July 15, 2026

Robert F. Kennedy Jr., Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

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

Dear Secretary Kennedy:

For over 57 years, the National Health Law Program (NHeLP) has advocated, educated, and litigated to preserve, protect, and expand access to health care for low-income and underserved populations. We appreciate the opportunity to comment on this Request for Information (RFI) regarding coverage of Essential Health Benefits (EHB).[1]

Since the enactment and early days of implementation of the Affordable Care Act (ACA), NHeLP has been deeply involved in conversations with the U.S. Department of Health and Human Services (HHS), the Center for Consumer Information and Insurance Oversight (CCIIO), state officials, and stakeholders, to advocate for improvements in access to key services through EHB coverage. EHBs are one of the most important provisions of the ACA. While the law significantly expanded access to health coverage through Medicaid expansion and key Marketplace reforms, the EHB provision helped ensure that coverage would be not just affordable but also comprehensive. The provision also provided the tools for HHS to address ongoing and emerging gaps in necessary care.

Since 2012, HHS under different administrations has worked closely with states to implement the EHB coverage requirement in accordance with the intent of the ACA of expanding access to services that were traditionally neglected in the U.S. health care system. Through the various iterations of the EHB benchmarking process, HHS has afforded states the flexibility of defining EHBs in a way that addresses the health care needs of their populations, while also protecting affordability for consumers. In short, the EHB benchmarking process has been a successful story of federalism: HHS has established minimum standards and allowed states to fill in the gaps recognizing that different states have different needs and priorities.

As such, our request to HHS is simple: use the authority the ACA gave the Department to improve upon the current EHB standards and expand access to care, but do not disrupt the process at a time where states are actively relying on the law and regulations to fix persisting problems with access to care. Above all, HHS should take no action that would lead to a reduction in coverage requirements and should continue to afford states significant flexibility in determining EHB coverage within the various benefit categories.

To that end, below we have provided feedback on various of HHS's questions under each specific topic in the RFI. While we do not purport to answer all of the questions, we provide specific comments for several sections, while also making general recommendations on others.

We also express our strong objection to the truncated, thirty-day public comment period for the 2026 EHB RFI. The EHB coverage and cost sharing protections are complex and of paramount importance to health care consumers, particularly people with disabilities or chronic conditions and those historically underserved. We note that a similar 2023 EHB RFI had a 60-day public comment period.[2] HHS provides no explanation of how comments on the 2023 EHB RFI inform the Department's thinking and makes no mention of that earlier RFI when describing the EHB regulatory history. We are concerned that HHS will seek to rush a rulemaking that seriously undermines EHB. It should not.

[1] U.S. Dep't of Health & Hum. Srvs., 91 Fed. Reg. 35938–35944 (June 15, 2026).
[2] U.S. Dep't of Health & Hum. Srvs., 87 Fed. Reg. 74097–74102 (Dec. 2, 2022). *See also* Héctor Hernández-Delgado & Wayne Turner, Nat'l Health Law Prog., *NHeLP Comments on Essential Health Benefits (EHB) Request for Information (RFI)* (Jan. 31, 2023), https://healthlaw.org/resource/nhelp-comments-on-essential-health-benefits-ehb-request-for-information-rfi/.

Topic 1: Typical Employer Plans and Typicality

HHS seeks comments regarding factors the Department should consider when determining typicality of employer plan coverage for purposes of defining EHB pursuant to 42 U.S.C. § 18022(b). We caution HHS that interpreting the typical employer plan (TEP) provision in any way that results in the exclusion or restriction of services as EHB would create or perpetuate significant gaps in EHB coverage and would be contrary to the ACA's design and intent. Moreover, such an interpretation is inconsistent with HHS's authority under the ACA to periodically review and update EHB. We urge HHS not to set coverage limits or exclusions and instead continue to define typicality as a general actuarial range based on broad array of comparison plans, just as it has done since the inception of the benchmarking process.

A. Typical Employer Plan

The ACA gave the HHS Secretary broad authority to define EHB coverage, except that EHB coverage must always extend to *at least* the ten categories listed in the statute.[3] Furthermore, the HHS Secretary has the authority and responsibility to periodically review and update EHB coverage when such review shows that updates are necessary to account for changes in medical evidence or scientific advancement or to close remaining gaps in coverage.[4] The Secretary's statutory authority to define, review, and update EHB is subject to the TEP provision, which states that "the Secretary shall ensure that the scope of [EHB]…is equal to the scope of benefits provided under a typical employer plan."[5]

We are concerned that HHS may seek to interpret the "equal to" phrase as requiring the exclusion of services not covered by a selection of employer-based plans. This interpretation is problematic for two reasons. First, it ignores the intent of Congress in enacting the EHB provision, which was to ensure access to services that were traditionally excluded from coverage. The statute requires that, in defining EHBs, the Secretary of HHS must ensure coverage of at least the ten listed categories. Congress specifically required coverage of such services, irrespective of typicality, because prior to the enactment of the ACA, individual and small-group market plans often excluded or severely limited coverage of services within those service categories. For example, prior to the ACA, 75% of non-group market plans did not cover maternity care and 45% did not cover inpatient/outpatient substance use disorder (SUD) services.[6]

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[3] 42 U.S.C. § 18022(b)(1) (emphasis added).
[4] 42 U.S.C. § 18022(b)(4)(G)–(H).
[5] 42 U.S.C. § 18022(b)(2)(A). The ACA states that what constitutes a typical employer plan is to be determined by the HHS Secretary and informed by a survey of employer-based plans, including multiemployer plans, conducted by the Department of Labor (DOL).
[6] Gary Claxton et al., KFF, *Would States Eliminate Key Benefits if AHCA Waivers are Enacted?* (2017), https://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/.

While coverage of some services within these and other EHB categories among employer plans can be expansive, many employer plans nonetheless also historically excluded or provided sparse coverage of the very same services for which the ACA meant to improve access.[7] As such, narrowly applying the TEP equivalence provision may end up dragging down coverage of EHBs to the point of making EHB protections meaningless. It would make no sense for the ACA to create a requirement to cover specific services and at the same time allow TEP to limit or exclude coverage. Under the harmonious-reading canon of statutory construction, a section requiring the scope of EHB benefits to be equal to the scope of coverage in a TEP arguably should not be construed as excluding any particular benefit because that would make it contradictory to other provisions in the ACA seeking improvements in coverage of EHBs.

Second, using TEP coverage to justify the exclusion of certain services as EHB is also contrary to the statute conferring HHS the authority to periodically review and update EHBs, particularly when new coverage requirements are necessary to account for changes in medical evidence and scientific advancement. If changes in medical evidence indicate that a particular service should be made available for beneficiaries, it likely will take some time for most employer plans to extend coverage to those services. The ACA provision requiring HHS to review and update EHB coverage clearly did not intend for beneficiaries in individual and small-group market plans to be at the mercy of employer plans deciding when to cover new and effective services and procedures.

Moreover, applying TEP coverage as an exclusionary factor would make the authority to review and update EHB meaningless. If Congress had intended EHB updates to be strictly limited by TEP coverage, it would not have expressly authorized HHS to review EHB and would not have provided clear bases for adding new benefits: changes in medical evidence and scientific advancement, difficulty accessing needed services due to coverage or costs, and remaining gaps in coverage. If Congress intended the TEP provision to be read exclusionary, HHS would only need to review TEP coverage when updating, irrespective of scientific advancement and gaps in coverage. Clearly, that is not what Congress did.

To determine typicality, HHS (and states through benchmarking) should always look at a comparison set of plans, rather than a single employer plan as representative of typical employer plans. We oppose any definition of typicality that would require full equivalence with any particular singular employer plan, or a benefit-by-benefit analysis rather than scope of coverage. Such an interpretation would not stand a rigorous statutory interpretation analysis, would not comport with Congress's intent, and would represent a significant departure from HHS's previous definitions of TEP.

[7] *See* Dep't of Labor, *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services* (2011) [hereinafter 2011 DOL Report].

First, to truly understand the TEP provision we must look at the meaning of the words in conjunction with each other. The word "typical" is an adjective meaning "showing all the characteristics that you would usually expect from a particular group of things" or as "combining or exhibiting the essential characteristics of a group."[8] This description or modification is done by indicating number or extent, ascribing a quality, or distinguishing one thing from another. By definition, therefore, no single plan should be used to define typicality; rather a set of plans creating a range of scope of benefits must be considered to arrive at typicality.

Second, the ACA explicitly tied the typicality analysis to a survey of employer-sponsored coverage conducted by the Department of Labor (DOL). While the statute does not provide further guidance as to the components of this survey, it is evident that Congress intended for an evaluation of a spectrum of employer insurance plans, rather than a single plan, to inform HHS's determination of typicality. Congress also expressly required the typicality analysis to include multiemployer plans.[9] Multiemployer plans, which result from collective bargaining agreements, have been found to have far more generous benefits and less cost sharing than other employer plans.[10] Under the benchmarking process, states should be allowed to use a broad spectrum of comparison plans to define EHBs, reflecting the broad spectrum of plans described in the ACA's TEP provision.

Finally, HHS has implemented typicality through benchmarking by having states look at a range of plans. Initially, the benchmarking process required states to select one benchmark plan out of that range that would be representative of TEP. HHS subsequently expanded state benchmark options, allowing states to create a benchmark plan that combines elements of coverage from all of the benchmark plan options. HHS further expanded upon this benchmark approach in recognition that not one single plan can define typicality. We strongly urge HHS to maintain an EHB definition process based on evaluation of a range of typicality and not propose some new typicality interpretation that cuts benefits or restricts state flexibility.

