RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To implement and adopt recommendations from the Social Justice and Health Disparities Working Group: 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.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1301(a)(1)(C)(ii) of the ACA requires QHP issuers to offer one silver-level and one gold-level plan at a minimum;

WHEREAS, D.C. Official Code §31-3171.09(5)(B)(i) requires QHP issuers to offer at least one bronze plan;

WHEREAS, 45 C.F.R. §155.1000(c) allows state exchanges to limit certification to those plans that it finds are in the best interest of qualified individuals and employers and 45 C.F.R. §156.200(d) allows state exchanges to require additional certification requirements beyond the federal minimums;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHPs;

WHEREAS, on March 22, 2013, the Executive Board adopted a Resolution to develop standardized benefit plans (benefits and cost-sharing) at each of the four metal level tiers based on input from consumers, employers, carriers, and based on early purchase preferences;

WHEREAS, on November 12, 2014, the Executive Board adopted a Resolution setting standard plans at all four metal level tiers for Plan Year 2016;

WHEREAS, on March 9, 2015, the Executive Board adopted consensus recommendations to modify the standard Bronze plan to be consistent with the 2016 Plan Year Actuarial Calculator released by the Center for Consumer Information and Insurance Oversight;

WHEREAS, on April 6, 2016, the Executive Board adopted a Resolution modifying the standard plans at all four metal level tiers for Plan Year 2017;

WHEREAS, on February 8, 2017, the Executive Board adopted a Resolution modifying the standard plans at all four metal level tiers, plus an HSA-compatible bronze plan for Plan Year 2018;

WHEREAS, on March 14, 2018, the Executive Board adopted a Resolution modifying the standard plans at the gold, silver and bronze copay levels for Plan Year 2019;

WHEREAS, on February 13 and May 8, 2019, the Executive Board adopted a Resolution modifying the standard plans at the gold, silver and bronze copay levels for Plan Year 2020;

WHEREAS, on April 1, 2020, the Executive Board adopted a Resolution modifying the standard plans at the gold, silver, bronze copay and bronze HSA-compatible levels for Plan Year 2021;

WHEREAS, on February 10, 2021, the Executive Board adopted a Resolution modifying the standard plans at the gold, silver, bronze copay and bronze HSA-compatible levels for Plan Year 2022;

WHEREAS, on July 14, 2021, the Executive Board adopted a Resolution adopting the recommendations of the Social Justice and Health Disparities Working Group;

WHEREAS, one of the recommendations of the Social Justice and Health Disparities Working Group directed the Standard Plans Working Group to 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, and listed a prioritization of chronic conditions for the Standard Plans Working Group to review, the first of which was diabetes. The recommendation also specified that the new insurance design should be developed for standard plans in the small group marketplace as well as individual marketplace for plan year 2023;

WHEREAS, the working group met eight times, once a week, between September 14 and November 2, 2021 by conference call;

WHEREAS, the working group came to consensus on the policy of providing certain services, medications, and supplies for Type 2 diabetics at $0 cost-sharing in standard plans as allowed by law;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendations from the Standard Plans Advisory Working Group:

> The Executive Board adopts the recommendation for standard plans for DC Health Link at the platinum, gold, silver, and bronze copay metal level tiers for 2023 as set forth in the *Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority*, dated November 8, 2021. The plans shall at least annually post the names of the specific medications, including insulin products, which have no cost-sharing, to be made available on the HBX website or their company websites.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 10th day of November 2021, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

____________________________ November 10, 2021
/s/ Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefit Exchange Authority

November 8, 2021

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 (working group), chaired Dania Palanker. The working group's charge was to modify the standard benefit plan for appropriate metal level tiers, to begin to implement the recommendations of the Executive Board's Social Justice and Health Disparities Working Group.

