the group primarily considered the impact of changes on AV limits under federal regulations, which had the strongest effects for silver and gold plans, it was noted that the changes would increase costs for all plans and likely increase premium cost.

Based on concerns about eliminating cost sharing, a proposal was offered to reduce cost sharing in standard plans to $10 per visit-- as an alternative to the proposal to eliminate cost sharing. Under this proposal, at least initially, the mental health services copay was set at $10; the copays for all other services including prescription medications and labs remained at $0. Ultimately, a third, middle-ground option –a $5 copay -- also was included for consideration. And, as described below, the differential between the copay for mental health therapy visits and the copay prescription drugs was eliminated.

One carrier expressed concerns that while benefit design is an area we can influence through this workgroup; the benefit design changes may have little impact in addressing the root cause of the mental health crisis. They cautioned that lowering cost share for prescription drugs could have unintended consequences such as overprescribing prescription drugs with serious consequences and more diagnosis, which could result in inaccurate diagnoses and impact on how children think and feel about themselves. They noted that the design also does not impact the prevalence of mental health and highlighted the need for societal changes to occur, including greater access to effective education, safer neighborhoods, better access to healthy food, and more parental education. This carrier stressed the importance of evaluating the impact of the design on utilization of therapy visits/prescription drugs as well as other services over time, and modifying the design as needed.

<u>Prescription drug classes and selected drugs covered</u>

There was discussion of the appropriateness of the drug classes, drugs within those classes, and other selected drugs proposed for $0 cost sharing under the unified treatment scenario. In general, carriers preferred a policy that permitted some flexibility in the implementation of the prescription drug $0 cost sharing. One carrier proposed that $0 cost sharing be applied only to generic drugs within the identified prescription drug classes.

Some carriers noted that it would be challenging to implement $0 cost sharing and to limit that cost sharing to drugs prescribed to children with the selected mental health diagnoses. Diagnosis information is not collected at the point of sale (when a consumer fills a prescription). Carriers indicated they could limit prescription drug cost sharing to enrollees under a particular age limit, but it would be more challenging to limit by diagnosis. Since some of the prescription drugs are used for conditions other than mental health conditions, carriers would likely apply $0 cost sharing to all claims for these drugs for all children and not just those presented by children with the selected mental health disorders. The benefit being it's simpler and easier operationally, but it is also more costly. In the alternative, carriers would need to develop new processes (e.g., to confirm a diagnosis at the point of sale) to limit $0 cost sharing to children with the selected diagnoses. Options suggested included stopping the prescription at the point of sale to identify the diagnosis or charge the normal cost sharing amount and only reduce after the fact as a credit or upon request. Overall, carriers are looking to implement the lower cost sharing without creating additional barriers for enrollees and other working group members agreed with the goal of decreasing barriers, not increasing barriers.

Some questions arose about the medical appropriateness of some of the prescription drugs proposed for inclusion. There was agreement that several of the classes are appropriate for treatment of the selected diagnoses in children (SSRI, SNRIs, Cyclic Antidepressants). However, there was some concern about eliminating cost sharing for benzodiazepines which are addictive and, some contended, not backed by a strong evidence base for the treatment of children. There also were questions about covering hydroxyzine. One carrier noted that substantial literature or guideline support for safe and effective use of hydroxyzine in children and adolescents is lacking and therefore recommended its elimination from the reduced cost sharing scenario.

Some concerns were raised about the inclusion of hormone therapy used in the treatment of gender dysphoria—specifically, that these are not mental health drugs, but hormonal interventions. These may be used as part of a patient's overall treatment plan, but they would not be prescribed by mental health providers. In addition, the vast majority of pediatric patients that would benefit from including these at lower cost sharing will instead be for other non-mental health indications. The Working Group's technical advisors, Dr. Willing and Dr. Baker, discussed the critical nature of hormone treatment as gender affirming care. They stated it is evidence based and serves as the standard of care for the pediatric population and these are appropriate treatments for gender dysphoria if the group is trying to consider barriers for marginalized minority pediatric population.

Ultimately, the list of covered medications was narrowed to address some concerns raised. For example, some classes were narrowed to specific medications, some medications were removed such as Benzodiazepines, a specific Beta Blocker, and Hydroxyzine. In addition, the policy design includes some flexibility for carriers in the implementation of the prescription drug cost sharing. Not all drugs in a class are required to be covered at the lower cost sharing level. Additionally, a carrier is not required to change the drugs that are on the carrier's formulary.

Considerations related to compliance with federal and district law

Several working group members raised concerns that limiting cost-sharing reductions to a specified age group or diagnosis could violate the new essential health benefit discriminatory benefit design standards under 45 C.F.R. 156.125.[1] HBX identified this change in law and developed a Working Group process that would result in recommendations consistent with federal regulations.

First, HBX partnered with two clinical experts on mental and behavioral health, Children's National Hospital, and Whitman-Walker Clinic and Institute, the latter of whom was brought on as a vendor to support this work. Both entities used their clinicians, claims data, clinical guidance and standards of care to design the various treatment scenarios put forth to the working group for consideration.

Second, the early proposals considered by the Working Group identified conditions based on the prevalence of mental and behavioral health conditions amongst communities of color in the District. Later iterations expanded the diagnostic scope to ultimately include all ICD-10 codes with an F identifier (i.e., Mental and behavioral health conditions under the ICD-10 coding system).

Third, related to limiting the lower cost-sharing change to the pediatric community, working group recommendations are based on clinical experts, statements from national mental and behavioral health organizations, clinical guidelines, and other relevant standards around mental and behavioral health. The Social Justice and Health Disparities working group actually first identified the specific need within the pediatric community for improved access to mental health services.[2] Since then, several organizations have repeatedly called out the existence of a mental health crisis in children.[3] Evidence includes the specific benefits of early intervention for mental health conditions[4] and specific treatment guidelines for the pediatric population,[5] and HBX identified other efforts that specifically reduced cost sharing for pediatric populations.[6]

HBX reached out to both District and federal regulators to discuss these proposals and gain a better understanding of how 45 C.F.R. 156.125 is being interpreted by regulators. Federal regulators highlighted a few facts from the final rule: states have primary enforcement authority, examples from the final regulation that illustrated prohibited benefit design such as eliminating benefits based on protected traits and raising cost sharing based on a protected trait, a rebuttable presumption of discrimination can be overcome with clinical evidence, and the final rule rejected a proposal requiring that clinical evidence be "peer-reviewed."