[8] Cambridge Dictionary, https://dictionary.cambridge.org/us/dictionary/english/typical; Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/typical.
[9] 42 U.S.C. § 18022(b)(2)(A). *See also* 29 U.S.C. § 1002(37)(A) (defining multiemployer plans).
[10] Jon R. Gabel et al., *Collectively Bargained Health Plans: More Comprehensive, Less Cost Sharing Than Employer Plans*, 34 HEALTH AFFAIRS 3 (Mar. 2015), https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0952.

B. Defining Scope of Plan Benefits

In selecting the plans that would constitute a range for typicality purposes, HHS should be as expansive and as inclusive as possible. Given that typicality is defined by looking at a group of plans, it is not enough to look at the largest plans by enrollment. Rather, the starting point to determine the scope of plan benefits in TEP should be the DOL survey summarizing coverage levels among a wide variety of employer plans, including both large and small employers. Additionally, since the statute requires the DOL to include multiemployer plans in its survey, those plans should always be part of the analysis.

We note that, at a minimum, the 15 plans that currently make up the typicality range for the state benchmarking process should be the starting point to determine typicality. Those plans are:

- The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State;
- The largest health plan by enrollment in any of the three largest small group insurance products by enrollment in the State's small group market;
- Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees;
- The coverage plan with the largest insured commercial non–Medicaid enrollment offered by a health maintenance organization (HMO) operating in the State.

While these plans represent a good starting point to establish a range of typicality, there are various additions we believe are necessary to determine typicality of employer plans. For instance, HHS should consider including Medicaid plans in the scope of benefits analysis. Individuals working for large employers are increasingly having to rely on Medicaid for their health care coverage. Excluding the federal government, the top five largest employers in the U.S. are Walmart, Amazon, FedEx, The Home Depot, and the United Parcel Service (UPS). Four out of five of these employers are on the Institute for Policy Studies' 2026 report America's 20 Largest Low-Wage Employers and the Affordability Crisis.[11] Collectively this accounts for approximately 6.7 million people in the U.S.

The report found that 15 of the 20 companies reported median pay in 2024 below the $35,631 income limit for a family of three to be eligible for Medicaid. Of these large employers, Walmart and The Home Depot on average paid wages that qualified for Medicaid. Amazon, on average, pays slightly above the income threshold for Medicaid,

[11] Sarah Anderson, America's 20 Largest Low-Wage Employers and the Affordability Crisis (Mar. 4, 2026), https://ips-dc.org/report-americas-20-largest-low-wage-employers-and-the-affordability-crisis/.

which would make employees eligible for premium assistance in the Marketplace. This data can be further gleaned from the handful of states that have disclosed data on these companies' reliance on public assistance programs. In Nevada, Walmart had almost 30% of their employees enrolled in Medicaid in 2024 and Amazon had about 48% of employees enrolled in Medicaid in 2024. Given the increasing reliance on public assistance health care programs from large employers circumventing their responsibilities to provide coverage to their employees, it would be reasonable to conclude that such programs are part of the typicality range of employer coverage.[12]

We also question HHS's sudden interest in self-funded plans in the typicality range analysis and caution against cherry-picking self-funded plans that provide skimpy benefits and that would drag down the scope of benefits, as such actions would impede the purpose of the EHB requirement. The RFI's language seems to suggest that self-funded plans are already included in the typicality analysis, despite the fact that no self-funded plan is contemplated in the 15 benchmarking plan options discussed above. Nonetheless, because 67% of all covered workers are covered by self-funded plans, we agree that typicality would be best defined by incorporating coverage among self-funded plans.[13] In addition, the statutory language extends to "plans" and is not limited to health insurance products. We therefore believe it is necessary to include self-funded plans to establish a range of typicality, but only to the extent that HHS looks at a wide range of self-funded plans and it does not result in the exclusion of any specific service as EHB.

By establishing a range of typicality defined by a combination of large-group insurance plans, small-group insurance plans, state-employee plans, federal employee plans, individual commercial plans, public assistance programs, and self-funded plans, HHS would be adopting a definition that more accurately resembles the scope of coverage typically covered by employer plans. We note that in 2025, HHS expressly rejected considering the scope of benefits provided by large employers because "larger employers tend to have more financial resources to provide a more generous benefit set."[14] HHS further posits, without citation or other evidence, that the TEP provision "acts to restrain the EHB from reflecting the more generous and costly health plans offered by very large employers."[15] This absurd claim has no basis in law.[16]

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[12] Medicaid, including for the expansion population, generally offers more generous benefits than other forms of health care coverage. *See* Nat'l Health Law Prog., What Makes Medicaid Medicaid? Series (Apr. 2023), https://healthlaw.org/resource/what-makes-medicaid-medicaid-series/. *See also* Geraldine Doetzer, Wayne Turner, & Shandra Hartly, Nat'l Health Law Prog., *NHeLP Comments on Idaho 1332 Waiver Application* (May 14, 2026), https://healthlaw.org/resource/nhelp-comments-on-idaho-1332-waiver-application/.

[13] KFF, 2025 Employer Health Benefits Survey (Oct. 2025), https://www.kff.org/health-costs/2025-employer-health-benefits-survey/.

[14] U.S. Dep't of Health & Hum. Srvs., 90 Fed. Reg. 27155 (June 25, 2025).

[15] *Id.*

[16] 42 U.S.C. § 18022.

In the 2026 RFI, HHS also asks whether scope of coverage in TEP should be defined using actuarial scope as opposed to a definition based on a specific set of benefits or any other alternative methodology. We strongly believe a scope of coverage analysis best captures the intent of the ACA and that HHS should refrain from using a benefit-by-benefit analysis. The TEP provision in the EHB statute clearly did not intend for HHS to do a benefit-by-benefit analysis in determining typicality. The statute clearly requires HHS to ensure EHB coverage is equal to the *scope* of coverage in TEP. If Congress intended HHS to require full equivalence broken down to benefits and categories, it would not have included the word "scope". The inclusion of this word requires a typicality range that enables EHB categories and services to be defined based on an actuarial scope.

We caution, however, that while some type of actuarial analysis is intended, specifically using actuarial value (AV) is not the correct methodology in this scenario. HHS incorrectly states that "[w]e also established typicality and generosity standards requiring States to demonstrate that the total AV of their EHB is no more or less generous than the total AV in the State's most and least generous typical employer plans…"[17] The current rule requires EHB benchmark plans to be "as or more generous than the scope of benefits in the least generous plan, and as or less generous than the scope of benefits in the most generous plan in the State."[18] This phrase contains no reference to AV, nor could it do so: whereas AV is defined using cost-sharing information, cost-sharing is irrelevant to the scope of coverage question.

HHS has specified that an accepted methodology would be to "calculate the *expected value* of covering all of the benefits at 100 percent actuarial value…in the proposed EHB-benchmark plan and in the "Typical Employer Plan" or "Comparison Plan" in order to determine whether the plan satisfies the actuarial tests.[19] Basing comparability on expected value is also consistent with the statute, which requires an analysis and certification of the benefits by the Chief Actuary at the Centers for Medicare and Medicaid Services (CMS), not actuarial value or cost sharing.[20]

For the reasons explained above, we are convinced that using an expected value score that sets a minimum and a maximum level of coverage that states may use to select their benchmark plan provides states with enough flexibility to address unmet health needs among their populations, while at the same time protecting consumers against significant increases in premiums. We urge HHS to continue to allow states to incorporate any service the state deems necessary into their EHB benchmark plan, including services that go

[17] 91 Fed. Reg. 35940.
[18] 45 C.F.R. § 156.111(b)(2)(ii).
[19] *See* Ctrs. For Medicare & Medicaid Srvs., Example of an Acceptable Methodology for Comparing Benefits of a State's EHB- benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii) (Apr. 9, 2018), https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-example-acceptable-methodology-for-comparing-benefits.pdf.
[20] 42 U.S.C. § 18022(b)(2)(B).

beyond the ten categories listed in the statute, as long as the resulting expected value of the plan is not lower than the expected value of the least generous benchmark plan option and does not exceed the expected value of the most generous benchmark plan option.

C. TEP Selection Approach

We support maintaining the current benchmarking approach that allows states to define EHBs. As we explain further in our comments responding to Topic 2: State Selection of EHB Benchmark Plans - National Standards and Variation Across States, this approach has allowed states to address unmet health needs among their populations by allowing them to create a benchmark plan within the actuarial range of typicality as defined by a comparison set of plans. By using a set of plans based on products offered to employees in the state, benchmarking allows states to better capture the scope of benefits provided by typical employer plans in their states. In turn, allowing states to look at an actuarial range rather than perform a benefit-by-benefit analysis has led to significant improvements in EHB coverage of services where gaps remain that contribute to widening disparities among underserved populations.

While we support maintaining the status quo when it comes to defining typicality for purposes of benchmarking, we urge HHS to make several adjustments in addition to expanding the list of plans generally that make up the typicality range. First, HHS should not allow states to continue defaulting to a small-group market plan. These plans are typically the least comprehensive options and, on their own, are not representative of employer coverage. By establishing these plans as the default, HHS is essentially allowing states that do not engage in the benchmarking process to circumvent the requirement that EHB coverage be tied to the scope of coverage in TEP.

Instead, we urge HHS to establish the largest national FEHBP plan as the default option, while maintaining states' ability to select a plan with a lower expected value. This approach would incentivize states to actively evaluate the health needs of their populations, engage in conversations with stakeholders, and select a plan that includes benefits that reflect those health needs. Absent that engagement from the state, consumers would still be able to access a comprehensive set of benefits with FEHBP as the default benchmark plan. This action would also prioritize the health of the population and lower long-term costs associated with unmet health needs over small premium increases.