Background

During the fall of 2020, the Health Benefit Exchange Authority (HBX) formed an Advisory Working Group, the Social Justice and Health Disparities Working Group (SJHDWG). The initial discussion document of the working group reflects the background surrounding its formation:

> The nation is in the midst of the COVID-19 pandemic, which is forcing a national reckoning over the disproportionate coronavirus-related illness and death in communities of color and other inequities that persist in this nation.
>
> These pandemic inequities reflect a long history in the U.S. of racism, inferior treatment, discrimination and mistreatment of Black people and other people of color in the health care system. Further, hospitals and providers in predominantly Black communities often have fewer resources to care for patients, as evidenced by recent funding decisions that disadvantaged smaller and minority-serving hospitals during this pandemic.
>
> In this context, the DC Health Benefit Exchange Authority has established the Social Justice and Health Disparities Working Group to study and develop recommendations for actions that may be taken to remedy health inequities and secure a healthier future for the District of Columbia.

The SJHDWG met every week over several months, and issued a Final Report on July 12, 2021 with recommendations for action. The relevant recommendation regarding standard plans 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 co-morbidities. 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.
> - 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.

The issues on the table for discussion by the working group for PY 2023 were implementation of the SJHDWG's recommendations regarding a Value-Based Insurance Design (VBID) to support adherence for patients with chronic conditions. The working group began with the first condition in the recommendation for the adult population – diabetes.

All of the working group's documents over eight meetings, including meeting notes, can be viewed on its HBX webpage.

Discussion

1. Overview

The working group started with a document published by CMS, the *Managing for Type 2 Diabetes Guide*. According to Jenny Libster, HBX staff, who was at CMS when the Guide – called a scenario - was developed, the scenario was developed by clinicians and includes claims for a well-maintained type 2 diabetic. Starting very broadly, with all the services, prescription drugs, and supplies listed in the scenario, the working group systematically went through various iterations of possible services, prescription drugs, and supplies being provided at zero cost-sharing and the effect on the actuarial value (AV) of the plans.[1] The working group started broadly as stated, and as the working group kept moving forward, it kept narrowing the number of services, prescription drugs, and supplies to be provided at zero cost-sharing, all the while hewing to the goal of the working group: helping diabetics maintain good health through adherence to their doctor's recommended protocols.

After eight meetings of the working group (once a week from September 14 through November 2), the group reached a conditional consensus (explained below) that provides zero cost-sharing for certain services, prescription drugs, and supplies, while keeping the plans within the allowed AV ranges and not increasing any other cost-sharing in the plans – i.e. the deductible is not increased, the maximum out-of-pocket (MOOP) is not increased, and nothing else in the standard plans has increased cost-sharing.

[1] A description of methodology our contract actuaries used to feed the VBID information into the actuarial calculator is provided as an endnote to this report.

2. Working Group Discussions

a. Prescription Drugs (Rx) and Medical Claims

The working group started very broadly, with the actuaries using MarketScan data running all the medical and pharmacy services listed in the scenario at zero cost-sharing through the AV calculator. The working group started with the standard silver plan. The initial run resulted on the silver plan resulted in increasing the AV by 0.5% to 72.46%, exceeding the allowable AV by 0.46%. Subsequent runs on the platinum, gold and bronze copay standard plans resulted in exceeding the allowable AV similarly.

Carriers consulted with their clinicians as the working group began to narrow the list of medical and pharmacy services. Kaiser Permanente suggested narrowing the targeted services to lab tests, office visits (PCP and specialists), and preferred medications, with the clarification that the $0 cost share apply only to services with a primary diagnosis of type 2 diabetes. Kaiser Permanente explained that the intent should be to remove cost-related barriers for services that manage diabetes with the aim of improving adherence and outcomes.

CareFirst agreed to limiting zero cost-sharing to preferred medications. There is always an exceptions process that could be used if a consumer and physician believe another Rx is appropriate.

The working group agreed with the general statements. The plans were run through the AV Calculator again using the narrower list of services, and unfortunately, did not change the AVs of the plans, requiring an increase in the MOOP or other cost-sharing.

In further discussion, CareFirst expressed concern that the proposals are mandating specific Rx, which is beyond the scope of the working group. HBX staff stated that the working group had never gone into that level of granularity, and has never trod into formularies.

On the operational side, it was noted that Rx claims do not come with a diagnosis code on them, so insofar as there would be a waiver of cost sharing, it would apply to all enrollees. This would be a problem for VBID; carriers cannot limit zero cost-sharing to just people with a given

diagnosis code (DX). We have to recognize that Rx would apply to any enrollee and just not type 2 diabetics.