The working group also discussed other laws such as compliance with IRS rules for HSA plans, actuarial value standards, mental health parity, in addition to nondiscrimination. As in prior years with the Standard Plan Working Group, HBX reiterated the proposed changes are subject to compliance with 2024 plan year standards, the 2024 Actuarial Value calculator, the new MOOP, and updates to mental health parity tool. As in prior years, HBX reconfirmed it will work with carriers to maintain compliance as laws change.

The DISB representative directly addressed compliance and stated that they had been in attendance for all working groups meetings and there is no cause for concern over noncompliance with District or federal law or regulations.

[1] "An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Beginning on the earlier of January 1, 2023 (the start of the 2023 plan year) or upon renewal of any plan subject to this rule, a non-discriminatory benefit design that provides EHB is one that is clinically-based." 45 C.F.R. 156.125(a)

[2] 2021 Recommendations of the Social Justice & Health Disparities Working Group to the District of Columbia Health Benefit Exchange, July 12, 2021, available at https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/HBX%20Social%20Justice%20and%20Health%20Disparities%20Working%20Group%20Final%20Report_0.pdf

[3] A declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association, available at https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/; U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID-19 Pandemic, December 7, 2021, available at https://www.hhs.gov/about/news/2021/12/07/us-surgeon-general-issues-advisory-on-youth-mental-health-crisis-further-exposed-by-covid-19-pandemic.html

[3] https://www.apa.org/news/press/op-eds/youth-mental-health-crisis; https://www.apa.org/news/press/op-eds/youth-mental-health-crisis; FACT SHEET: Biden-Harris Administration Announces Two New Actions to Address Youth Mental Health Crisis, July 29, 2022, available at https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/29/fact-sheet-biden-harris-administration-announces-two-new-actions-to-address-youth-mental-health-crisis/; The crisis of Youth Mental Health, National Alliance on Mental Illness, April 2022, available at https://www.nami.org/Blogs/From-the-CEO/April-2022/The-Crisis-of-Youth-Mental-Health; and Joint Letter to President Biden on Children's Mental Health, October 13, 2022, available at https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/behavioral-health/LT-President-ChildrensMentalHealth-101322.pdf .

[4] See e.g., Screening for Anxiety in Children and Adolescents

US Preventive Services Task Force Recommendation Statement. October 11, 2022, available at https://jamanetwork.com/journals/jama/fullarticle/2797219, and Children and Adolescents Mental Health: A Systematic Review of Interaction-Based Interventions in Schools and Communities, Fronters in Psychology, April 24, 2019, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6491840/#:~:text=The%20effects%20of%20the%20mental,improvement%20in%20personal%20well%2Dbeing.

[5] See e.g. Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, May 18, 2020, available at https://www.jaacap.org/article/S0890-8567(20)30280-X/fulltext

[6] US Preventive Services Task Force Recommendations, Anxiety in Children and Adolescents: Screening ,October 11, 2022, available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-anxiety-children-adolescents; and US Preventive Services Task Force Recommendations, Depression and Suicide Risk in Children and Adolescents: Screening, October 11, 2022, available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-children-adolescents.

AV offsets considered: Value-Based Insurance Design and No-Value Care

The group considered Value-Based Insurance Design and No-Value Care and increasing deductibles and the Maximum Out of Pocket limit to bring standard plans that fell outside of the Actuarial Value range for a specific metal level.

The group heard a presentation from Dr. Beth Beaudin-Seilers from the Altarum Institute. Dr. Beaudin-Seilers provided an overview of recent research to identify no value services. She reviewed the process used to arrive at services labeled as no-value services and provided a list of 33 services fitting these criteria.

The Work Group requested an AV analysis from Oliver Wyman of the no-value services presented by Dr. Beaudin-Seilers and the low-value services analyzed by the working group last year. They noted that there was no specific rules or guidance provided as to how many of the no value services should be identified in practice (e.g., list of procedure codes, diagnosis codes, etc.) and that carriers would need to provide additional specification in order to consistently and accurately adjudicate no value services at 100% member cost sharing. Additional time and discussion with clinicians, and other knowledgeable parties, would be needed to determine how it should be applied in practice. For example, some of the recommendations advise against certain procedures for "low-risk" patients, but do not clearly identify who is "low risk" vs "high risk," which would make implementation challenging. They also noted that there are some states (OR, CO, ME) which have studied these types of services and may be able to provide some additional information and/or guidance if needed.

OW provided a "high-level" estimate due to these limitations, and utilizing a prior brief referenced in the study which included cost estimates. They noted the main impact was based on spinal fusion. The high-level estimate showed that moving the 33 no value care services to 100% member coverage, up to the plan's out-of-pocket maximum, would have approximately a -0.20% impact on the Metal AV for the Gold and Silver plans and about a -0.05% impact on the Bronze plan. This is a potentially significant change. However, the Work Group determined that there was not sufficient time to consider this VBID option with specificity. Noting the interest by working group members in decreasing the AV and costs of standard plans, HBX staff stated the working group could reconvene earlier next year to delve into the low and no-value services further.

The group also discussed increasing deductibles or MOOP to offset AV increases outside of the permissible actuarial value ranges for metal levels as suggested by OW. Overall, the working group had consensus around increasing the MOOP as opposed to the deductible recognizing the tradeoff of increasing costs for the sickest versus accessing care at the front end.

Arriving at Final Recommendations

By the 7th meeting and right through the final meeting, the central point of discussion was the cost sharing level to apply. The options varied the copay amount for mental health services between $0 and $10. All options set the maximum age at 18 (i.e., up to the 19th birthday), covering all mental health diagnoses (all codes in Chapter 5 of the ICD-10, the F codes), and including the same list of prescription drug classes and drugs, and related services for the treatment, with unlimited visits.

The group also discussed the decision to apply a higher cost sharing to mental health visits and a lower copay to drugs and labs. Some working group members asserted that the copay should be equal between therapy and prescription drugs, so as to avoid sending a signal or indicating a preference for treatment with prescription medications over therapy services.

Additional analysis was requested to understand the AV impact of unlimited visits with a $0, $5, and $10 copays, with the same copay applied, across the board, for all services and drugs. Ultimately, through

one-on -one conversations between working group members and HBX staff (in advance of the final November 4 meeting), the group coalesced around two options – the $0 and $5 options.

The AV analysis shared for these two options showed that: (1) The $5 copay options raised the AV for the Gold, Silver options out of permissible range, and (2) The $0 copay option raised the AV for the Gold, Silver and Bronze options out of the permissible range.

