July 15, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted via regulations.gov.

RE: "Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard"

Dear Administrator Oz,

United States of Care (USofCare) is pleased to submit the following response to the request for information by the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) as it reviews the Essential Health Benefits (EHB) framework under the Affordable Care Act (ACA). USofCare values CMS's interest in the EHB framework and appreciates the opportunity to comment.

USofCare is a nonpartisan, nonprofit organization working to ensure everyone has access to quality, affordable health care regardless of who they are, where they live, or how much money they make. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people tell us will bring them peace of mind and make a positive impact on their lives. We uplift the voices of people whose perspectives and experiences with the health care system shape our advocacy. Through our work in the states, we identify perspectives from everyday people to amplify on both the state and federal levels.

Federal regulations require that enrollees in plans offered on the individual or small group markets and people enrolled as part of a state's Medicaid expansion are provided with coverage for ten areas of health care known as essential health benefits (EHBs). Currently, EHBs include ten categories of coverage without annual or lifetime limits. Prior to the establishment of the ten EHB categories under the ACA, most plans were unlikely to cover all ten essential health benefits, and plans that did cover any EHBs usually only did so with strict dollar limitations. Prior to the EHB requirements, 62% of individual market enrollees did not have coverage for maternity services, 34% did not have coverage for substance abuse services, 18% did not have coverage for mental health services, and 9% did not have coverage for prescription drugs. Since requirements were implemented, millions of people gained coverage for, and benefited from, these services which previously may not have been covered by their plan.

To ensure people have access to these critical care services, CMS developed a state benchmark approach to satisfy the EHB requirement while also allowing states the ability to adapt the requirement to fit people's demonstrated health care needs. **USofCare believes CMS's state benchmark approach to EHB allows states the flexibility to establish their own EHB coverage requirements while ensuring that people's coverage remains comprehensive and comparable to what people typically receive through private insurance.** To that end, we focus our comments on the following topics to ensure that EHBs continue to provide people with affordable, dependable, and sustainable access to care:

1. **Preserving existing consumer protections and state flexibility**

2. **Preventing reductions in access**
3. **Addressing high health care costs**

Preserving existing consumer protections and state flexibility

We appreciate CMS's interest in reviewing the impact of EHB on everyday people and state policymakers and regulators more broadly. **We believe any review of the EHB framework should remain true to the statute's original intent: to ensure access to comprehensive, affordable health coverage for all people.** CMS plays an essential role in this process through its unique state benchmark approach which relies on establishing robust, minimum national standards that protect people across all markets – including people with employer-sponsored coverage – paired with significant operational flexibilities for states.

CMS is right to consider ways to improve the EHB process. **In doing so, however, we believe CMS should continue to allow states the authority and flexibility to build upon this federal floor to ensure their benefit packages reflect the health care needs of their local populations through the benchmarking process.** States from across the country have used the flexible benchmarking process to close coverage gaps and respond to advances in medicines and related therapies to improve care for people, including Alaska to cover hearing aids and massage therapy and North Dakota to cover hearing aids and weight loss and diabetes drugs. In that vein, we encourage CMS to reaffirm its commitment to allowing states the flexibility to add benefits to their benchmark plan and restart its review of applications submitted by California, Nevada, and Utah to cover services like in vitro fertilization, treatment for autism spectrum disorder, and substance use disorder treatment.

At the same time, we recognize federal statute requires CMS to undergo periodic review of EHB to ensure they reflect best medical practice and address coverage gaps for people. More than 40 states and the District of Columbia still rely on benchmark plans developed more than a decade ago, and we believe these plans likely don't reflect benefits offered by employer-sponsored coverage today. **A periodic, evidence-based review process, guided by full public transparency and comment opportunity, would provide states with a much-needed update and should be used by CMS to build upon, and not restrict, the existing 10 EHB categories**. These new categories could then be incorporated into each state's benchmark plan to provide comprehensive coverage for people that even more rigorously reflects best medical practices and each states' individual needs. Anything short of this open, transparent process could lead to additional administrative complexity for CMS and needlessly restrict the existing flexibilities states have enjoyed over the past 15 years to ensure EHB are responsive to people's demonstrated health care needs.