We also note that states that have yet to update their benchmark plans using the current benchmarking approach have benchmark plans that are based on plans that were in effect in 2017. As a result, those benchmark plans are unlikely to reflect the scope of coverage in TEP as it exists today. At a minimum, HHS should require all states to update their benchmark plans using the 2024 versions of the benchmark options.

Finally, in line with keeping an approach that allows states to use a range of typicality, we urge HHS to allow states to incorporate add-on plans for benefits that are not currently considered EHBs for purposes of determining the typicality range. For example, some state marketplaces offer family dental plans that can be added to the health insurance plan selection. If states were allowed to incorporate adult dental benefits to their EHB benchmark plan, they would likely only be able to do so if the addition keeps the benchmark plan below the generosity level of the most generous benchmark plan option. Because adult dental services tend to be costlier, states have had difficulty meeting the generosity limit when adding adult dental services.

This problem reflects the fact that adult dental services are traditionally offered separate or in addition to health insurance plans, but it ignores the fact that the majority of large and small employers offer some type of dental plan.[21] Notably, the 2011 DOL survey found that employer plans "typically grouped dental services into categories, such as preventive services (typically exams and cleanings), basic services (typically fillings, dental surgery, periodontal care, and endodontic care), major services (typically crowns and prosthetics), and orthodontia."[22] As such, HHS should rescind the regulatory prohibition on adult dental services as EHB at 42 C.F.R. § 156.115(d), and allow states to include in the range of typicality family dental (or other service-specific) plans offered in conjunction with any of the benchmark plan options.

Topic 2: State Selection of EHB Benchmark Plans - National Standards and Variation Across States

We have previously recommended that HHS establish robust federal definitions in all ten EHB categories and allow states to build upon a federal minimum.[23] While robust federal minimum standards remain important, we recognize the important role that the benchmarking approach has played in allowing states to address urgent and unmet health care needs for their residents. We strongly urge HHS to retain the state benchmarking approach, and support, rather than obstruct, state benchmarking efforts. We also oppose any efforts to cut or reduce EHB coverage standards. For additional discussion regarding scope of benefits and the role of HHS in establishing national standards while maintaining state flexibility, see our responses to Topic 4 below.

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[21] Mployer, The Borring Yet Obligatory Guide to dental & Vision Insurance For Employers, (Sept. 18, 2024), https://mployeradvisor.com/blog/the-boring-yet-oblig≥agostoatory-guide-to-dental-vision-insurance-for-employers.

[22] 2011 DOL Report, *supra* note 7, at 9.

[23] Wayne Turner, Héctor Hernández-Delgado & Fabiola Carrión, Nat'l Health Law Prog., *NHeLP Letter to HHS Sec. Becerra - Re: Advancing Health Equity Through Essential Health Benefits* (Dec. 6, 2021), https://healthlaw.org/resource/nhelp-letter-to-hhs-sec-becerra-re-advancing-health-equity-through-essential-health-benefits/. Note that HHS has already established minimum definitions in three EHB categories: prescription drugs (45 C.F.R. § 156.122), preventive services (45 C.F.R. § 156.115(a)4)), and habilitative and rehabilitative services (45 C.F.R. § 156.115(a)(5)).

As of 2024, more than a dozen states have updated their EHB benchmark plans, adding or improving benefits to better meet the needs of residents, including:

- Illinois - telepsychiatry and topical anti-inflammatory medication; placed time limitations on opioid prescriptions; added coverage for opioid-reversal agents to be provided with opioid prescriptions, and removed barriers to prescription of buprenorphine products for medication-assisted treatment;
- Oregon - spinal manipulation, acupuncture, and opioid-reversal agents to be provided with opioid prescriptions and removed barriers to prescription of buprenorphine products for medication-assisted treatment;
- New Mexico - artery calcification testing and new formulary drugs; expanded coverage for weight loss services; and removed limitations on prosthetic coverage;
- Michigan - opioid-reversal agents to be provided with opioid prescriptions and removed barriers to prescription of buprenorphine products for medication-assisted treatment;
- Vermont - hearing aids/exams;
- Virginia - removed barriers to coverage for medical formula and prosthetic devices;
- North Dakota - hearing aids, nutritional counseling, periodontal disease services, PET scans, and opioid-reversal agents to be provided with opioid prescriptions;
- Washington State - human donor milk, hearing aids and exams, and artificial insemination;
- Colorado - acupuncture treatments, mental health wellness exams, abortion services, expanded prescription drug coverage, and transition-related services to treat persons with gender dysphoria;
- Washington, DC - infertility treatment;
- Alaska - hearing aids/exams, massage therapy, additional chiropractic visits, temporomandibular joint (TMJ) services, and expanded the nutritional counseling benefit. [24]

Through updates to their EHB benchmark plans, these states have significantly improved and expanded benefits to meet the needs of residents. The current benchmarking framework ensures that improvements were well-within actuarial limits with minimal impact on premiums. Moreover, the broader impact on health outcomes and quality of life, particularly for persons with disabilities and chronic conditions, has been incalculable. HHS should be working with states to facilitate these improvements. Instead, this Administration has obstructed state efforts.

To our knowledge, at least three states submitted EHB benchmark proposals by the May 7, 2025 deadline for changes to take effect by January 2027:

[24] Ctrs. For Medicare & Medicaid Srvs., Information on Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/marketplace/resources/data/essential-health-benefits.

- California – fertility services, improved coverage of hearing aids and durable medical equipment including hearing aids;[25]
- Nevada – expanded coverage of HIV and hepatitis C treatments, as well as drugs approved for the treatment of, and withdrawal from, opioid use disorder;[26]
- Utah – behavioral health treatment for autism spectrum disorder.[27]

Each of these states invested considerable time and resources developing their EHB benchmark proposals. They solicited public input, conducted hearings, commissioned actuarial analyses, engaged in deliberative processes, and in some cases enacted legislation, all while relying on the EHB benchmarking framework proposed by HHS nearly fifteen years ago. The three states also submitted the required actuarial evaluations, which show that by staying within the actuarial limits, the new benchmark plans would not result in significant increases in premiums.

However, HHS has refused to act upon these applications. in February 2026, HHS confirmed that it halted review of pending EHB benchmark updates.[28] HHS also cancelled, without explanation, EHB Benchmark Modernization grants, which provide funding for states to evaluate benchmark plans for potential changes and to comply with federal actuarial requirements when seeking changes.[29] HHS should immediately approve these pending EHB benchmark updates and restore grants to states to review their benchmark plans.

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[25] California Dep't of Managed Health Care, Press Release, DMHC Applies to Update California's Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs (May 5, 2025), https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx.

[26] Nevada Div. of Ins., Lewis & Ellis, LLC, Plan Year 2027 Benchmark Plan Change Actuarial Report (Feb. 11, 2025), https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Healthcare_Reform/Individuals_and_Families/Essential_Health_Benefits/NV457-2302%20DRAFT%20Nevada%20EHB%20actuarial%20report(1).pdf.

[27] Utah Insurance Dep't, Proposed 2027 Utah Essential Health Benefit Plan (May 5, 2025), https://insurance.utah.gov/proposed-2027-utah-ehb-plan/.

[28] U.S. Dep't of Health & Hum. Servs., 91 Fed. Reg. 6302 (May 20, 2026); State insurance regulators from California, Utah, and Nevada with pending applications, as well as consumer advocacy organizations, harshly criticized HHS for its lack on action. *See* Amy Lovten, *Stakeholders Push Admin to Restart Review of EHB Benchmark Plans*, INSIDE HEALTH POLICY (Apr. 22, 2026); Letter from NAIC Consumer Representatives to NAIC President Scott A. White et al., *Re: Protecting state flexibility in Essential Health Benefits* (Apr. 2, 2026), https://docs.google.com/document/d/1LblVVLDMhDPut90af1XH5WJgbNr2aaJoQEY0mdLFeWM/edit?tab=t.0.

[29] EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange, CMS-2U2-25-001, https://www.grants.gov/search-results-detail/356740.

Topic 3: Affordability and Cost

What does cost mean when determining EHB categories? Cost can be viewed in terms of the short term and the long term. Often in health care systems, lowering one cost may increase the cost in another area. When thinking of what aspects of EHBs most significantly influence premium levels in the individual and small-group markets, it is not appropriate to ignore the cost of cutting coverage, services, or the scope of care, particularly given the ACA and its EHB provisions were passed to increase coverage and to reduce the burden of health care costs on the population.[30]

Federal policy changes that directly impact the risk pool are a significant driver of health care cost growth. Rising consumer costs and cuts to covered services, particularly in the ACA Marketplace, results in fewer people enrolling in ACA plans. These actions decrease the risk pool leading to an increase in health care costs spread across a smaller population.[31] If more people are disincentivized to maintain health care coverage or priced out of health care, the average health expense per person rises. Even if we consider that risk pooling can lead to lower premiums for people who use less health care services, a "healthy" person can become "unhealthy" suddenly through accident or illness. Further, the cost increase for people who need more frequent care outweigh the cost savings of those who do not.[32] Health care is not just for healthy people.

