NATIONAL HEALTH COUNCIL

July 15, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard [CMS–9874–NC]

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to provide comments in response to the Request for Information (RFI) on the Essential Health Benefits (EHB) framework and the statutory requirement that the scope of EHB be equal to the scope of benefits provided under a typical employer plan.

Created by and for patient organizations more than 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, and sustainable health care. Made up of nearly 200 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

The NHC has long viewed the EHB framework as a foundational patient protection for individuals and families who rely on comprehensive, predictable, and nondiscriminatory coverage to manage acute and chronic conditions, disabilities, rare diseases, behavioral health conditions, and other complex health needs. For patients, EHB are not experienced as statutory categories, but through whether they can fill a prescription, access rehabilitation services, continue treatment without interruption, or afford the care their clinician recommends. How medically necessary items and services are classified under the EHB framework has significant implications for patients, including key protections such as the prohibition on annual and lifetime dollar limits, whether cost sharing counts toward the annual limitation on cost sharing, and whether benefit design is subject to the safeguards intended to make coverage meaningful.

Changes that may appear modest from a regulatory perspective can therefore have profound consequences for individuals managing chronic or complex health conditions.

The NHC appreciates CMS' interest in evaluating whether the current EHB framework continues to reflect changes in the health care system, employer sponsored coverage, medical evidence, scientific advancement, and patient needs. As CMS undertakes this review, we urge the agency to preserve EHB as a meaningful floor of patient protection while thoughtfully modernizing the framework to reflect current science, clinical practice, and patient needs, rather than narrowing access to care or shifting additional costs to patients.

Summary of Recommendations

The NHC recommends that CMS:

- Maintain EHB as a comprehensive and patient-centered coverage standard that protects access to medically necessary care for people with chronic diseases, disabilities, rare conditions, behavioral health needs, and other complex or ongoing health needs.
- Preserve state flexibility within clear federal guardrails that prevent discriminatory benefit design, inappropriate coverage gaps, and excessive variation in access based on state of residence.
- Avoid relying solely on actuarial value, aggregate benefit comparisons, or historical reference plans when assessing whether benefits are equal in scope to those provided under a typical employer plan, because those tools may obscure whether patients can access the specific items and services they need.
- Improve transparency regarding the scope of EHB, the process for updating benchmark plans, the implications of benefit classifications for patient protections, and opportunities for patients and patient organizations to meaningfully participate in state and federal review processes.
- Strengthen oversight of prescription drug coverage, habilitative and rehabilitative services and devices, behavioral health, preventive services, chronic disease management, and other areas where nominal coverage may not translate into meaningful access.
- Establish a predictable and transparent process for periodic EHB review that incorporates patient engagement, current clinical evidence, scientific advancement, affordability considerations, and safeguards against coverage disruption.
- Provide sufficient lead time, transition protections, and monitoring if future refinements to the EHB framework are proposed, particularly where changes may affect patients receiving ongoing treatment or services.

Typical Employer Plans and Typicality

The NHC recognizes that section 1302 of the Affordable Care Act requires the Secretary to ensure that the scope of EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. At the same time, the NHC encourages CMS to interpret that requirement in a manner that reflects the patient-protective purpose of the EHB framework and avoids converting “typicality” into a static or purely actuarial exercise. Employer-sponsored coverage has evolved substantially since the original EHB-benchmark plans were selected, and a framework

that relies too heavily on older reference plans may fail to account for changes in medical evidence, clinical guidelines, health care delivery, prescription drug development, behavioral health needs, telehealth, care management, and other services that are now more central to patient access and outcomes than they may have been when many benchmark plans were first established.