Also, carriers may have a limitation on Rx they will need to work through with their pharmacy benefit managers (PBM). In CareFirst's case, their formularies are applicable to all plans within the jurisdiction, so any change to standard plans would have to be applied to everyone in the individual and small group markets.

On the medical side, they can do it as medical claims come with a DX. CareFirst said it would discuss the issue with clinicians to get their input on what the right scope of services should be.

CareFirst came back the next week, reporting its discussion with medical directors and pharmacists about what appropriate services and Rx would be to look at for treatment of diabetes. CareFirst recommends the following services at $0 with a primary diagnosis code of diabetes to implement VBID for diabetes beyond the existing $0 preferred insulin and diabetic supplies:

- PCP visit
- The following drugs, to the extent they are covered by the insurer:
    - acarbose
    - alogliptin
    - alogliptin/metformin
    - alogliptin/pioglitazone
    - glimepiride
    - glipizide
    - glipizide ext-rel
    - glipizide/metformin
    - glyburide
    - glyburide, micronized
    - glyburide/metformin
    - metformin
    - metformin ext-rel
    - miglitol
    - nateglinide
    - pioglitazone
    - pioglitazone/glimepiride

  - pioglitazone/metformin
  - repaglinide
  - tolbutamide
- Lipid panel test (1x per year at $0)
- Hemoglobin A1C (2x per year at $0)
- Microalbumin urine test or nephrology visit (1x per year at $0)
- Dilated retinal exam (1x per year at $0)
- Basic metabolic panel (1x per year at $0)
- Liver function test (1x per year at $0)
- Nutrition counseling visits (unlimited at $0)

Key notes:

- CareFirst does not recommend specialist visits at $0. Continuity of care is vital and the PCP is in the appropriate place to quarterback the member's care. Moreover, specialist intervention is required when diabetes is uncontrolled. We believe it is important to incentivize enrollees to control their diabetes.
- NDC is too granular to define drugs for this requirement. In addition, the existing NDC list includes many drugs that are not indicated for diabetes. For example, Klonopin is a benzodiazepine (controlled substance for anxiety) and CellCept is an immunosuppressant (to prevent transplant rejection).

CareFirst stated that diabetes is about treatment and trying to control the condition, and it is important to have continuity of care, so the PCP is the appropriate person for this management. We have concerns about specialists because they are involved when there are complications. And, nutrition counseling is important for this population.

The working group discussed whether to limit the $0 cost share to generics only or generics and preferred. Kaiser Permanente clarified that the suggested language for drugs should apply to the medications preferred by the carrier and not refer to a specific tier level. CareFirst stated that insulin is important because it manages and controls diabetes. The working group agreed on a technical issue regarding which classes of Rx would be run through the AV calculator and what codes would be used for the calculation. The working group also agreed it would develop alternative language to a listing of specific Rx. The refined proposal to be run through the AV calculator was:

*PCP visits, dilated retinal 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.

At the last meeting of the working group, the refined proposal above was run through the AV calculator. The working group was pleased to learn that by narrowing the list of services, Rx, and supplies to be run through the AV calculator at zero cost-sharing, the plans were all within the allowed AV ranges with no increase in other cost-sharing.

However, there was one last issue to discuss. Before its final meeting, HBX staff compared the CMS scenario to the working group's list. The scenario listed a podiatrist visit once a year. The carriers agreed that such a visit would be appropriate if recommended by the PCP. That addition would require one last pass through the AV calculator to ensure that the results were still within the allowable AV ranges. All were hopeful that the addition of the service would have a de minimis, if not zero, effect on the calculator. Based on the need to obtain that information, and acknowledging that the Draft AV Calculator for PY 2023 has not yet been issued and would require a further review by the working group, the working group reached a conditional consensus on the list of services, Rx, and supplies to be provided at zero cost-sharing:

*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.