A. Essential Health Benefits and Affordability

HHS's premise regarding affordability of EHBs is flawed. HHS assumes that EHBs are driving premium increases, and, by implication, are connected with broader health care affordability concerns. HHS has repeatedly advanced, without evidence, the claim that EHBs are a significant factor in the high price of health care – for instance, in the Notice of Benefit and Payment Parameters (NBPP) for 2027, HHS asserted without evidence that the current policies governing defrayal of EHBs drive up premiums, increase federal spending on advance premium tax credits (APTCs), and discourage enrollment by unsubsidized

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[30] *See* S. Rept. No. 111-89 at 4 ("[T]his legislation achieves the goals of expanding health care coverage to the uninsured, reducing health care costs and improving the quality of care by transforming the health care delivery system"); see also Administration of Barack H. Obama, 2010, Remarks on Signing the Patient Protection and Affordable Care Act (March 23, 2010) ("Once this reform is implemented, health insurance exchanges will be created, a competitive marketplace where uninsured people and small businesses will finally be able to purchase affordable, quality insurance…And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care."). 20 42 U.S.C. § 18022(b)(4)(H).

[31] Linda J. Blumberg & Justine Giovannelli, The Commonwealth Fund, *What Health Insurance Risk Pooling is and Why It's Key to Maintaining Affordability* (Mar. 2026), https://www.commonwealthfund.org/publications/explainer/2026/mar/health-insurance-risk-pooling-key-maintaining-affordability.

[32] *Id.*

enrollees (those not receiving any premium tax credits).[33] These unfounded assertions are in line with the longtime targeting of EHB requirements by those hostile to the ACA.[34]

Certainly, the cost of health care is a matter of great public concern. A recent KFF survey found that the cost of health care was the most significant of the public's "economic anxieties," outranking other cost concerns like food and housing.[35] However, the administration talks out of both sides of its mouth when it comes to health care affordability: it states a desire to bring down the cost of health care while simultaneously "engag[ing] in numerous legislative and regulatory efforts that have made health care coverage "more expensive" and "less comprehensive," and which "seriously undermine and destabilize the health insurance market."[36] The administration's actions belie its stated focus. Rather than promoting affordability, it attempts to sabotage the ACA and tries to mask those efforts under a veneer of promoting affordability. But the proof is in the numbers. ACA premiums are up over 20% in 2026 due to the expiration of the enhanced premium tax credits that offered critical relief from high health care costs, and deductibles have reached a "record high" of $3,786 per person in 2026 – up 37% from 2025.[37]

Reaching back even further, there is a direct through-line from efforts to undermine the ACA to the affordability issues we see today, including premium increases. Rejecting Medicaid expansion forced enrollees who would otherwise be eligible for Medicaid into Marketplace coverage, which contributed to increased premiums in non-expansion states because these enrollees are generally more expensive to insure.[38] In addition, more than

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[33] U.S. Dep't Health & Hum Servs., 91 Fed. Reg. 6292, 6333 (Feb. 11, 2026).

[34] *See, e.g.*, Charley E. Willison & Phillip M. Singer, *Repealing the Affordable Care Act Essential Health Benefits: Threats and Obstacles*, 107 AJPH PERSPS. 1225 (Aug. 2017), https://pmc.ncbi.nlm.nih.gov/articles/PMC5508159/pdf/AJPH.2017.303888.pdf (commenting that, while the ultimate outcome of Republicans' 2017 efforts to repeal and replace the ACA was uncertain at the time, it was clear that "EHBs [would] continue to be a target of Republican health-reform attempts").

[35] Geraldine Doetzer et al., Nat'l Health Law Prog., *NHeLP Comments on 2027 Notice of Benefit & Payment Parameter NPRM* (Mar. 12, 2026), https://healthlaw.org/resource/nhelp-comments-on-2027-notice-of-benefit-payment-parameter-nprm/ [hereinafter NHeLP 2027 NBPP Comments] (citing Shannon Schumacher et al., *KFF Health Tracking Poll: Health Care Costs, Expiring ACA Tax Credits, and the 2026 Midterms*, KFF (Jan. 29, 2026), https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-expiring-aca-tax-credits-and-the-2026-midterms/).

[36] NHeLP 2027 NBPP Comments, *supra* note 38, at 35–36.

[37] NHeLP 2027 NBPP Comments, *supra* note 38, at 9 (citing John Holihan et al., Urban Inst., *Understanding the Extraordinary Increase in ACA Premiums in 2026* (Dec. 2025), https://www.urban.org/sites/default/files/2025-12/Understanding%20the%20Extraordinary%20Increase%20in%20ACA%20Premiums%20in%202026_1217.pdf); Matt McGough et al., KFF, *What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles* (May 19, 2026), https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/ (expiration of APTCs has fueled deductible increases by forcing lower-income enrollees to shift from silver plans to bronze plans, which have much higher deductibles).

[38] *See* Aditi P. Sen & Thomas DeLeire, *The Effect of Medicaid Expansion on Marketplace Premiums*, U.S. Dep't of Health & Hum. Servs. Asst. Sec'y for Plan. & Evaluation, *The Effect of Medicaid*

1.4 million individuals are in the coverage gap in the ten states that have refused to expand Medicaid, with household income too low to qualify for Marketplace subsidies.[39]

Efforts to limit the extent to which the federal government can bolster insurance companies against financial losses ("risk corridor" payments) caused insurers to increase premiums, and to exit some markets altogether.[40] Promoting "junk plans" that offer skimpy coverage but are comparatively inexpensive, which lure younger and healthier consumers away from the ACA Marketplace, destabilizes the risk pool and leads to higher costs (including premiums) for those who remain.[41] Eliminating the individual mandate similarly impacted the risk pool and overall costs.[42] Reflecting on these efforts, one analysis remarked that it was an "open question" whether "any plan delivering quality health care at an affordable price could survive a relentless assault" like that launched against the ACA.[43]

Moreover, premiums should not be considered as the sole or even primary hallmark of affordability. As discussed more fully below, health care affordability is a nuanced, multifaceted issue; it is not reducible to a single measurement (such as premiums). Ultimately, irrespective of any impact that any EHB category may have on premiums, the reality is that weakening EHB standards in any way will increase costs by eroding the value and comprehensiveness of ACA coverage and forcing people to delay or forgo care.

B. The Impact of Essential Health Benefits on Population Health

The cost of specific EHB categories, services, or coverage features has no bearing on the need for those types of care. When this cost is passed to the consumer, they are more likely to delay care which leads to worsening health outcomes and higher cost of care. One study compared the rates of delayed care between people with chronic conditions who are

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Expansion on Marketplace Premiums (Sept. 6, 2016), https://aspe.hhs.gov/sites/default/files/private/pdf/206761/McaidExpMktplPrem.pdf (estimating that, in 2015, Marketplace premiums were about 7 percent lower in expansion states than in non-expansion states).

[39] KFF, *How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?* (Feb. 25, 2025), https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/.

[40] Robert Pear, *Marco Rubio Quietly Undermines Affordable Care Act*, N.Y. TIMES (Dec. 9, 2015), https://www.nytimes.com/2015/12/10/us/politics/marco-rubio-obamacare-affordable-care-act.html.

[41] *See, e.g.*, Amy Killelea & JoAnn Volk, *The Peddling of "Junk Plans" To Consumers Facing Higher Insurance Premiums*, HEALTH AFF. FOREFRONT (Jan. 16, 2026), https://www.healthaffairs.org/content/forefront/peddling-junk-plans-consumers-facing-higher-insurance-premiums.

[42] *See, e.g.*, Christine Eibner & Sarah Nowak, Commonwealth Fund, *Understanding the Impact of the Elimination of the Individual Mandate Penalty* (Aug. 9, 2018), https://www.commonwealthfund.org/blog/2018/understanding-impact-elimination-individual-mandate-penalty.

[43] Thomas B. Edsall, *Killing Obamacare Softly*, N.Y. TIMES (July 27, 2017), https://www.nytimes.com/2017/07/27/opinion/health-care-obamacare.html (emphasis added).

enrolled in high-deductible health plans with employer insurance. This study found that membership in a high-deductible health plan and lower incomes were independently associated with a higher probability of delayed care due to cost.[44] Despite both groups containing people with chronic illnesses, those on high-deductible health plans were more likely to delay or forgo care.

The cost of delayed care is clear and can be observed in other contexts, like the COVID-19 pandemic. One study explored the impact of delayed care due to the public health emergency. The researchers found that, even though there were high rates of care recovery, almost one in five older adults who experienced delayed care reported being negatively impacted.[45] Further, they found that those with two or more chronic conditions had an increased likelihood of delayed medical care even though this group likely needs more frequent health care.[46]

Delayed medical care is associated with both higher costs and worsening health outcomes. This has been well-established by researchers. One study looked at hospitalization during a six-month period in 1987. They found that individuals who are low-income and lack insurance are 12 times more likely to delay care.[47] They also found that 64% of people who delayed care did not think their condition was serious.[48] Ultimately, the researchers reported that those who delayed care had a nine percent longer hospital visit.[49] Other researchers have found similar results. KFF polling found that approximately one-third of adults report delaying or foregoing care and that three in four uninsured adults under the age of 65 reported going without care because of cost.[50] Further, they found that 43% of adults reported not taking their prescribed medication due to costs.[51]

Even insured adults felt the burden of health care costs and approximately four in ten adults under the age of 64 reported concern about affording their health care.[52] Even more concerning, those with employer-sponsored insurance and Marketplace coverage

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[44] Alison A. Galbraith et al., *Delayed and Forgone Care for Families with Chronic Conditions in HIgh-Deductible Health Plans*. 18;27(9) J GEN INTERN MED. 1105 (Jan. 18, 2012). https://pmc.ncbi.nlm.nih.gov/articles/PMC3514993/.
[45] Selena Zhong, Megan H. Scheetz, & Elbert S. Huang, *Delayed Medical Care and its Perceived Health Impact Among U.S. Older Adults During the COVID-19 Pandemic*, 13;70(6) J AM. GERIATRICS SOC'Y. 1620 (Apr. 13, 2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9177755/.
[46] *Id.*
[47] Joel S. Weissman et al., *Delayed Access to Health Care: Risk Factors, Reasons, and Consequences*, 114;4 ANNALS OF INTERN MED. 325 (Feb. 15, 1991). https://www.acpjournals.org/doi/10.7326/0003-4819-114-4-325.
[48] *Id.*
[49] *Id.*
[50] Grace Sparks et al., KFF, *Americans' Challenges with Health Care Costs* (Apr. 30, 2026). https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/.
[51] *Id.*
[52] *Id.*

considered their health care coverage fair or poor in terms of cost.[53] KFF researchers noted the health impacts of delaying or foregoing care.[54] They found that two in ten adults reported that their health worsened due to delayed or foregone care. Uninsured adults under the age of 65 were twice as likely to report worsened health from delayed or foregone care compared to those with health insurance.[55] All of this sharply indicates a need for more generous coverage and assistance with health care costs such as the disappointingly abandoned enhanced premium tax credits.