The NHC recommends that CMS evaluate typicality using a combination of data sources and qualitative review rather than relying on any single reference plan, market segment, or actuarial measure. While actuarial value and plan comparisons may provide useful information about the relative generosity of plan designs, they do not necessarily show whether a plan covers the specific drugs, devices, therapies, services, and supports that patients need to manage serious and ongoing health conditions. Two plans may appear comparable in aggregate while differing significantly in their coverage of specialty medications, habilitative services, rehabilitation, durable medical equipment, behavioral health care, chronic disease management, or other services that are essential to patients but may be less visible in a broad actuarial comparison. For this reason, the NHC encourages CMS to treat actuarial analysis as one tool within a broader review, rather than as a substitute for examining whether the scope of benefits is adequate, balanced across the statutory categories, nondiscriminatory, and aligned with contemporary standards of care.

The NHC also urges CMS to exercise caution before treating self-funded employer plans as more representative of a typical employer plan solely because they cover a substantial share of people with employer-sponsored insurance. Self-funded plan data may offer useful insight into current employer coverage patterns, but such data may also be less transparent, less standardized, and more difficult for regulators, states, patients, and consumer representatives to evaluate. If CMS considers self-funded plan data as part of a future typicality analysis, the NHC recommends that such data be used only as part of a broader evidence base and accompanied by safeguards to ensure that limited data availability or plan transparency does not result in an underinclusive EHB standard or weaken protections for people with high-cost or complex health needs.

In addition, the NHC cautions CMS against interpreting “equal in scope” in a way that allows plans to substitute aggregate actuarial generosity for meaningful access to specific benefits. From the patient perspective, the question is not only whether a benchmark plan or comparison plan has a similar overall value, but whether the resulting EHB package includes the items and services needed by people with diverse and often complex health needs. A methodology that gives insufficient attention to benefit design details, exclusions, quantitative treatment limits, utilization management, tiering, network design, and exceptions processes may overlook the ways in which coverage can appear adequate on paper but fail patients in practice. The NHC therefore encourages CMS to evaluate typicality in a way that accounts for both breadth of coverage and practical access to care.

State Flexibility, Federal Guardrails, and Variation Across States

The NHC supports an EHB framework that allows states to respond to specific population needs and market conditions, provided that state flexibility operates within a

clear federal framework that preserves comprehensive coverage and prevents discriminatory benefit design. State variation can allow benchmark plans to be updated in ways that better reflect local needs, emerging evidence, and gaps identified by patients and consumer advocates. However, variation can also create inequities when patients with similar health needs have materially different access to medically necessary benefits depending on where they live. The NHC therefore encourages CMS to evaluate state variation not only from the perspective of issuer operations, state regulation, or market competition, but also from the perspective of patients who may experience differences in access, affordability, continuity of care, and protection from discriminatory benefit design.

In evaluating the effects of state variation, the NHC recommends that CMS pay particular attention to benefit areas that are important for people with chronic diseases, disabilities, rare conditions, behavioral health needs, maternal health needs, pediatric needs, and other circumstances that may require ongoing, specialized, or high-cost care. Differences in benchmark coverage for rehabilitative and habilitative services and devices, prescription drugs, behavioral health services, chronic disease management, pediatric services, maternity and newborn care, and other patient-centered benefits may have significant consequences even when aggregate plan comparisons suggest that benefit packages are broadly similar. The NHC encourages CMS to use patient access, affordability, and continuity-of-care measures to assess the practical impact of state variation, rather than relying only on formal benefit classifications or claims-based comparisons that may reflect underlying differences in prices, utilization, population health, or market structure.

The NHC further recommends that CMS improve the transparency of EHB benchmark plans and state update processes so that patients, patient organizations, and other stakeholders can understand what is included as EHB, how benchmark changes are evaluated, and how EHB classifications affect patient protections. Public-facing documentation should be clear enough for patients and advocates to use without specialized actuarial or regulatory expertise, while also providing sufficient detail for meaningful review of covered items and services, limitations, exclusions, and potential access implications. The NHC has previously emphasized the importance of communicating EHB benchmarks in language that is understandable and consistent, and that principle remains critical as CMS evaluates whether current approaches are working for patients.