Preventing reductions in access

We appreciate CMS seeking comment on how to approach the typicality standard and encourage CMS to utilize this standard in a way that ensures people are protected and covered when they need it and avoid any reductions in access. **States have utilized the existing framework and flexibilities to ensure coverage is robust and meets the unique needs of their population.** It has also allowed states to increase access and reduce barriers to important services, like mental health and substance use disorder (SUD) services, for people. This is particularly important for rural populations where access challenges have been particularly acute. Certain subgroups within rural communities, including farmers, ranchers, and other agricultural workers, are disproportionately likely to have coverage on the individual market and thus benefit from EHB.

We urge CMS to use typicality as a guide for minimum coverage levels rather than maximum coverage levels. We are concerned about any regulations that would require EHB coverage to not exceed the coverage typically provided by employer-based plans. Employer plans have traditionally excluded the very same services the ACA meant to improve access to, including mental health and SUD services, maternity and newborn care, and rehabilitative and habilitative services. It also takes time for many employer plans to respond to changes in medical evidence or scientific advancements that indicate that a particular and relatively new service should be made available for enrollees.

Relatedly, we are also concerned about CMS relying on measures that consider what plans cost – rather than what they cover – when determining a "typical" employer plan. This concern extends to the use of actuarial value (AV) in determining EHB, as that is generally used to determine the share of costs an enrollee versus a plan are expected to pay. **Utilizing some measure related to AV to determine benefits will likely lead to people having higher out-of-pocket costs and could lead to a "race to the bottom" within plans and we oppose any shift toward this metric.**

Additionally, while we expect to continue to see more plans enter the market that offer lower premiums with less generous coverage, they should not be looked at as a typical plan for the purposes of establishing the benchmark benefits a plan must provide. These plans have low premiums because they offer less generous and comprehensive coverage, and they therefore should not set the standard for how robust a state's benchmark should be. While these plans may appear cheaper initially, they often leave people with high out-of-pocket costs or don't cover what people need. They can also lead to other costs for states and the health care system overall, such as increases in unmet need, unaddressed medical conditions, or unnecessary emergency room visits.

Addressing high health care costs

We appreciate CMS's emphasis in the RFI on health care affordability for people. Our own public opinion research shows that nearly three-in-four people agree that health care costs are unaffordable. We work at both the state and federal levels to promote policy solutions, ranging from reference-based pricing to limits on the growing corporatization of health care, that lower the cost of care and save people money.

The research is clear. High health care prices, including those charged by hospitals, rather than EHB are a dominant factor in driving people's health care costs up, including the premiums people pay. **By contrast, any premium increases tied to states' decisions to expand EHB have been marginal at best:** an actuarial analysis in Virginia found that expanding EHB to cover medical formula and advanced prosthetics raised premiums by just 0.37%. A similar study in Washington found that expanding EHB to cover human donor milk, hearing aids, and fertility services increased premiums by just 0.09%. In many cases, EHBs may even save people money by increasing access to critical preventive care services, which can allow people and their providers to identify and address conditions early before they're more costly to treat down the road. If states move to restrict access to critical EHB services, such as behavioral health services or prescription drugs, it could delay people's treatment, increase avoidable emergency department utilization, and ultimately increase overall health care spending and people's health care costs through increased premiums and out-of-pocket costs.

Given recent Marketplace changes under H.R. 1 and projected corresponding decline in Marketplace enrollment nationwide, we urge CMS to carefully consider how these broader coverage and eligibility changes affect people's health care affordability challenges and market

stability more broadly. **People have long depended on the comprehensive coverage provided by EHB; any change to this benefit package could cause additional people to drop off coverage, which *would* raise premiums for the remaining covered populations and increase costs for taxpayers through higher premium tax credits. Thus, protecting comprehensive EHB requirements is an essential component of maintaining a diverse, stable risk pool that keeps coverage affordable long term for people across demographics.**

Conclusion

Thank you for the opportunity to respond to the request for information as CMS reviews the EHB framework. We hope that the information provided will guide the agency through future rulemaking periods. We are grateful for the opportunity to share the lessons learned from our work listening to people and our earned expertise from our unique approach to state work.

If you have any questions or further comments, please reach out to Alyssa Penna, Director of Federal Policy, at apenna@usofcare.org.

Sincerely,

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United States of Care