The breadth of research on the impact of cost on delaying or foregoing care, and the clear evidence of higher overall costs on health systems and on health overall indicate that the crisis of affordability does not sit with specific EHB categories, services, or coverage features. It rests on deep flaws in the system that the ACA and EHB requirements have attempted to address. Requesting information on the cost of certain EHB categories and services is deeply concerning.

C. Coverage and Affordability Tradeoffs

EHB standards are a signature feature of the ACA. Prior to the ACA, most individual health insurance plans did not cover all ten EHBs, and they frequently imposed dollar limits on the limited benefits that were covered.[56] A 2012 study found that more than half of those enrolled in individual plans in 2010 (before required coverage of EHBs became effective) were enrolled in plans that offered too few services and required too much cost-sharing to be sold on the ACA Marketplace.[57] These plans offered extremely limited coverage that forced consumers to pay substantial out-of-pocket costs, or to delay or forgo care altogether, risking costly complications down the line. Robust EHB standards – including a broad range and scope of services required to be covered – advance affordability by reducing out-of-pocket costs for consumers, improving access to preventive services, and promoting standardization and stability in the individual market.

Eliminating access to services (including by removing coverage mandates such as EHB standards) often leads to greater utilization of more costly services down the line, creating and exacerbating affordability issues, including increased emergency department visits, hospitalizations, and treatment costs for conditions exacerbated by lack of access to early

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[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] Dania Palanker et al., Commonwealth Fund, *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers* (Mar. 24, 2017), https://www.commonwealthfund.org/blog/2017/eliminating-essential-health-benefits-will-shift-financial-risk-back-consumers.
[57] *Id.*; *see also* Jon R. Gabel et al., *More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014*, 31 HEALTH AFF. 1339 (June 2012).

intervention and preventative care.[58] For example, after making cuts to Medicaid preventative oral health services for adults, the Idaho legislature conducted a fiscal analysis and found that providing adult dental care would result in $2.5 million in cost savings from reduced emergency department visits and hospitalizations.[59] Additionally, lawmakers found that providing adult dental coverage in Medicaid reduces treatment costs for conditions resulting from or worsened by lack of access to preventative oral health care, such as diabetes, cardiovascular disease, pneumonia, and dementia.[60]

Cuts to services can also destabilize the health care system by forcing providers to bear the costs of uncompensated care, which will ultimately shift the costs onto insurers and patients.[61] This would lead to higher monthly premiums and out-of-pocket expenses across the entire health care system.[62] Additionally, prior authorization leads to increased costs, delays in care, and increased use of health care resources. Results from the American Medical Association's (AMA) annual nationwide survey reveal that nearly 90% of physicians surveyed reported higher overall utilization of health care resources due to prior authorization.[63] According to AMA President Bruce A. Scott, MD, prior authorization creates roadblocks to care, resulting in increased overall costs when worsening health conditions bring patients to emergency department visits.[64] Patients are also forced to pay additional costs for ineffective initial treatments, increased office visits, hospital stays, and emergency and urgent care visits.[65] While purportedly designed to save money for the health care system and protect health care resources, prior authorization ultimately drives costs for patients and delays in care.[66]

HHS's supposition that cutting needed health care services would reduce premiums is in error. Overwhelming evidence shows that cutting or restricting access to services actually increases overall health care costs and leads to poorer health outcomes.

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[58] HHS has even recognized in the past that making care less effective by weakening EHB standards will result in "spillover effects," including increased use of costly emergency services and additional burden on government-funded or safety-net providers. NHeLP 2027 NBPP Comments, *supra* note 38; U.S. Dep't of Health & Hum. Servs., 82 Fed. Reg. 51052, 51131 (Nov. 2, 2017).
[59] *See* Betsy Z. Russell, Idaho House narrowly approves restoring non-emergency Medicaid dental benefits, THE SPOKESMAN-REVIEW (Feb. 12, 2018), https://www.spokesman.com/stories/2018/feb/12/idaho-house-narrowly-approves-restoring-non-emerge/.
[60] ID Code § 56-255 (2025); HB 465 Statement of Purpose and Fiscal Note (July 1, 2018), H0465SOP.pdf.
[61] *See* Health Foundation for Western & Central New York, How the Medicaid Cuts Will Affect All of Us (July 2, 2026), https://hfwcny.org/how-the-medicaid-cuts-will-affect-all-of-us/.
[62] *Id.*
[63] *See* Tanya Albert Henry, Prior authorization delays care–and increases health care costs, American Medical Association (Aug. 12, 2024), https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-delays-care-and-increases-health-care.
[64] *See id.*
[65] *See id.*
[66] *See id.*

Additionally, eliminating coverage for certain categories of care that may raise premiums by some small amount would result in massive cost increases for people who then have to pay for that care themselves. One analysis determined that if insured inpatient care costs were divided evenly only between the people who used the benefit in a given year, each person would incur costs exceeding $33,000; depending on the kind of care someone needed, they may incur costs significantly above that average amount.[67]

Weakening EHB standards will also permit insurers to "offer sparser benefit coverage as means to cherry-pick healthier consumers and exclude high-risk patients," incentivizing payers to engage in a "race to the bottom" in terms of plan quality and benefits offered.[68] Over time, individuals in need of a higher level of services will gravitate to plans that may still offer them, while healthier individuals with lower health care utilization needs will likely remain in coverage that has lower premiums but is much skinnier.[69] The risk is an effective "bifurcation" of the individual market risk pool that may substantially increase costs for those with higher health care utilization needs.[70] Moreover, if an individual opting for one of those skinnier plans suddenly finds themselves in need of services that are limited or not covered, they face the steep costs that the ACA's EHB provisions sought to limit.[71]

It is no secret how payers will operate in the absence of standards governing their conduct; we can look to the state of the pre-ACA individual market for context. Before the

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[67] Linda J. Blumberg & Jessica Banthin, Robert Wood Johnson Found. & Urban Inst., *The Implications of Eliminating Essential Health Benefits: An Update* (Nov. 2020), https://www.rwjf.org/en/insights/our-research/2020/11/the-implications-of-eliminating-essential-health-benefits--an-update.html.

[68] Willison & Singer, *supra* note 37, at 1226; *see also* Frank Lalli, *The Health Care Law's 10 Essential Benefits*, AARP MAG. (Aug./Sept. 2013), https://web.archive.org/web/20130824144349/https://www.aarp.org/health/health-insurance/info-08-2013/affordable-care-act-health-benefits.html.

[69] *See, e.g.*, Craig Hanna & Cori Uccello, Am. Acad. of Actuaries, *How Changes to Health Insurance Market Rules Would Affect Risk Adjustment* (May 2017), https://actuary.org/how-changes-to-health-insurance-market-rules-would-affect-risk-adjustment/ ("[i]f health plans are allowed to offer major categories of benefits . . . as an optional benefit or have the ability to place internal limits on them, enrollees needing the benefits will enroll in plans covering those benefits without limitations").

[70] NHeLP 2027 NBPP Comments, *supra* note 38, at 30 (discussing similar risks in relation to expanded availability of catastrophic plans); *see also* Mandy Spears, Sycamore Inst., *How Changes to Essential Health Benefits Could Affect Tennessee* (July 13, 2017), https://sycamoretn.org/changes-essential-health-benefits-tennessee/ (commenting that "[s]tandardizing benefits limits the potential for segmented risk pools"). A bifurcated or segmented risk pool is also completely inconsistent with the ACA's fundamental "single risk pool" concept. 42 U.S.C § 18032(c); 45 C.F.R. § 156.80.

[71] *See, e.g.*, Matthew Fiedler, Brookings Inst., *Allowing states to define "essential health benefits" could weaken ACA protections against catastrophic costs for people with employer coverage nationwide* (May 2, 2017), https://www.brookings.edu/articles/allowing-states-to-define-essential-health-benefits-could-weaken-aca-protections-against-catastrophic-costs-for-people-with-employer-coverage-nationwide/.