Oliver Wyman presented two independent options to offset the AV to bring the gold, silver, and bronze plans' metal AV into the necessary range: (1) increases to the deductible or (2) increases to the maximum out-of-pocket (MOOP). They did not provide an option for increasing the deductible for the gold plan as an increase in the deductible increases the metal AV for this plan (counterintuitively) through a quirk with the AV Calculator. OW also did not provide an option for increasing the MOOP for the bronze plan as it is already at the maximum allowable amount in 2023 and the AV Calculator does not allow an input above that amount.

Two Options: $0 Copay and $5 Copay for All Services (including drug and labs), unlimited visits

Plan	Current Metal AV	Age 18, $0 Copay	Age 18, $5 Copay
Platinum Plan 2023	89.89%	89.94%	89.92%
Gold Plan 2023	81.92%	82.05%	82.02%
Silver Plan 2023	71.95%	72.16%	72.14%
Bronze Copay Plan 2023	64.91%	65.01%	65.00%

AV Offsets

	Deductible – Current	Deductible – Adjusted
Silver - $0 Copay	$4,850	$5,175
Silver - $5 Copay	$4,850	$5,150
Bronze - $0 Copay	$7,500	$7,700
	MOOP – Current	**MOOP – Adjusted**
Gold - $0 Copay	$5,800	$5,925
Gold - $5 Copay	$5,800	$5,900
Silver - $0 Copay	$8,850	$9,100
Silver - $5 Copay	$8,850	$9,100

Vote

On Friday, November 4, 2022, the SPWG met to consider the two draft recommendations and vote.

Lacking consensus on the copay level, two votes were held. SPWG members had the option to vote Yes, No, or Abstain on each of the two options of reduced cost sharing of $5 and $0 pre-deductible. There were a substantial majority of votes in favor of reducing cost sharing for the treatment of pediatric mental health conditions.

The two final options were as follows:

OPTION 1 [ATTACHMENT A]

$5 Copay for All Services (including drugs and labs)

Plan	Current Metal AV	Age 18, $5 Copay
Platinum Plan 2023	89.89%	89.92%
Gold Plan 2023	81.92%	81.91%
Silver Plan 2023	71.95%	71.95%
Bronze Copay Plan 2023	64.91%	65.00%

AV Offset

	MOOP – Current	MOOP – Adjusted
Gold - $5 Copay	$5,800	$5,900
Silver - $5 Copay	$8,850	$9,100

OPTION 2 [ATTACHMENT B]

$0 Copay for All Services (including drugs and labs)

Plan	Current Metal AV	Age 18, $0 Copay
Platinum Plan 2023	89.89%	89.94%
Gold Plan 2023	81.92%	81.91%
Silver Plan 2023	71.95%	71.97%
Bronze Copay Plan 2023	64.91%	64.91%

AV Offset

	Deductible – Current	Deductible - Adjusted
Bronze* - $0 Copay	$7,500	$7,700
	MOOP – Current	**MOOP – Adjusted**
Gold - $0 Copay	$5,800	$5,925
Silver - $0 Copay	$8,850	$9,100

*Bronze plan to be changed to increase MOOP, instead of deductible, if 2024 MOOP is extended.

Other Elements of the Proposal

Some other elements of the proposal that were discussed and are important to note.

- **Implementation Flexibility:** HBX made assurances to work collaboratively with carriers as they develop these plans should they encounter additional operational challenges. The flexibility with respect to prescription drugs has been noted.

- **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.

- **Evaluation:** Workgroup members acknowledge the importance of proceeding with this social justice policy goes hand in hand with evaluation on the effects of the lower cost sharing to determine whether it is reducing barriers to access and narrowing racial, ethnic, and other disparities. All committed to evaluation activities in the years ahead to determine effects and whether changes to the policy might be appropriate.

Discussion

At the request of the Chair, in advance of the vote, some participants shared their perspectives on pediatric mental health and the policy under discussion. A few key takeaways are noted here:

- Allison Mangiaracino (Kaiser Permanente): We agree that that healthcare is simply unaffordable for many, and certainly cost sharing has a disproportionate impact on patients of color. But we disagree on the remedy being proposed today. We believe that the pediatric mental health crisis and racial disparities are driven by social determinants of health, provider shortages, and insufficient delivery system reform. Moving to $5 co pays does not address the problem. We've also talked about non-discrimination and we believe this leaves us vulnerable to claims of discrimination. On the AV offsets, in our view, increasing the MOOP will disproportionately impact the sickest enrollees, that includes individuals who have diabetes and cardiovascular disease, HIV, breast cancer, etc. And these are the conditions targeted by the social justice workgroup recommendations. In the long term as we consider these proposals year to year, it is important to remember that these changes aren't neutral and will result in higher cost sharing for others and higher premiums. We believe this will be challenging to implement and challenging to explain to consumers with some surprises when someone falls outside of the criteria. So, for those reasons, we'll be voting no. We appreciate the thoughtful discussion in this workgroup.

- Jennifer Storm (CareFirst BlueCross Blue Shield): We have concerns, similar to Kaiser Permanente, about removing the cost share for these benefits—including the impacts to AV and premiums for rest of our members. The social justice recommendations would have us expand the conditions in the future for which there's lower cost sharing. What is the greatest barrier? It may be the premium, because we've created an additional barrier to purchasing the plan. We don't necessarily agree with the full approach. In voting it is important to have a copay to keep premiums down and we would vote for $5. We still have some internal concerns.

- Keith Blecher (UnitedHealthcare): I think we would directionally be supportive of either $0 or the $5, with a preference probably toward the $5 copay on the drugs and the visits. We're also supportive of removing the visit limits completely. Not having any visit limits, because it just creates operational complexity, and it doesn't really appear to get as much. We talked a lot about barriers to care in regard to copays. But there's a barrier to care from higher premiums, too. So, to help offset these already expensive plans, we would lean toward the $5 copay.

- Paul Speidell (Aetna, A CVS Health Company): I think we feel good about assurances that we've been given from the health benefit exchange staff that anything that goes through and how we

implement things would have to be compliant with all the relevant requirements at the federal level as well as with DC law. I agree that operationally this can be challenging to implement. We're looking at how we can do that, running the numbers through our system, we have concerns about being able to meet the mental health parity requirements at any copay level, but feel better about meeting them at $0. So, we favor the $0 copay approach.