The NHC also recommends that CMS consider whether current variation across states affects both the benefits covered and the extent to which patients can rely on EHB-related protections when they are choosing coverage or using care. A patient may reasonably assume that a service falling within one of the ten statutory categories will be protected in a comparable way across states, but the benchmark-based framework can produce meaningful differences in the details of what is covered, how it is covered, and whether a particular item or service falls within the scope of EHB. To the extent CMS continues to preserve state flexibility, the NHC encourages the agency to pair that flexibility with federal review, transparency, and nondiscrimination safeguards that reduce the risk of access to necessary care depending too heavily on state of residence.

Affordability and Cost

The NHC recognizes that affordability is central to meaningful coverage and that the scope of EHB may affect premiums, cost sharing, federal expenditures, issuer participation, and market stability. However, the NHC urges CMS to avoid approaching affordability solely as a question of whether narrowing benefits could reduce premiums. For people with chronic diseases, disabilities, and complex health needs, inadequate coverage often shifts costs rather than reducing them, and those shifted costs may appear as delayed care, avoidable complications, greater reliance on emergency departments, interruptions in treatment, worsened health outcomes, caregiver burden, and increased spending elsewhere in the health care system. An affordability analysis that focuses primarily on premiums without also considering out-of-pocket costs, non-covered services, delayed access, and downstream health consequences would not fully capture the patient impact of changes to EHB.

The NHC recommends that CMS evaluate affordability through a total-patient-cost lens. Patients experience affordability through premiums, deductibles, copayments, coinsurance, drug tiering, medical benefit cost sharing, non-covered services, out-of-network exposure, and the cumulative burden of navigating coverage restrictions. Whether a service is classified as an EHB can also determine whether cost sharing counts toward the annual limitation on cost sharing, which is a significant protection for patients who require high-cost medications, devices, therapies, or services. For that reason, the NHC encourages CMS to evaluate the relationship between EHB scope and affordability in a way that accounts for both premiums and patient financial exposure at the point of care.

The NHC encourages CMS to identify and address benefit design practices that may undermine the protections EHB coverage is intended to provide. Even when a service or treatment is covered, patients may still face significant financial barriers if benefit design increases out-of-pocket costs or limits the financial protections associated with EHB coverage. For example, issues with copay accumulator and maximizer programs may increase patient out-of-pocket costs and limit access to needed treatment. In addition, the growing practice of classifying certain covered prescription drugs as non-EHBs may prevent manufacturer cost-sharing assistance from counting toward annual deductibles and out-of-pocket maximums, leaving patients responsible for substantial costs. CMS should evaluate whether these practices are consistent with the goal of ensuring that EHB coverage remains affordable, meaningful, and accessible for patients with ongoing health care needs.

The NHC also recommends that CMS assess whether cost-management tools support appropriate, evidence-based care or instead create barriers to medically necessary treatment. Utilization management, network design, formulary management, and payment approaches may be used to manage costs, but these tools can also delay access, disrupt stable treatment, create administrative burden for patients and providers, and disproportionately affect people with high-cost or complex conditions. In considering how issuers, employers, and other entities manage costs associated with benefits included as EHB, the NHC encourages CMS to examine how these strategies

affect access to medically necessary care, whether exceptions and appeals processes are timely and usable, and whether specific patient populations experience disproportionate barriers.

Evaluation of benefit affordability should also account for the long-term value of benefits that may improve outcomes and reduce avoidable costs. Preventive services, behavioral health care, chronic disease management, habilitative and rehabilitative services, prescription drugs, remote monitoring, care coordination, and other patient-centered services can help patients maintain function, manage conditions, avoid complications, and reduce preventable acute care. Treating these services only as premium drivers risks undervaluing their role in improving health and supporting long-term affordability. The NHC recommends that CMS incorporate patient experience, clinical evidence, and health outcomes data when evaluating whether benefit scope contributes to overall value.

Scope of Benefits Included as EHB

The NHC encourages CMS to maintain and strengthen EHB as a comprehensive coverage standard across all ten statutory categories. The NHC has previously emphasized that EHB are necessary to ensure patients have appropriate access to needed medicines and services but are not always sufficient on their own. A benefit may be formally included in a benchmark plan but still fail patients if coverage is subject to restrictive limits, unclear definitions, inadequate networks, unaffordable cost sharing, or administrative barriers that make the benefit difficult to use. The NHC therefore urges CMS to examine both the formal scope of covered benefits and the practical access conditions that determine whether coverage is meaningful.