b. Other Issues

i. Bronze HSA standard plan

The working discussed, but rejected, applying the VBID design to the Bronze HSA-compatible standard plan. HSA plans are subject to IRS regulation and guidance. There is some concern that the IRS guidance is in conflict with previous guidance. We would need to be careful because there are some legal interpretations and we would not want to create a conflict with federal law. The working group was not sure that the IRS guidance lets you waive cost sharing for office visits, for example. It is questionable how much more can be done regarding our VBID design under the IRS guidance.

ii. SHOP

The Executive Board adopted the recommendations of the SJHDWG that the VBID plan design would apply to SHOP as well as the individual market. For a variety of reasons, the plans will be identical in both markets.

iii. Low Value Services

During one of the SJHDWG early meetings, a presenter identified some services considered to be low value: spinal fusion, Vitamin D testing, proton beam for prostate cancer, vertebroplasty and kyphoplasty.

The working group members appreciated that we are thinking about high and low value services, but by narrowing the proposal the working group agreed we would not need to change cost sharing for low value services as it had an de minimis effect (0.04%) on the AV. Also, the working group did not think it was clear that including low value services will drive consumer behavior as designed. The working group thought that perhaps it could be looked at in future years.

iv. Pediatric Mental Health

The working group discussed trying to incorporate pediatric mental health into the 2023 VBID plan design, and had our actuaries start to work on some MarketScan data. However, it was

realized rather quickly that incorporating pediatric mental health into the VBID plan design required more time than the working group had to develop for PY 2023. This issue will be tackled in the future as the working group works its way through the list of conditions contained in the SJHDWG Final Report.

v. Section 1332 Waiver

A working group member thought that HBX should consider pursuing a 1332 waiver to help cover the costs of this benefit design. Another member thought we needed statutory authority to pursue such a waiver. Another member noted that a 1332 waiver is beyond the scope of our charge.

vi. Discrimination

A working group member said she would like some legal guidance about what we can and cannot do under nondiscrimination. She had some concerns about DX codes and age. The chair thought this should not fall under discrimination because we are not discriminating against a DX or age. HBX legal staff reviewed the question and concluded that we had no problems regarding discrimination with this VBID design.

Consensus Recommendations

Over the course of the meetings, the working group reached consensus to recommend amendments to the 2023 standard plans as noted above on a conditional basis. The conditional recommendation is reflected in the attached displays for Standard Plans 2023 VBID Design for Type 2 Diabetes: Pending AVC. (Attachment)

End Note: VBID Plan Design and Actuarial Value Calculator

The first step in determining the metal AV impact of covering specified type 2 diabetic services at $0 member cost sharing was to determine the percentage of each AV Calculator benefit grouping that was made up by these services. MarketScan data, which is a large group commercial database, was used as a credible data source and was limited to the DC, VA, and MD region, which represents approximately 11.5 million member months. The percentage for each AV Calculator benefit category was determined differently for medical and pharmacy services. For medical services, type 2 diabetic services were identified by the presence of a type

2 diabetes primary diagnosis code (i.e., E11*). For pharmacy services, type 2 diabetic services was determined based on National Drug Codes (NDCs) where 80% or more of utilization was attributed to type 2 diabetic members. A type 2 diabetic member was someone that had a medical claim in the calendar year with a primary diagnosis code for type 2 diabetes. The AV Calculator inputs were then adjusted to reflect $0 cost sharing for type 2 diabetic services for the benefit categories where there was an impactful percentage of services for type 2 diabetes (e.g., an effective copay was calculated). The revised plan design was then run through the AV Calculator to determine the metal AV of the plan that reflects the estimated impact of $0 cost sharing for type 2 diabetic services.

After conversations with the various carriers in DC, a few changes to the identification of diabetic services were requested. For medical services, the request was to limit the identification of type 2 diabetic services to only a specific list of procedure codes. For pharmacy services, the request was to limit the identification of type 2 diabetic claims to a subset of the previously identified NDCs. These limitations were done to better reflect the intent of the regulation and the adjudication practices and limitations of the carriers. With the second iteration of the metal AV calculation, all current standard plans remain in the necessary metal AV range.