- Howard Leibers (DISB): I've been in all of these meetings, and we've looked at this, and I don't believe there should be any cause for concern over non-compliance with federal or other law or regulations. I think this really comes down to a matter of a pricing and an AV perspective. I don't think that there's a bias.

- Claire McAndrew (Waxman Strategies): First I want to say I'm just very supportive of this direction overall, that we are taking this approach to making these services more accessible and reducing barriers to access that may come from cost sharing. I think for me, personally, I am landing at $5 just because of the MOOP and the deductible considerations and looking at the $200 increase in the bronze spend deductible. The balance is making me feel very comfortable with $5 when we have other things to consider. And I still feel comfortable that that's a massive improvement in access from where we are today with how high the copays are for some of these services and the barriers they place on folks.

Some key take aways from other members of the working group are noted here:

- Jodi Kwarciany (Vice Chair): I'm very pleased with our work here making mental health care more affordable and accessible for children in D.C. – it couldn't come at a more critical time. Understanding how $0 copays may shift other forms of cost-sharing, I most support $5 as I think that strikes the best balance.

- Dave Chandrasekaran (Vote Empowerment Project): The $0 copay is powerful. Any cost sharing is a perceived barrier and the psychological impact of have $0 copay would promote accessing care. I also support unlimited visits limits seeing the limited AV impact. I am open to compromising and am supportive of both $0 and $5 copay in the final vote. Although some think explaining this will be hard, but this is an overcome-able barrier. Education will be critical, and we can partner with the broker community to educate employers and their workers, and we can partner with DC Health.

- Janice Davis (The Living Capital Group): Mental health treatment for children is critical. We should think of it as preventive care because proper care sets you up for life. I'm supportive of these incredible efforts in the District and if we can do $0, we should do that, but I'm also supportive of modest cost sharing. As a broker when you explain to employers that insurers are do things to make it better for consumer, they aren't expecting that, this is a great effort. We are dealing with a pediatric mental health crisis, and we are addressing the issue.

- Cheryl Fish-Parcham (Families USA): I am in favor of the general principle of our efforts. We should increase the age limit for pediatric mental health with low cost-sharing as young adulthood is a common time for greater mental health needs, including the onset of psychosis.

It is also a time of transition for many kids. Families may be facing high college costs, and young people living on their own are likely to have very modest incomes. I don't have strong feelings either way about the copay. I tend to think that a modest copay is not a big barrier to care and keeping a $5 copay lowers the deductible/MOOP damage.

Dr. Leighton Ku, Chair, closed with the following: We recognize that either option will raise the price for everyone and that some challenges lay outside of the boundaries of our work here such as provider shortage and stigma. But with this work, we have substantially reduced the cost sharing for children in this mental health crisis. These non-consensus recommendations will go to the HBX Insurance Market Committee for deliberation and vote and then if successful to the full HBX Executive Board.

The votes were as follows:

Roll Call Vote: The $5 COPAY option, with unlimited visits.

Name	Organization	VOTE
Dr. Leighton Ku	Chair	Y
Jodi Kwarciany	Vice Chair	Y
Keith Blecher	UnitedHealthcare	Y
Dave Chandrasekaran	Voter Empowerment Project	Y
Janice Davis	The Living Capital Group	Y (via staff)
Cheryl Fish-Parcham	Families USA	Y (via staff)
Allison Mangiaracino	Kaiser Permanente	N
Claire McAndrew	Waxman Strategies	Y
Paul Speidell	Aetna, a CVS Health Company	N
Jennifer Storm	CareFirst BlueCross Blue Shield	Y

Roll Call Vote: The $0 COPAY option, with unlimited visits.

Name	Organization	VOTE
Dr. Leighton Ku	Chair	N
Jodi Kwarciany	Vice Chair	Abstain*
Keith Blecher	UnitedHealthcare	Y
Dave Chandrasekaran	Voter Empowerment Project	Y
Janice Davis	The Living Capital Group	Y (via staff)
Cheryl Fish-Parcham	Families USA	Y (via staff)
Allison Mangiaracino	Kaiser Permanente	N
Claire McAndrew	Waxman Strategies	Abstain
Paul Speidell	Aetna, a CVS Health Company	Y
Jennifer Storm	CareFirst BlueCross Blue Shield	N

*Note: During the meeting Ms. Kwarciany cast a Yes vote, but she followed-up with staff within minutes of the meeting to correct her vote to Abstain.

Working Group Members

The Standard Plans Advisory Working Group and supporting advisors include representatives from qualified health plans from both the individual and small group markets, consumer groups, providers, actuaries, and trade associations. The SPWG met 9 times (on September 13, 20, 27; October 4, 11, 18, 25; November 1 and 4) by video conference call. Recommendations were reached over the course of the meetings.

Name	Organization
Dr. Leighton Ku	Chair, HBX Executive Board, George Washington University
Jodi Kwarciany	Vice Chair, HBX Standing Advisory Board, National Alliance on Mental Illness
Keith Blecher	UnitedHealthcare
Dave Chandrasekaran	Voter Empowerment Project, HBX Standing Advisory Board
Alexandra O'Brien/Jennifer Storm	CareFirst BlueCross Blue Shield
Janice Davis	The Living Capital Group
Allison Mangiaracino	Kaiser Permanente
Claire McAndrew	Waxman Strategies, HBX Standing Advisory Board
Cheryl Parcham	Families USA
Paul Speidell	Aetna, a CVS Health Company

Consultants, Technical Advisors, and Staff

Name	Organization
Purvee Kempf	DC Health Benefit Exchange Authority
Jenny Libster	DC Health Benefit Exchange Authority
Ellen O'Brien	DC Health Benefit Exchange Authority
Howard Liebers	DC Department of Insurance, Securities, and Banking
Tonya Kinlow	Children's National Hospital
Dr. Laura Willing	Children's National Hospital
Sarah Hoffman	Children's National Hospital
Alana Aronin	Children's National Hospital
Dr. Kellan Baker	Whitman-Walker Institute
Lienna Feleke-Eshete	Whitman-Walker Institute
Peter Scharl	Oliver Wyman
Kris Hathaway	America's Health Insurance Plans

The Working Group gratefully acknowledges the work of the team from Children's National Hospital, the Whitman-Walker Institute, and Oliver Wyman in support of the working group's deliberations.