ACA established the concept of EHBs and related coverage requirements, most individual health insurance plans did not offer coverage for maternity care, and a significant minority did not cover any mental health or SUD services.[72] Irrespective of whether their insurance covered it, people still needed this care – their medical needs did not cease to exist simply because their health coverage was lacking. But because there was no requirement for individual insurance plans to cover these services, people faced exorbitant costs when accessing them. Prior to the ACA, maternity care was often an expensive add-on to individual health insurance plans.[73] Out-of-pocket spending for mental health care was much higher, especially among younger people.[74] Prescription drugs, if covered at all, could be subject to separate deductibles costing thousands of dollars.[75]

For individuals in need of maternity care, mental health or SUD services, or prescription drugs that may have been subject to major limitations on coverage or potentially not covered at all, the affordability of their premiums was likely of little importance while they were paying thousands or even tens of thousands of dollars for care their health insurance plans did not cover.

Further, many financial protections for Marketplace enrollees and individuals in large group plans that cover EHBs – such as bans on dollar limits, caps on annual out-of-pocket costs, and the use of premium tax credits – only apply to EHBs.[76] Weakening EHB standards by limiting the scope of what may be covered as EHB risks limiting the reach of these important financial protections and further exacerbating existing affordability issues for a wide range of consumers. For instance, if any maternity care service were no longer considered an EHB, insurers could subject that service to annual or lifetime limits or remove caps on out-of-pocket spending, making it significantly less affordable.[77]

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[72] *See, e.g.*, Michelle Lilienfeld & Héctor Hernández-Delgado, Nat'l Health Law Prog., *Detrimental Effects of Allowing the States to Waive the Essential Health Benefits* (June 26, 2017), https://healthlaw.org/resource/detrimental-effects-of-allowing-states-to-waive-the-essential-health-benefits/; Gary Claxton et al., *supra* note 6.

[73] *See, e.g.*, Lisa Gillespie, *This is Why Men Pay for Maternity Coverage, Too*, LOUISVILLE PUB. MED. (Apr. 6, 2017), https://www.lpm.org/news/2017-04-06/this-is-why-men-pay-for-maternity-coverage-too; Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), https://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html?hp.

[74] *See, e.g.*, Jesse C. Baumgartner et al., Commonwealth Fund, *The ACA at 10: How Has It Impacted Mental Health Care?* (Apr. 3, 2020), https://www.commonwealthfund.org/blog/2020/aca-10-how-has-it-impacted-mental-health-care.

[75] *See, e.g.*, Sarah Lueck, Ctr. on Budget & Pol'y Priorities, *Pre-ACA Health Insurance Market Isn't Worth Returning To* (Mar. 24, 2017), https://www.cbpp.org/blog/pre-aca-health-insurance-market-isnt-worth-retuxrning-to.

[76] 42 U.S.C. §§ 300gg-11, 18022(c); 45 C.F.R. § 147.126.

[77] *See, e.g.*, Fiedler, *supra* note 74 (discussing similar effects on large employer plans if states were able to obtain waivers of EHB).

Robust EHB standards promote affordability and market stability by creating a standardized benefit minimum coverage floor that forecloses the "races to the bottom" in which payers engaged prior to the ACA and improves access to care broadly in a way that does not incentivize or even compel consumers to delay or forgo care, resulting in greater costs down the line.

D. End-of-Life Care

1. Strengthening End-of-Life Care to Improve Affordability and Patient Autonomy

End-of-life care is a significant driver of health care costs generally. Cost estimates of the care a person receives at the end of their life vary based on factors such as where they live and the kind of care they receive (e.g., hospitalization as opposed to in-home hospice care), but research has determined that the cost of care in a person's final month of life can reach the tens of thousands of dollars.[78] These costs have an impact on federal spending: a 2010 study determined that payments for people in their final year of life constituted more than 25% of all Medicare spending in 2006.[79] Opting for hospice care or palliative care at the end of life can contain costs and provide a better quality of life while honoring the individual's wishes and preference, but these options remain underutilized.[80]

In part, these costs are driven by a lack of knowledge and communication about what an individual wants at the end of their life. The care a person receives at the end of their life is often out of sync with their preferences.[81] For instance, while most people state that their preference is to die at home, more than 25% still die in the hospital.[82] And, often,

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[78] *See, e.g.*, Eric French et al., *End-of-Life Medical Expenses* 12 (Fed. Res. Bank of Richmond, Working Paper No. 18-18, 2018), https://www.richmondfed.org/-/media/RichmondFedOrg/publications/research/working_papers/2018/pdf/wp18-18.pdf (average cost of hospital care in the final 12 months of life is about $35,000); Ashish K. Jha, *End-of-Life Care, Not End-of-Life Spending*, A7 JAMA HEALTH FORUM 1 (July 13, 2018), https://jamanetwork.com/channels/health-forum/fullarticle/2760146. Of course, the cost of care for any individual person is highly dependent on a variety of factors, including where the person lives and the setting in which they die. *See* End of Life Care, Dartmouth Atlas Proj., https://www.dartmouthatlas.org/interactive-apps/end-of-life-care/ (last visited July 7, 2026).

[79] Gerald F. Riley & James D. Lubitz, *Long-Term Trends in Medicare Payments in the Last Year of Life*, 45 HEALTH SERV'S RES. 565, 570 (Apr. 2010), https://pmc.ncbi.nlm.nih.gov/articles/PMC2838161/.

[80] *See* Youngmin Kwon et al., *Contemporary Patterns of End-of-Life Care Among Medicare Beneficiaries With Advanced Cancer*, 6 JAMA HEALTH FORUM e245436 (Feb. 21, 2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2830176; John G. Cagle et al., *Hospice Utilization in the United States: A Prospective Cohort Study Comparing Cancer and Noncancer Deaths*, 68 J. AM. GERIATRIC SOC'Y 783 (Apr. 2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC12424130/pdf/nihms-2105751.pdf.

[81] *See* Jha, *supra* note 78.

[82] *See id.*; *see also* Riley & Lubitz, *supra* note 79, at 565 (commenting that "existing patterns of care do not meet the needs and preferences of terminally ill patients").

"aggressive care" may end up being the default despite not being in line with a person's wishes.[83] Conversely, individuals who have engaged in some end-of-life planning are more likely to receive limited or "comfort" care at the end of their lives than people who have not completed a living will or appointed a surrogate decision-maker.[84]

Yet most people never complete an advance directive, appoint a surrogate decision-maker, or engage in other end-of-life planning.[85] Open communication is important to honor individuals' wishes and to contain costs, but "the health community and other leaders have not fully and productively utilized public education and engagement strategies to make that knowledge available" in meaningful and relevant ways.[86]

Early health reform proposals included a provision for "Advance Care Planning Consultation" (ACPC), which would have allowed Medicare providers to be reimbursed for having conversations with patients about their options and preferences for end-of-life care.[87] This provision was borne of the recognition that individual wishes and desires often are not honored at the end of life, resulting in unnecessary suffering and distress for the patient and their loved ones, as well as unnecessary costs associated with providing potentially unwanted intensive life-sustaining measures.[88]

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[83] *See, e.g.*, Janet Dolgin, *Reimbursing Clinicians for Advance-Care-Planning Consultations: The Saga of a Healthcare Reform Provision*, 28 HEALTH LAW. 2, 4 n.25 (2015); *see also Being Prepared for the Final Days*, CBS NEWS (Apr. 27, 2014), https://www.cbsnews.com/news/being-prepared-for-the-final-days/.

[84] A 2010 study found that people who had not completed a living will were more likely to receive aggressive life-sustaining care than people who had, and that people who had appointed a health care durable power of attorney (DPOA) were less likely to die in the hospital or receive "all care possible" than people who had not. Maria J. Silveira & Kenneth M. Langa, *Advance Directives and Outcomes of Surrogate Decision Making Before Death*, 362 NEW ENG. J. MED. 1211 (Apr. 2010), https://www.nejm.org/doi/pdf/10.1056/NEJMsa0907901?__cf_chl_f_tk=R73O3Wz5RCPg_NDg6dri7ETtokpNeZkA1.yxaz4jjfY-1782921743-1.0.1.1-_y57DXPvLdoXRpt4uqL7fx_NSR1_yAeJ5Rq3_yXw43E.

[85] *See, e.g.*, Catherine L. Auriemma et al., *Completion of Advance Directives and Documented Care Preferences During the Coronavirus Disease 2019 (COVID-19) Pandemic*, 3 JAMA NETWORK OPEN e2015762 (July 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768372 (commenting that fewer than 1/3 of adults have completed an advance directive); Jaya K. Rao et al., *Completion of Advance Directives Among U.S. Consumers*, 46 AM. J. PREVENTIVE MED. 65, 68 (Jan. 2014), https://www.ajpmonline.org/action/showPdf?pii=S0749-3797%2813%2900521-7 (while roughly 68 percent of survey respondents reported having concerns about end-of-life care, fewer than half had discussed the treatment they wanted in the event of a serious illness, and only about 26 percent had an advance directive).

[86] INST. OF MED., DYING IN AMERICA: IMPROVING QUALITY AND HONORING INDIVIDUAL PREFERENCES NEAR THE END OF LIFE 346 (2015) [hereinafter "Dying in America"].

[87] *See* America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong. § 1233 (2009). This bill was one of several health reform proposals that ultimately culminated in the enactment of the ACA.

[88] *See* 155 Cong. Rec. H8,811-05 (daily ed. July 27, 2009) (statement of Rep. Blumenauer); 155 Cong. Rec. E2,072-01 (daily ed. July 27, 2009) (Extension of Remarks).