Prescription drug coverage remains one of the most important areas for patient access and one of the areas where nominal coverage may not be sufficient. The NHC has previously raised concerns that drug-counting methodologies, while useful as an initial measure, are not adequate as the sole mechanism for ensuring appropriate access or nondiscrimination. The NHC continues to recommend that CMS evaluate prescription drug coverage in a way that looks beyond the number of drugs covered in a category or class and considers whether formularies provide access to clinically distinct products, drugs without adequate alternatives, drugs used by patients with complex or rare conditions, newly approved therapies, and medications that may be essential for patients who have already failed or cannot tolerate other therapies. The NHC also encourages CMS to consider how tier placement, coinsurance, prior authorization, step therapy, non-medical switching, formulary exception processes, and midyear formulary changes affect whether patients can obtain needed medications in practice.

The NHC recommends that CMS continue to give careful attention to habilitative and rehabilitative services and devices. These services are particularly important for people with disabilities, developmental conditions, injuries, chronic illnesses, and functional limitations, and they are not interchangeable. Habilitative services help individuals acquire, maintain, or improve skills and functioning, while rehabilitative services help individuals regain skills or functioning that have been lost or impaired. Benchmark plans that combine habilitative and rehabilitative limits, apply restrictive visit caps, exclude

important devices, or rely on unclear medical necessity definitions may undermine access for patients who need these services to live, work, learn, communicate, and participate in their communities. The NHC encourages CMS to evaluate whether current EHB policies are sufficiently clear and protective in this area and whether additional guidance is needed to ensure that patients can access both habilitative and rehabilitative services and devices.

Behavioral health services, including mental health and substance use disorder services, also warrant continued attention within the EHB framework. The inclusion of behavioral health as an EHB category is a critical protection, but patients continue to experience barriers related to network adequacy, service availability, cost sharing, utilization management, and fragmentation between behavioral health and physical health care. The NHC recommends that CMS evaluate whether EHB-benchmark plans reflect contemporary behavioral health needs and evidence-based models of care, including integrated care, crisis services, medication treatment for substance use disorders, and ongoing management for people with serious mental illness or co-occurring conditions. The NHC also encourages CMS to consider the interaction between EHB and other federal protections, including mental health parity requirements, so that formal benefit inclusion translates into actual access.

The NHC further recommends that CMS evaluate preventive services, wellness services, and chronic disease management as central components of a patient-centered EHB framework. For individuals with chronic conditions, prevention and disease management are not limited to annual screenings or general wellness activities; they may include monitoring, counseling, care coordination, self-management support, medications, devices, rehabilitation, behavioral health support, and other services that help patients avoid complications and maintain quality of life. The NHC encourages CMS to consider whether benchmark plans adequately reflect current clinical guidelines and whether limitations on these services undermine the ability of patients and providers to manage ongoing conditions effectively.

The NHC also urges CMS to evaluate how variation in EHB-benchmark plans affects services that are particularly important for children, pregnant individuals, newborns, families, people with disabilities, and others whose access needs may not be fully captured through aggregate plan comparisons. Pediatric services, maternity and newborn care, oral and vision care, and other population-specific benefits can have long-term implications for health, development, family stability, and equity. The NHC recommends that CMS assess these benefits with attention to both formal coverage and real-world access, including cost sharing, provider networks, benefit limits, and consumer understanding.

Finally, the NHC recommends that CMS consider defining and analyzing EHB at a level of detail sufficient to prevent ambiguity. Broad category labels may be useful for organizing benefits, but they are often insufficient for patients, advocates, issuers, regulators, and providers trying to understand what is covered. Coverage for a broad category such as inpatient hospital services, rehabilitative services, laboratory services, or chronic disease management may encompass many distinct items and services, and lack of specificity can make it difficult to identify gaps or enforce protections. The NHC

encourages CMS to explore standardized templates, clearer sub-benefit descriptions, and more detailed public-facing benchmark documentation that identifies covered services, limitations, exclusions, and relevant patient protections.