ATTACHMENT A

DC HBX STANDARD PLAN WORKING GROUP
$5 COPAY RECOMMENDATION
FOR PEDIATRIC MENTAL HEALTH COST SHARING FOR STANDARD PLANS

1. **Mental Health Services and Medications with Modified Cost Sharing**
   For ALL mental health conditions.
   - Includes all primary diagnosis codes beginning with F (not secondary or lower), see ICD-10 CM online at Comprehensive Listing ICD-10-CM Files (cdc.gov)
   - For visits, we are not differentiating between visit types for initial assessments, medical evaluation and management visits, and follow-up therapy visits. We have CPT codes that correspond to all visit types and all modalities, e.g., telehealth.

2. **Ages Covered**
   Up to 19th birthday, consistent with pediatric ACA services.

3. **Cost-Sharing with AV Offset:**

$5 Copay for All Services (including drugs and labs)

Plan	Current Metal AV	Age 18, $5 Copay
Platinum Plan 2023	89.89%	89.92%
Gold Plan 2023	81.92%	81.91%
Silver Plan 2023	71.95%	71.95%
Bronze Copay Plan 2023	64.91%	65.00%

AV Offset

	MOOP – Current	MOOP – Adjusted
Gold - $5 Copay	$5,800	$5,900
Silver - $5 Copay	$8,850	$9,100

4. **Bronze HSA Plan**
   No modification to Bronze HSA plan (which must comply with federal law).

5. **Compliance with Federal Law**
   All modifications are conditioned on compliance with applicable federal laws. HBX will work with carriers to ensure compliance.

UNIFIED TREATMENT SCENARIO FOR ADDRESSING MENTAL HEALTH CONDITIONS AMONG CHILDREN IN DC

For encounters with All ICD-10 F codes (all mental health conditions) among patients up to 19th birthday:

VISIT TYPES	CPT CODES	SERVICE TYPES	SPECIALTY	DESCRIPTION OF INCLUDED SERVICES
New, Follow up	11981 90835 90836 90837 90838 90839 90840 90846 90847 90853 96127 99202 99203 99204 99205 99211 99212 99213 99214 99215 99244 99245 99354 99355 99442 99443 99484 99492 99493 99494	Primary Care, Mental Health Care	Behavioral Health/Psychiatry; Internal Medicine/Infectious Disease/Family Medicine/Gynecology/Endocrinology	New medical visit; New patient, screening/assessment; Evaluation and management; Psychotherapy crisis; Individual therapy; Family/Group therapy

Related services for gender dysphoria only:

RELATED SERVICES TO BE COVERED WITH $5 COST SHARING		CPT CODE
Laboratory Tests	Testosterone (free and total)	84402, 84403
	Estradiol	82670, 30289
	Hemoglobin and hematocrit (or complete blood count)	85014, 85018, 85025
	Comprehensive metabolic panel	80053
	25 OH-D Vitamin D	82306
	Lipid panel	80061
	Luteinizing hormone and follicle-stimulating hormone	83001, 83002
	Prolactin	84146
Imaging	DEXA scan	77080
	Bone age x-ray	77072
Procedures	Hormone therapy injection	96372

Related to RX for $5 cost sharing (see Addendum for additional information):

Medications (developed based on treatment of most prevalent mental health conditions, but not limited to use with these conditions: anxiety, PTSD, depression, gender dysphoria, ADHD, and conduct disorders among patients 18 years of age and under). When the Coverage Type is listed as Class, there have been no exclusions of drugs within the class. When the Coverage Type is listed as Selected Medication(s), only selected drugs within the class are eligible for reduced cost sharing. Not all drugs in a class are required to be covered at the lower cost sharing level. Additionally, a carrier is not required to change the drugs that are on the carrier's formulary.

MEDICATION CLASS/GROUP	COVERAGE TYPE
SSRIs	Class (Carrier flexibility to select drugs from their formulary)
SNRIs	Class (Carrier flexibility to select drugs from their formulary)
Atypical antidepressants	Class (Carrier flexibility to select drugs from their formulary)
Anti-hypertensives	Selected Medication: Prazosin
Atypical anxiolytics	Class (Carrier flexibility to select drugs from their formulary)
Alpha agonists	Selected Medications: Clonidine, Clonidine ER, Guanfacine, Guanfacine ER
Beta blockers	Selected Medication: Propranolol
Anti-manic agents	Class (Carrier flexibility to select drugs from their formulary)
Stimulants	Class (Carrier flexibility to select drugs from their formulary)
Anti-psychotics	Selected Medications: Quetiapine, Aripiprazole, Brexpiprazole, Lurasidone
GnRH analogs	Class (Carrier flexibility to select drugs from their formulary)
Sex hormones	Class (Carrier flexibility to select drugs from their formulary)
Nonsteroidal anti-androgens	Class (Carrier flexibility to select drugs from their formulary)
5-alpha reductase inhibitors	Class (Carrier flexibility to select drugs from their formulary)

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Platinum Plan ~~2023~~ 2024***

Actuarial Value		89.92 ~~89.89~~%	
Individual Overall Deductible		$0	
Other individual deductibles for specific services			
Medical		$0	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		$2,000	
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	
	Specialist visit	$40	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests**	$20	
	X-rays and diagnostic imaging	$40	
	Imaging (CT/PET scans, MRIs)	$150	
Drugs to treat Illness or Condition***	Generic	$5	
	Preferred brand	$15	
	Non-preferred Brand	$25	
	Specialty	$100	
Outpatient Surgery	Facility fee (e.g. hospital room)	$250	
	Physician/Surgeon fee		
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	$75	
Need Immediate Attention	Emergency room services (waived if admitted)	$150	
	Emergency medical transportation	$150	
	Urgent Care	$40	
Hospital Stay	Facility fee (e.g. hospital room)	$250 per day up to 5 days	
	Physician/surgeon fee		
Mental/Behavioral Health	M/B office visits	$20	
	M/B outpatient services	$20	
	M/B inpatient services	$250 per day up to 5 days	
Health, Substance Abuse needs	Substance abuse disorder office visits	$20	
	Substance abuse disorder outpatient services	$20	
	Substance abuse disorder inpatient services	$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services: Hospital	$250 per day up to 5 days	
	Delivery and all inpatient services: Professional		

*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, 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

	Home health care	$20	
	Outpatient rehabilitation services	$20	
	Outpatient habilitation services	$20	
	Skilled nursing care	$150 per day up to 5 days	
	Durable medical equipment	10%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	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	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** 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.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Gold Plan 2024 ~~2023~~***