Unfortunately, the ACPC was derided as creating government-backed "death panels" that would have rationed access to health care based on a subjective judgment of "worthiness" and led to "government-encouraged euthanasia."[89] Although this cruel and outrageous claim was patently false, it gained immense traction. Within days of the infamous Facebook post that brought the term into the public consciousness, 86% of people surveyed had heard the claim, and fully half of them either believed it or were not sure whether it was true.[90] Despite being demonstrably *untrue*, the claim also had remarkable longevity – 29% of people still believed it in 2016, nearly 7 years after the ACPC was originally proposed and debated.[91] Unfortunately, these widespread lies about the ACPC made it so politically toxic that it was ultimately excluded from further health reform legislation.[92]

However, open communication, such as that which would have been facilitated by the ACPC in its original form, is critical to honor a person's desires for the end of their life – more specifically, to ensure they can have a "good death." Typically, though, these conversations are not reimbursable; as such, they often go neglected until it is too late (if they happen at all).[93]

2. Enabling Choice as a Cost-Containment Measure

Education about patients' options at the end of life can help contain costs.[94] Often, patients are not aware of all options for care available to them at the end of life, which hinders patient choice and encourages the "default" to more aggressive (and more costly) care than what the patient actually wants.[95] A 2013 study noted that "limited knowledge or

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[89] *See* Justin Bank, *Palin vs. Obama: Death Panels*, FactCheck.org (Aug. 14, 2009), https://web.archive.org/web/20111017194545/http://factcheck.org/2009/08/palin-vs-obama-death-panels/; Robert Pear, *Obama Returns to End-of-Life Plan That Caused Stir*, N.Y. TIMES (Dec. 25, 2010), https://www.nytimes.com/2010/12/26/us/politics/26death.html.

[90] *See* Brendan Nyhan, *Why the "Death Panel" Myth Wouldn't Die: Misinformation in the Health Care Reform Debate*, 8 THE FORUM 1, 10 (2010), https://web.archive.org/web/20190604135225/http://www.dartmouth.edu/~nyhan/health-care-misinformation.pdf.

[91] *See* Jeffrey Young, *Politicians Lie Because It Works: Death Panels Edition*, HUFFPOST (Apr. 18, 2016), https://www.huffpost.com/entry/death-panels-obamacare_n_571503d1e4b0060ccda3c0a9.

[92] *See* Christi Parsons & Andrew Zajac, *Senate committee scraps healthcare provision that gave rise to 'death panel' claims*, L.A. TIMES (Aug. 14, 2009), https://www.latimes.com/archives/la-xpm-2009-aug-14-na-health-end-of-life14-story.html.

[93] *See* Virginia Tilden et al., *Advance care planning as an urgent public health concern*, 60 NURSING OUTLOOK 418, 419 (2012), https://www.nursingoutlook.org/article/S0029-6554(12)00250-3/pdf.

[94] *See, e.g.*, David Kendall & Elizabeth Quill, *A Better End of Life*, Third Way (Sept. 29, 2015), https://www.thirdway.org/report/a-better-end-of-life (finding that "increasing the likelihood that people will use advance directives that are accessible when and where needed" would garner federal savings of up to $15.2 billion over 10 years).

[95] *See, e.g.*, Kwon et al., *supra* note 8 (finding that clear communication about the patient's preferences at the end of life can limit the use of likely unwanted intensive life-extending treatments for patients with advanced cancer); *see also* Dolgin, *supra* note 83, at 4 n.25 (referring to the "default" option of aggressive care).

misconceptions regarding hospice and palliative care" may impede timely hospice referral.[96] Additionally, negative misunderstandings of hospice, such as thinking it is "only about death" or "seen as giving up," can make people less receptive to the idea of hospice care and therefore less likely to utilize it.[97] These misconceptions are common; a 2018 study found that more than 37% of survey respondents had at least one misconception about hospice care and more than 53% had at least one misconception about palliative care.[98]

However, electing hospice care earlier generates significant cost savings, meaning there is significant financial benefit to ensuring individuals are educated about their choices. One analysis determined that, if all Medicare enrollees who enter hospice care in the last eight weeks of life were to enter hospice even just five days earlier, the cost savings to the Medicare program could be as high as $1.5 billion per year.[99] This is in line with findings that about half of the average per capita Medicare spending on people who died in a given year was on inpatient hospital services.[100] Educating patients and their loved ones on what hospice is as opposed to what it is not, and thereby removing some of the anxiety and stigma around it, is therefore critical to improving understanding and uptake of hospice.

In addition to education, documenting an individual's wishes has also been proven to result in lower costs. For instance, at a major health system in La Crosse, Wisconsin, where virtually all adults die with a completed advance directive, the average cost of end-of-life care is substantially lower than the national average.[101] Individuals who have completed advance directives have been found to spend less on end-of-life care.[102] Advance care

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[96] Amy S. Kelley et al., *Hospice Enrollment Saves Money For Medicare And Improves Care Quality Across A Number of Different Lengths-Of-Stay*, 32 HEALTH AFF. 552 (Mar. 2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC3655535/pdf/nihms464299.pdf.

[97] *See, e.g.*, Ariel Shalev et al., *Awareness and Misperceptions of Hospice and Palliative Care: A Population-Based Survey Study*, 35 AM. J. HOSPICE & PALLIATIVE MED. 431 (Mar. 2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC5866727/pdf/nihms951283.pdf.

[98] *Id.*

[99] *Technical Report: Modeling Potential Medicare Spending Impacts from Earlier Hospice Election*, ATI Advisory (Apr. 9, 2026), https://researchinstituteforhomecare.org/wp-content/uploads/ATI_Modeling-Medicare-Impacts-from-Earlier-Hospice-Election.pdf [hereinafter ATI Advisory Report].

[100] The same study found that only about 9.7% of that spending was on hospice services. Juliette Cubanski et al., KFF, *Medicare Spending at the End of Life: A Snapshot of Beneficiaries Who Died in 2014 and the Cost of Their Care* (July 14, 2016), https://www.kff.org/medicare/medicare-spending-at-the-end-of-life/.

[101] *See* Joseph Shapiro, *Why This Wisconsin City is the Best Place to Die*, NAT'L PUB. RADIO (Nov. 16, 2009), https://www.npr.org/2009/11/16/120346411/why-this-wisconsin-city-is-the-best-place-to-die. However, it is important to note that an advance directive or living will is generally insufficient on its own to constitute fulsome end-of-life planning. Discussions and patient education should be an ongoing process, not a "one-and-done" activity where an advance directive is executed and the patient's wishes are never discussed again. *See* Dying in America, *supra* note 86, at 118 ("'Putting it in writing' remains important but does not substitute for the discussion").

[102] Likely due to their preference for less aggressive care. *See* Yujun Zhu & Susan Enguidanos, *Advance directives completion and hospital out-of-pocket expenditures*, 17 J. HOSP. MED. 437, 441–42 (June 2022), https://shmpublications.onlinelibrary.wiley.com/doi/epdf/10.1002/jhm.12839.

planning in general leads to fewer unwanted (and costly) hospitalizations during the final weeks or months of life.[103]

3. Honoring Individual Autonomy at the End of Life

There are also important synergies between cost-savings strategies and "ethical practices that uphold cherished values of dignity and informed self-determination."[104] In other words, education and open communication helps honor individuals' wishes in addition to containing costs. Those who have engaged in end-of-life planning are less likely to choose costly and intensive life-sustaining measures in the final days or weeks of life, reflecting that many people do not want such interventions at the end of their lives.[105] Election of hospice in general positively impacts the individual's quality of life, as well as that of their loved ones. It minimizes "unnecessary suffering" and avoids "futile interventions."[106] It has been reported to provide enrollees and their loved ones with "a sense of hope, relief, and improved quality of life resulting from the care provided."[107] Electing hospice can even extend the individual's life.[108]

Too often, however, advance care planning occurs too late.[109] As we have discussed, it sometimes does not occur at all.[110] It then falls on the patient's loved ones to "face the challenge of divining [the patient's] wishes," which may result in their wishes not being honored at all.[111] The outcome is "too much unwanted aggressive and futile treatment," which may be inconsistent with what the patient wanted.[112] Encouraging education options and proactive planning for the end of life can maximize opportunities to ensure the

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[103] Dolgin, *supra* note 83, at 6.
[104] Joshua E. Perry, *A Missed Opportunity: Health Care Reform, Rhetoric, Ethics, and Economics at the End of Life*, 29 MISS. C. L. REV. 409, 425 (2010).
[105] *See, e.g.*, Dolgin, *supra* note 83, at 3–4; see also Dying in America, *supra* note 86, at 22.
[106] ATI Advisory Report, *supra* note 102, at 1.
[107] Channing E. Tate et al., *"It's Like a Death Sentence but It Really Isn't" What Patients and Families Want to Know About Hospice Care When Making End-of-Life Decisions*, 37 AM. J. HOSPICE & PALLIATIVE MED. 721 (Sept. 2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC8403502/pdf/nihms-1734985.pdf.
[108] *See* Rev. Shuji Moriichi et al., *Dispelling Myths: Common Misconceptions Around Hospice*, 81 CSA J. 11, 12 (2020), https://progressally6yogf8hc32ioroi.s3.amazonaws.com/list/Journal/81/Moriichi.pdf.
[109] *See* Tilden et al., *supra* note 96, at 419; *see also* Kendall & Quill, *supra* note 97 ("families and health care providers do not turn to [advance directives] until a person is incapacitated or 'absolutely, hopelessly ill'").
[110] *See* Auriemma et al., *supra* note 85, at 1; Rao et al., *supra* note 88, at 68.
[111] Michelle Goldberg, *The Health-Care Lie Machine*, THE DAILY BEAST (Aug. 4, 2009), https://web.archive.org/web/20091214051524/https:/www.thedailybeast.com/blogs-and-stories/2009-08-04/the-right-wing-lie-machine/full/.
[112] Tilden et al., *supra* note 96, at 419; *see also* Perry, *supra* note 107, at 410 (20% to 30% of Medicare expenditures on physician and hospital services during the final 2 months of life have "no meaningful impact").