Updating EHB

The NHC supports a regular, transparent process for reviewing and updating EHB so that benchmark plans and federal standards keep pace with medical evidence, scientific advancement, health care delivery changes, and patient needs. A review cycle of every three to five years could provide predictability for states, issuers, patient organizations, and other stakeholders, while also helping to prevent the EHB framework from becoming tied to outdated plan designs. At the same time, the NHC recommends that CMS retain the ability to conduct targeted or event-driven reviews before the next scheduled cycle when warranted by significant changes in clinical practice, technology, public health needs, employer coverage patterns, or patient access concerns.

The NHC encourages CMS to ensure that any EHB review process includes meaningful patient and caregiver engagement. Patients and patient organizations can provide information that is not always visible in claims data or plan documents, including whether nominal coverage is usable, whether benefit limits create practical access barriers, whether cost sharing prevents adherence to treatment, and whether exceptions processes are understandable and timely. Incorporating patient input early in the review process, not only after technical completed analyses have already been completed, can help shape the questions CMS asks and the evidence CMS considers.

The NHC also recommends that CMS incorporate current clinical guidelines, evidence-based practices, medical advancements, and health outcomes data into any review of whether EHB needs to be modified or updated. The statutory direction to periodically review EHB to account for changes in medical evidence or scientific advancement is especially important for patients with conditions where treatment standards evolve rapidly or where new technologies, therapies, diagnostics, and care models may become clinically important before older benchmark plans reflect them. The NHC encourages CMS to ensure that the EHB framework is adaptable enough to recognize meaningful advances while preserving stability for patients and markets.

At the same time, the NHC urges CMS to treat EHB review as a patient-protective process rather than a vehicle for reducing coverage. Any review of additional or expanded benefits should examine cost implications, but it should also examine whether lack of coverage creates financial hardship, delayed care, worse outcomes, or cost shifts to patients, families, providers, and other payers. The NHC recommends that CMS assess both the cost of including a benefit and the consequences of excluding it, particularly where the benefit is important for chronic disease management, disability-related needs, behavioral health, maternal health, pediatric care, or access to prescription drugs and devices.

State Processes for Updating EHB-Benchmark Plans

The NHC supports a state benchmark update process that allows states to strengthen and modernize coverage while preserving federal oversight and transparency. Since state benchmark plans play a central role in determining what is treated as EHB, the process for updating those benchmarks should be accessible, predictable, and understandable to patient organizations and other stakeholders. The NHC encourages CMS to ensure that states have a clear pathway to propose improvements to benchmark plans, particularly where current benchmarks are outdated or do not reflect contemporary standards of care, while also ensuring that proposed changes are reviewed for compliance with statutory requirements, nondiscrimination protections, and patient access implications.

The NHC recommends that CMS clarify the documentation states must provide when submitting proposed benchmark updates. States should be encouraged to explain the rationale for proposed changes, identify the affected EHB categories, describe the evidence supporting the update, assess potential impacts on premiums and out-of-pocket costs, and describe how the state engaged patients, consumer representatives, providers, issuers, and other stakeholders. Where a proposed change may affect people with chronic diseases, disabilities, rare conditions, behavioral health needs, or other complex health needs, the NHC recommends that CMS request specific information on how the state evaluated those impacts and what safeguards are in place to prevent unintended access barriers.

The NHC also recommends that CMS provide technical assistance to states and stakeholders participating in the benchmark update process. States may vary in their capacity to conduct detailed benefit reviews, actuarial analyses, stakeholder engagement, and patient impact assessments. Patient organizations may also need clear timelines, plain-language materials, and accessible data to participate meaningfully. The NHC encourages CMS to develop guidance, templates, and examples that can help states prepare complete applications and help stakeholders understand how proposed benchmark changes may affect coverage.