Actuarial Value			81.91 ~~81.92~~%	
Individual Overall Deductible			$500	
Other individual deductibles for specific services				
Medical			$500	
Prescription Drugs			$0	
Dental			$0	
Individual Out-of-Pocket Maximum			$5,900 ~~5,800~~	
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		$25	
	Specialist visit		$50	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests**		$30	
	X-rays and diagnostic imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat Illness or Condition***	Generic		$15	
	Preferred brand		$50	
	Non-preferred Brand		$70	
	Specialty		$150	
Outpatient Surgery	Facility fee (e.g. hospital room)		$525	
	Physician/Surgeon fee		$75	
Outpatient Non-Surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic		$75	
Need Immediate Attention	Emergency room services (waived if admitted)		$300	
	Emergency medical transportation		$300	
	Urgent Care		$60	
Hospital Stay	Facility fee (e.g. hospital room)		$600 per day up to 5 days	X
	Physician/surgeon fee			X
Mental/Behavioral Health	M/B office visits		$25	
	M/B outpatient services		$25	
	M/B inpatient services		$600 per day up to 5 days	X
Substance Abuse needs	Substance abuse disorder office visits		$25	
	Substance abuse disorder outpatient services		$25	
	Substance abuse disorder inpatient services		$600 per day up to 5 days	X
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	$600 per day up to 5 days	X
		Professional		X

*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, 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 staff model HMO setting.

Help recovering or other special health needs	Home health care	$30	
	Outpatient rehabilitation services	$30	
	Outpatient habilitation services	$30	
	Skilled nursing care	$300 per day up to 5 days	
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	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	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** 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.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Silver Plan 2024 ~~2023~~ *****

Actuarial Value			71.95%	
Individual Overall Deductible			$5,200	
Other individual deductibles for specific services				
Medical			$ 4,850	
Prescription Drugs			$350	
Dental			$0	
Individual Out-of-Pocket Maximum			$9,100 ~~8,850~~	
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		$40	
	Specialist visit		$80	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests**		$60	
	X-rays and diagnostic imaging		$80	
	Imaging (CT/PET scans, MRIs)		$400	
Drugs to treat Illness or Condition***	Generic		$20	
	Preferred brand		$50	X
	Non-preferred Brand		$70	X
	Specialty		$150	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)		$400	X
	Emergency medical transportation		$400	X
	Urgent Care		$90	
Hospital Stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental/Behavioral Health	M/B office visits		$40	
	M/B outpatient services		$40	
	M/B inpatient services		20%	X
Health, Substance Abuse needs	Substance abuse disorder office visits		$40	
	Substance abuse disorder outpatient services		$40	
	Substance abuse disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X

*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, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.
****Coinsurance may not apply in staff model HMO setting.

Help recovering or other special health needs	Home health care	$50	
	Outpatient rehabilitation services	$65	
	Outpatient habilitation services	$65	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	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	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** 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.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Bronze Copay Plan 2024 ~~2023~~***

Actuarial Value			~~64. 91%~~65.00%	
Individual Overall Deductible			$8,350	
Other individual deductibles for specific services				
Medical			$7,500	
Prescription Drugs			$850	
Dental			$0	
Individual Out-of-Pocket Maximum			$9,100	
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		$45	
	Specialist visit		$105	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests**		$55	X
	X-rays and diagnostic imaging		$80	X
	Imaging (CT/PET scans, MRIs)		$500	X
Drugs to treat Illness or Condition***	Generic		$25	
	Preferred brand		$75	X
	Non-preferred Brand		$100	X
	Specialty		$150	X
Outpatient Surgery	Facility fee (e.g. hospital room)		40%	X
	Physician/Surgeon fee		40%	X
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic		40%	X
Need Immediate Attention	Emergency room services		40%	X
	Emergency medical transportation		40%	X
	Urgent Care		$100	
Hospital Stay	Facility fee (e.g. hospital room)		40%	X
	Physician/surgeon fee		40%	X
Mental/Behavioral Health	M/B office visits		$45	
	M/B outpatient services		$0	
	M/B inpatient services		40%	X
Health, Substance Abuse needs	Substance abuse disorder office visits		$45	
	Substance abuse disorder outpatient services		$0	
	Substance abuse disorder inpatient services		40%	X
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	40%	
		Professional		

*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, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.*Coinsurance may not apply in a staff model HMO setting.

Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	$50	X
	Outpatient rehabilitation services	$50	X
	Outpatient habilitation services	$50	X
	Skilled nursing care	30%	X
	Durable medical equipment	30%	X
	Hospice services	30%	X
Child eye care	Eye exam (OD)	$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	
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 or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	

***** 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.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
HSA Bronze Plan ~~2023~~2024

Actuarial Value		64.56%	
Individual Overall Deductible		$6,350	
Other individual deductibles for specific services			
Medical		$6,350	
Prescription Drugs		Integrated with Medical	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,900	
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	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	20%	X
Health, Substance Abuse needs	Substance abuse disorder office visits	20%	X
	Substance abuse disorder outpatient services	20%	X
	Substance abuse disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception services	$0	X
	Delivery and all inpatient services – Hospital	20%	X
	Delivery and all inpatient services – Professional		X

*Diabetes supplies, as defined by the carrier, and preferred brand insulin are provided with no cost-sharing.
**Coinsurance may not apply in a staff model HMO setting.

Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	2%	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 (OD)	$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	
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 or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	

ATTACHMENT B

DC HBX STANDARD PLAN WORKING GROUP
$0 COPAY RECOMMENDATION
FOR PEDIATRIC MENTAL HEALTH COST SHARING FOR STANDARD PLANS

1. **Mental Health Services and Medications with Modified Cost Sharing**
   For ALL mental health conditions.
   - Includes all primary diagnosis codes beginning with F (not secondary or lower), see ICD-10 CM online at Comprehensive Listing ICD-10-CM Files (cdc.gov)
   - For visits, we are not differentiating between visit types for initial assessments, medical evaluation and management visits, and follow-up therapy visits. We have CPT codes that correspond to all visit types and all modalities, e.g., telehealth.

2. **Ages Covered**
   Up to 19th birthday, consistent with pediatric ACA services.

3. **Cost-Sharing with AV Offset:**

$0 Copay for All Services (including drugs and labs)

Plan	Current Metal AV	Age 18, $0 Copay
Platinum Plan 2023	89.89%	89.94%
Gold Plan 2023	81.92%	81.91%
Silver Plan 2023	71.95%	71.97%
Bronze Copay Plan 2023	64.91%	64.91%

AV Offset

	Deductible – Current	Deductible - Adjusted
Bronze* - $0 Copay	$7,500	$7,700
	MOOP – Current	**MOOP – Adjusted**
Gold - $0 Copay	$5,800	$5,925
Silver - $0 Copay	$8,850	$9,100

*Bronze plan to be changed to increase MOOP, instead of deductible, if 2024 MOOP is extended.