Working Group Members

The Standard Plans Advisory Working Group is comprised of representatives from all of DC Health Link's qualified health plan carriers, consumer representatives, a trade association representative, and a producer. Eight weekly meetings were held, from September 14 through November 2, by Zoom video call. The consensus recommendations on VBID design for Type 2 diabetes were reached over the course of the meetings.

Dania Palanker, Chair	Georgetown
Janice Davis	Producer
Dave Chandrasekaran	DC Health Link Consumer

Kris Hathaway	America’s Health Insurance Plans
Cheryl Fish-Parcham	Families USA
Robert Metz, Cory Bream, Dwayne Lucado, Alex O’Brien, Jennifer Storm	CareFirst
Allison Mangiaracino, Denise Barton, Stephen Chuang, Sam Ongwen, Devi Vijayakumari, Theresa Young	Kaiser Permanente
Paul Spiedell	Aetna
Keith Blecher, Seung Baick, Ryan Morgan	UnitedHealthGroup
Staff Advisors & Support	
Mary Beth Senkewicz, Jenny Libster	HBX
Howard Liebers	DISB
Peter Scharl, Tammy Tomczyk, Mary Adomshick	Oliver Wyman

The working group gratefully acknowledges the work of Mr. Scharl, Ms. Tomczyk, and Ms. Adomschick with Oliver Wyman in support of the working group’s deliberations.

VBID PLAN DESIGN TYPE 2 DIABETES FOR PLANS STARTING IN 2023: PENDING FINAL AVC

Standard Plans Advisory Working Group **Attachment**
Platinum Plan ~~2022~~2023

Actuarial Value		~~88.99~~89.04%	
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.

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**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)

***Diabetes A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, and preferred brand insulin 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

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Help recovering or other special health needs	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	

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Gold Plan ~~2022~~2023

Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Actuarial Value		~~81.95~~81.98%	
Individual Overall Deductible		$0	
Other individual deductibles for specific services			
	Medical	$500	
	Prescription Drugs	$0	
	Dental	$0	
Individual Out-of-Pocket Maximum		$4,950	
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)	$600	
	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)	$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:

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

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*** ~~Diabetes~~ A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, ~~and preferred brand insulin~~ 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	

Standard Plans Advisory Working Group
Silver Plan ~~2022~~2023

Actuarial Value		~~71.96~~71.99%	
Individual Overall Deductible		$4,250	
Other individual deductibles for specific services			
Medical		$4,000	
Prescription Drugs		$250	
Dental		$0	
Individual Out-of-Pocket Maximum		$8,250	
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)	$300	
Drugs to treat Illness or Condition*~~~~**	Generic	$15	
	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)	$350	X
	Emergency medical transportation	$350	X
	Urgent Care	$90	
Hospital Stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee		X
Mental/Behavioral Health	M/B office visits	$40	
	M/B outpatient services	$0	
	M/B inpatient services	20%	X
Health, Substance Abuse needs	Substance abuse disorder office visits	$40	
	Substance abuse disorder outpatient services	$0	
	Substance abuse disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services: Hospital	20%	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)

***Diabetes A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, and preferred brand insulin 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	

Standard Plans Advisory Working Group
Bronze Copay Plan ~~2022~~2023

Actuarial Value		64.~~96~~99%	
Individual Overall Deductible		$8,350	
Other individual deductibles for specific services			
Medical		$7,500	
Prescription Drugs		$850	
Dental		$0	
Individual Out-of-Pocket Maximum		$8,550	
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	$60	
	Specialist visit	$125	
	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	$60	
	M/B outpatient services	$0	
	M/B inpatient services	40%	X
Health, Substance Abuse needs	Substance abuse disorder office visits	$60	
	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%%	X
	Delivery and all inpatient services – Professional	40%%	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)

*** ~~Diabetes~~ A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, ~~and preferred brand insulin~~ 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	

Standard Plans Advisory Working Group
HSA Bronze Plan ~~2022~~2023

Actuarial Value		64.99%	
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)	20%	X
	Outpatient rehabilitation services	20%	X
	Outpatient habilitation services	20%	X
	Skilled nursing care	20%	X
	Durable medical equipment	20%	X
	Hospice services	20%	X
Child eye care	Eye exam (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	