In balancing federal oversight and state flexibility, the NHC recommends that CMS maintain a review process that is robust enough to identify patient access concerns without unnecessarily preventing states from improving coverage. A purely high-level compliance review may miss important benefit-specific issues, while an overly rigid process may discourage states from modernizing outdated benchmarks. The NHC encourages CMS to use a targeted approach in which benefit-by-benefit review is applied where a proposed change raises questions related to patient access, nondiscrimination, benefit category balance, affordability, or consistency with current standards of care.

Market Stability, Implementation, and Transition Protections

The NHC appreciates CMS' recognition that potential changes to how EHB are defined, interpreted, or updated may create transition and operational challenges. Changes to EHB can affect plan design, rate filings, product development, state regulatory review, formulary design, provider contracting, consumer education, and patient decision-making. For patients receiving ongoing treatment, changes to benefit classification,

coverage limits, cost-sharing protections, or utilization management can also create immediate and serious risks to continuity of care. The NHC therefore recommends that any future refinements to the EHB framework include adequate lead time, clear communication, and transition protections.

The NHC encourages CMS to align any future implementation timelines with rate filing, plan certification, and open enrollment processes so that states and issuers can operationalize changes and consumers can understand their coverage options before selecting a plan. Where changes are significant or complex, phased implementation may be appropriate to reduce disruption and allow CMS to monitor early effects. The NHC recommends that CMS also consider whether different types of changes require different implementation timelines, as a technical documentation change may require less lead time than a change affecting benchmark content, formulary classification, benefit limits, or consumer cost-sharing protections.

The NHC urges CMS to prioritize continuity of coverage for patients receiving ongoing care. Transition protections may be especially important for patients using prescription drugs, rehabilitation or habilitation services, behavioral health services, durable medical equipment, home-based services, or other treatments that cannot be interrupted without risk of harm. CMS should consider implementing protections such as advance notice, temporary continuation of coverage, exceptions processes, care transition periods, and targeted monitoring of complaints, denials, appeals, and access problems.

The NHC also recommends that CMS monitor both market-level and patient-level indicators after any future EHB refinements. Market-level indicators such as plan withdrawals, premium changes, enrollment volatility, and issuer participation may help identify broad disruption, but they will not necessarily reveal whether specific patient populations are losing access to needed care. Patient-level indicators, including complaints, appeals, denials, formulary exceptions, out-of-pocket spending, delayed care, network access problems, and utilization changes in key benefit categories, will be necessary to understand whether EHB changes are affecting real-world access. The NHC encourages CMS to make monitoring findings public where appropriate and to identify corrective tools that can be used if unintended consequences emerge.

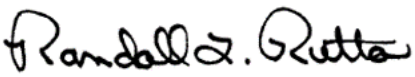
Conclusion

The EHB framework remains one of the Affordable Care Act’s most important patient protections. For individuals and families managing chronic diseases, disabilities, rare conditions, behavioral health needs, and other complex health needs, the scope of EHB affects whether coverage is comprehensive, affordable, predictable, and usable. The NHC appreciates CMS’ interest in reviewing the framework to ensure that it continues to reflect current market conditions, medical evidence, scientific advancement, and patient needs. At the same time, the NHC urges CMS to preserve the core purpose of EHB as a meaningful coverage floor and to avoid changes that would narrow benefits, increase patient cost exposure, or allow excessive variation in access based on state of residence.

The NHC recommends that CMS use this review to strengthen and modernize EHB through improved transparency, patient engagement, federal guardrails, periodic review, and careful oversight of benefit areas where nominal coverage may not translate into meaningful access. A patient-centered EHB framework can preserve state flexibility and market stability while ensuring that patients have access to the medically necessary care they need to manage their health and live as fully as possible.

Thank you for the opportunity to provide comments. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs, at kbeer@nhcouncil.org or Shion Chang, Assistant Vice President, Policy & Regulatory Affairs, at schang@nhcouncil.org if you or your staff would like to discuss these comments in greater detail.

Sincerely,



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