4. **Bronze HSA Plan**
   No modification to Bronze HSA plan (which must comply with federal law).

5. **Compliance with Federal Law**
   All modifications are conditioned on compliance with applicable federal laws. HBX will work with carriers to ensure compliance.

UNIFIED TREATMENT SCENARIO FOR ADDRESSING MENTAL HEALTH CONDITIONS AMONG CHILDREN IN DC

For encounters with All ICD-10 F codes (all mental health conditions) among patients up to 19th birthday:

VISIT TYPES	CPT CODES	SERVICE TYPES	SPECIALTY	DESCRIPTION OF INCLUDED SERVICES
New, Follow up	11981 90835 90836 90837 90838 90839 90840 90846 90847 90853 96127 99202 99203 99204 99205 99211 99212 99213 99214 99215 99244 99245 99354 99355 99442 99443 99484 99492 99493 99494	Primary Care, Mental Health Care	Behavioral Health/Psychiatry; Internal Medicine/Infectious Disease/Family Medicine/Gynecology/Endocrinology	New medical visit; New patient, screening/assessment; Evaluation and management; Psychotherapy crisis; Individual therapy; Family/Group therapy

Related services for gender dysphoria only:

RELATED SERVICES TO BE COVERED WITH ZERO COST SHARING		CPT CODE
Laboratory Tests	Testosterone (free and total)	84402, 84403
	Estradiol	82670, 30289
	Hemoglobin and hematocrit (or complete blood count)	85014, 85018, 85025
	Comprehensive metabolic panel	80053
	25 OH-D Vitamin D	82306
	Lipid panel	80061
	Luteinizing hormone and follicle-stimulating hormone	83001, 83002
	Prolactin	84146
Imaging	DEXA scan	77080
	Bone age x-ray	77072
Procedures	Hormone therapy injection	96372

***Related to RX for zero cost sharing (see Addendum for additional information)*:**

Medications (developed based on treatment of most prevalent mental health conditions, but not limited to use with these conditions: anxiety, PTSD, depression, gender dysphoria, ADHD, and conduct disorders among patients 18 years of age and under). When the Coverage Type is listed as Class, there have been no exclusions of drugs within the class. When the Coverage Type is listed as Selected Medication(s), only selected drugs within the class are eligible for reduced cost sharing. Not all drugs in a class are required to be covered at the lower cost sharing level. Additionally, a carrier is not required to change the drugs that are on the carrier's formulary.

MEDICATION CLASS/GROUP	COVERAGE TYPE
SSRIs	Class (Carrier flexibility to select drugs from their formulary)
SNRIs	Class (Carrier flexibility to select drugs from their formulary)
Atypical antidepressants	Class (Carrier flexibility to select drugs from their formulary)
Anti-hypertensives	Selected Medication: Prazosin
Atypical anxiolytics	Class (Carrier flexibility to select drugs from their formulary)
Alpha agonists	Selected Medications: Clonidine, Clonidine ER, Guanfacine, Guanfacine ER
Beta blockers	Selected Medication: Propranolol
Anti-manic agents	Class (Carrier flexibility to select drugs from their formulary)
Stimulants	Class (Carrier flexibility to select drugs from their formulary)
Anti-psychotics	Selected Medications: Quetiapine, Aripiprazole, Brexpiprazole, Lurasidone
GnRH analogs	Class (Carrier flexibility to select drugs from their formulary)
Sex hormones	Class (Carrier flexibility to select drugs from their formulary)
Nonsteroidal anti-androgens	Class (Carrier flexibility to select drugs from their formulary)
5-alpha reductase inhibitors	Class (Carrier flexibility to select drugs from their formulary)

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Platinum Plan 2024***

Actuarial Value			~~89.89%~~89.94%	
Individual Overall Deductible			$0	
Other individual deductibles for specific services				
Medical			$0	
Prescription Drugs			$0	
Dental			$0	
Individual Out-of-Pocket Maximum			$2,000	
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	
	Specialist visit		$40	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests**		$20	
	X-rays and diagnostic imaging		$40	
	Imaging (CT/PET scans, MRIs)		$150	
Drugs to treat Illness or Condition***	Generic		$5	
	Preferred brand		$15	
	Non-preferred Brand		$25	
	Specialty		$100	
Outpatient Surgery	Facility fee (e.g. hospital room)		$250	
	Physician/Surgeon fee			
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic		$75	
Need Immediate Attention	Emergency room services (waived if admitted)		$150	
	Emergency medical transportation		$150	
	Urgent Care		$40	
Hospital Stay	Facility fee (e.g. hospital room)		$250 per day up to 5 days	
	Physician/surgeon fee			
Mental/Behavioral Health	M/B office visits		$20	
	M/B outpatient services		$20	
	M/B inpatient services		$250 per day up to 5 days	
Health, Substance Abuse needs	Substance abuse disorder office visits		$20	
	Substance abuse disorder outpatient services		$20	
	Substance abuse disorder inpatient services		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	$250 per day up to 5 days	
		Professional		

*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, 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

	Home health care	$20	
	Outpatient rehabilitation services	$20	
	Outpatient habilitation services	$20	
	Skilled nursing care	$150 per day up to 5 days	
	Durable medical equipment	10%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	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	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** Treatment of mental health conditions for children 18 and under will be provided with $0 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Gold Plan 2024***

Actuarial Value		~~81.92%~~81.91%	
Individual Overall Deductible		$500	
Other individual deductibles for specific services			
Medical		$500	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		~~$5,925~~$5,800	
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	$25	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests**	$30	
	X-rays and diagnostic imaging	$50	
	Imaging (CT/PET scans, MRIs)	$250	
Drugs to treat Illness or Condition***	Generic	$15	
	Preferred brand	$50	
	Non-preferred Brand	$70	
	Specialty	$150	
Outpatient Surgery	Facility fee (e.g. hospital room)	$525	
	Physician/Surgeon fee	$75	
Outpatient Non-Surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	$75	
Need Immediate Attention	Emergency room services (waived if admitted)	$300	
	Emergency medical transportation	$300	
	Urgent Care	$60	
Hospital Stay	Facility fee (e.g. hospital room)	$600 per day up to 5 days	X
	Physician/surgeon fee		X
Mental/Behavioral Health	M/B office visits	$25	
	M/B outpatient services	$25	
	M/B inpatient services	$600 per day up to 5 days	X
Substance Abuse needs	Substance abuse disorder office visits	$25	
	Substance abuse disorder outpatient services	$25	
	Substance abuse disorder inpatient services	$600 per day up to 5 days	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services – Hospital	$600 per day up to 5 days	X
	Delivery and all inpatient services – Professional		X

*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, 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 staff model HMO setting.

Help recovering or other special health needs	Home health care	$30	
	Outpatient rehabilitation services	$30	
	Outpatient habilitation services	$30	
	Skilled nursing care	$300 per day up to 5 days	
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	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	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** Treatment of mental health conditions for children 18 and under will be provided with $0 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Silver Plan 2024***

Actuarial Value			71.97%~~71.95%~~	
Individual Overall Deductible			$5,200	
Other individual deductibles for specific services				
Medical			$ 4,850	
Prescription Drugs			$350	
Dental			$0	
Individual Out-of-Pocket Maximum			~~$8,850~~$9,100	
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		$40	
	Specialist visit		$80	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests**		$60	
	X-rays and diagnostic imaging		$80	
	Imaging (CT/PET scans, MRIs)		$400	
Drugs to treat Illness or Condition***	Generic		$20	
	Preferred brand		$50	X
	Non-preferred Brand		$70	X
	Specialty		$150	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)		$400	X
	Emergency medical transportation		$400	X
	Urgent Care		$90	
Hospital Stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental/Behavioral Health	M/B office visits		$40	
	M/B outpatient services		$40	
	M/B inpatient services		20%	X
Health, Substance Abuse needs	Substance abuse disorder office visits		$40	
	Substance abuse disorder outpatient services		$40	
	Substance abuse disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X

*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, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.
****Coinsurance may not apply in staff model HMO setting.

Help recovering or other special health needs	Home health care	$50	
	Outpatient rehabilitation services	$65	
	Outpatient habilitation services	$65	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	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	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** Treatment of mental health conditions for children 18 and under will be provided with $0 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Bronze Copay Plan 2024***

Actuarial Value		64.91%	
Individual Overall Deductible		$8,350	
Other individual deductibles for specific services			
Medical		~~$7,500~~$7,700	
Prescription Drugs		$850	
Dental		$0	
Individual Out-of-Pocket Maximum		$9,100	
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	$45	
	Specialist visit	$105	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests**	$55	X
	X-rays and diagnostic imaging	$80	X
	Imaging (CT/PET scans, MRIs)	$500	X
Drugs to treat Illness or Condition***	Generic	$25	
	Preferred brand	$75	X
	Non-preferred Brand	$100	X
	Specialty	$150	X
Outpatient Surgery	Facility fee (e.g. hospital room)	40%	X
	Physician/Surgeon fee	40%	X
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	40%	X
Need Immediate Attention	Emergency room services	40%	X
	Emergency medical transportation	40%	X
	Urgent Care	$100	
Hospital Stay	Facility fee (e.g. hospital room)	40%	X
	Physician/surgeon fee	40%	X
Mental/Behavioral Health	M/B office visits	$45	
	M/B outpatient services	$0	
	M/B inpatient services	40%	X
Health, Substance Abuse needs	Substance abuse disorder office visits	$45	
	Substance abuse disorder outpatient services	$0	
	Substance abuse disorder inpatient services	40%	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services – Hospital	40%	
	Delivery and all inpatient services – Professional		

*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, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.*Coinsurance may not apply in a staff model HMO setting.

Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	$50	X
	Outpatient rehabilitation services	$50	X
	Outpatient habilitation services	$50	X
	Skilled nursing care	30%	X
	Durable medical equipment	30%	X
	Hospice services	30%	X
Child eye care	Eye exam (OD)	$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	
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 or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	

***** Treatment of mental health conditions for children 18 and under will be provided with $0 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
HSA Bronze Plan ~~2023~~2024

Actuarial Value		64.56%	
Individual Overall Deductible		$6,350	
Other individual deductibles for specific services			
Medical		$6,350	
Prescription Drugs		Integrated with Medical	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,900	
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	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	20%	X
Health, Substance Abuse needs	Substance abuse disorder office visits	20%	X
	Substance abuse disorder outpatient services	20%	X
	Substance abuse disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception services	$0	X
	Delivery and all inpatient services – Hospital	20%	X
	Delivery and all inpatient services – Professional		X

*Diabetes supplies, as defined by the carrier, and preferred brand insulin are provided with no cost-sharing.
**Coinsurance may not apply in a staff model HMO setting.

Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	2%	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 (OD)	$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	
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 or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	

ADDENDUM

The vote taken by the HBX Standard Plan Working Group on November 4, 2022 included the below chart for lower cost sharing for prescription drugs for pediatric mental health conditions and reflects the development of the policy. A revised chart, as shown in Attachment A and B is included in the final Standard Plan Working Group report for clarity. The Executive Board Insurance Market Committee which met on November 9, 2022 considered the revised chart. No changes in the policy are intended.

Medications (developed based on treatment of most prevalent mental health conditions, but not limited to use with these conditions: anxiety, PTSD, depression, gender dysphoria, ADHD, and conduct disorders among patients 18 years of age and under). Not all drugs in a class are required to be covered at the lower cost sharing level. Additionally, a carrier is not required to change the drugs that are on the carrier's formulary.

MEDICATION CLASS/GROUP	SPECIFIC MEDICATIONS TO BE COVERED WITH LOWER COST SHARING
SSRIs	All
SNRIs	All
Atypical antidepressants	All (e.g., SARIs, mirtazapine, trazodone)
Anti-hypertensives	Prazosin
Atypical anxiolytics	All (e.g., buspirone)
Alpha agonists	Clonidine, Clonidine ER, Guanfacine, Guanfacine ER
Beta blockers	Propranolol
Anti-manic agents	All (e.g., lithium)
Stimulants	All (e.g., amphetamine, methylphenidate)
Anti-psychotics	Quetiapine, Aripiprazole, Brexpiprazole, Lurasidone
GnRH analogs	All (e.g., Lupron, Triptorelin, Histrelin)
Sex hormones	All (e.g., oral/transdermal/injectable estradiol, injectable/transdermal testosterone, progesterone)
Nonsteroidal anti-androgens	All (e.g., bicalutamide, spironolactone)
5-alpha reductase inhibitors	All (e.g., finasteride, dutasteride)