individual's wishes and desires are honored, while limiting at least some of the fear and anxiety that the individual and their loved ones may feel during the end-of-life period.[113]

4. The Importance of Robust Coverage and the Ideal Hospice Benefit

A robust hospice benefit is critical to ensure the best possible care at the end of life. The optimal hospice benefit is one that acknowledges and cares for the "whole person" – physically, emotionally, mentally, and spiritually. Medical care is only one component of the ideal hospice experience.[114] "Multidimensional solutions" that address the person's needs for things such as assistance with activities of daily living (ADLs), transportation, home modifications for accessibility, access to durable medical equipment (DME), companionship, and spiritual care are critical to ensuring a high-quality end of life and a "good death."[115] Good care coordination is critical to ensure maximum access to all necessary services.[116]

Moreover, hospice should not be viewed as simply "a means of managing death."[117] Instead, it should be viewed as both "a tool for palliation of symptoms" and a service that provides guidance and support, allowing patients and their loved ones to focus on spending time together in a comfortable environment, such as the patient's home.[118] When end-of-life care is done right, patients and their loved ones often report improvement in emotional well-being, including feeling relieved and even hopeful in their final moments of life.[119]

5. The Role of Essential Health Benefits in Strengthening End-of-Life Care

States can incorporate additional features into the hospice benefits offered through their benchmark plans to improve the quality and reach of the service.

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[113] *See* Dolgin, *supra* note 83, at 5.
[114] Dying in America, *supra* note 86, at 45 ("Death is not a strictly medical event").
[115] Christina Staudt, *Whole-Person, Whole-Community Care at the End of Life*, 15 AM. MED. ASS'N J. ETHICS 1069, 1070 (Dec. 2013), https://journalofethics.ama-assn.org/sites/joedb/files/2018-05/msoc1-1312.pdf; *see also* Tate et al., *supra* note 107 (recounting anecdotes about a hospice volunteer arranging a "final fishing trip" for a patient; members of the hospice team being available to answer a caregiver's questions at 3:00 AM; and a "hospice worker" attending a patient's funeral).
[116] Dying in America, *supra* note 86, at 46. Primary care is an important component of good care coordination. *Id.* at 49–50.
[117] Jeffrey M. Peppercorn et al., *American Society of Clinical Oncology Statement: Toward Individualized Care for Patients with Advanced Cancer*, 29 J. CLINICAL ONCOLOGY 755, 756 (Feb. 2011), https://pubmed.ncbi.nlm.nih.gov/21263086/.
[118] *Id.* at 756; Deirdre van Dyk, AARP, *Hospice Provides Compassionate End-of-Life Care* (Mar. 3, 2025), https://www.aarp.org/caregiving/medical/hospice-need-to-know/.
[119] *See* Tate et al., *supra* note 107; *see also* Ping Liu & Xueyan Liao, *The Impact of Hospice Care on the Prognosis, Quality of Life, and Emotional Well-being of Patients With Chronic Heart Failure*, 27 J. HOSPICE & PALLIATIVE NURSING E10 (Feb. 2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC11708997/pdf/jhpn-27-e10.pdf.

- **Avoid placing quantitative or temporal limitations on the hospice benefit.** For instance, some states impose a lifetime limit of six months on hospice benefits in their benchmark plans, but not all people in hospice care necessarily die within six months of entering hospice.[120] This is not to say it is per se inappropriate to limit hospice care to people who are reasonably expected to die within six months of enrollment (although some states allow a longer period); only that the course of any disease can be unpredictable and the transition off of hospice care for a person who has a terminal illness but has been enrolled in hospice for longer than six months can be quite traumatic.[121] Lifetime limits should therefore be avoided in line with the overall goal of hospice to support each individual person's wants, needs, and specific situation.
- **Consider incorporating family supports following the patient's death into the hospice benefit.** For instance, Nevada offers a bereavement benefit to the families of individuals who were on hospice after the individual dies.[122] This is in line with the Medicare hospice benefit, which requires hospice providers to offer up to a year of bereavement counseling to the patient's loved ones following the patient's death.[123]
- **Commit resources to active outreach to ensure timely enrollment in hospice.** People who enroll in hospice earlier incur fewer costs and enjoy a better quality of life than people who take up hospice benefits later in their disease course, as discussed above.[124] Active outreach and education can increase awareness of hospice care and its offerings, clear up common misconceptions that impede hospice uptake, and ensure that patients are adequately equipped to decide what they want the end of their lives to look like.

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[120] The proportion of hospice patients surviving past six months varies, but research generally shows that this group is a "significant minority" of hospice patients. *See, e.g.*, Krista L. Harrison, *The Hidden Curriculum of Hospice: Die Fast, Not Slow*, 40 HEALTH AFF. 844, 847 (May 2021) https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.00259 (20% of hospice enrollments last longer than six months, and 17% of hospice enrollees are disenrolled while still alive); Pamela S. Harris et al., *Can Hospices Predict which Patients Will Die within Six Months?*, 17 J. PALLIATIVE MED. 894, 894 (2014), https://pmc.ncbi.nlm.nih.gov/articles/PMC4118712/pdf/jpm.2013.0631.pdf (12% to 15% of patients survive past six months after entering hospice). However, even hospice stays exceeding six months generate savings – the average savings for people enrolled in hospice for more than six months is 11% but can be as high as 25% depending on disease group. *See* Nat'l Opinion Res. Ctr. at U. Chicago, *Value of Hospice in Medicare* 9–10 (Mar. 2023), https://allianceforcareathome.org/wp-content/uploads/Value_Hospice_in_Medicare.pdf (savings ranged from 4% for people with neurodegenerative diseases to 25% for people with chronic kidney disease/end-stage renal disease).

[121] *See* Harrison, *supra* note 120, at 846 (describing the involuntary disenrollment of the author's dying stepfather from hospice after six months).

[122] Ctrs. For Medicare & Medicaid Srvs., *Nevada EHB Benchmark Plan (2017-2026)* 44–45 (2014).

[123] 42 C.F.R. §§ 418.64(d)(1)(ii), 418.204(c). However, the Medicare benefit is different in that, while hospice providers are required to offer bereavement counseling to loved ones, they cannot be reimbursed for doing so, which can alienate hospice providers, creating provider capacity issues.

[124] Kelley et al., *supra* note 99 (timely hospice enrollment reduces hospital utilization for patients at the end of life, which is an outcome associated with higher care quality and increased accord with patients' wishes).

Topic 4: Scope of Benefits Included as EHB

As we have explained before, we believe the current benchmarking approach affords states the necessary flexibility to adjust EHB coverage to the health care needs of their populations. However, this important flexibility should not lead HHS to abdicate its responsibilities of defining, reviewing, and updating EHBs as required by the ACA, particularly where coverage gaps persist that disproportionately impact underserved individuals, such as individuals with chronic conditions and disabilities, Black, Indigenous and Other People of Color (BIPOC), LGBTQI+ individuals, among others. Regional or local considerations, by states and/or plans, should be relevant to decisions about providing *additional* coverage. That is, states and plans should be free to expand benefits packages to improve upon the national standard or take into account local needs, but minimum federal coverage standards are often helpful and even necessary.

HHS has already promulgated rules defining minimum coverage standards in various categories of EHB. Federal rules, for example, provide a definition for habilitative and rehabilitative services that sought to clarify that plans are required to cover both types of services on similar footing.[125] HHS has similarly adopted minimum standards for prescription drug coverage, a standard that has been essential in protecting access to key medications that are necessary for individuals living with chronic conditions, such as HIV, hepatitis B, SUD, and diabetes.[126] More recently, HHS also implemented a requirement for plans to comply with behavioral health parity rules as a condition of EHB coverage, ensuring that plans are not circumventing mental health and SUD coverage requirements by imposing harsh quantitative and non-quantitative limitations.[127]

At a minimum, moving forward, HHS should refrain from cutting, reducing, or otherwise restricting current coverage standards. In a 2018 confidential memo obtained through a public records request, then CMS Administrator Seema Verma recommended cutting the EHB prescription drug benefits by imposing mandatory, nationwide caps on coverage.[128] Administrator Verma acknowledged that such cuts would result in significant harm to consumers where "[i]nsufficient coverage could cause conditions to worsen, which could cause public health problems (e.g., preventable spread of contagious diseases) and greater costs to the health care system."[129] Verma conceded that the proposal would make it harder for consumers to access the prescription drugs they need and would lead to adverse

[125] 45 C.F.R. § 156.115(a)(5).
[126] 45 C.F.R. § 156.122.
[127] 45 C.F.R. § 156.115(a)(3).
[128] Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Servs., Memorandum to Sec. Azar, Dep't of Health & Hum. Servs., *Re: Key 2020 Payment Notice Issues, Policy #4 – Establishing a National Drug Count for the Essential Health Benefits Prescription Drug Benefit,* 14–18 (Aug. 29, 2018) (on file with NHeLP).
[129] *Id.* at 16.

selection by insurers, but nonetheless recommended HHS move forward with the proposed cuts.[130] Fortunately, Secretary Azar did not advance Verma's proposal.

Given this history, and the ongoing efforts of the current administration to undermine and end health care access for millions of people, we remain concerned that HHS will seek to cut coverage and benefits in EHB. As Administrator Verma recognized, benefit cuts would not only harm consumers, but would lead to greater overall health care costs.

Furthermore, we believe HHS should continue using its authority to address barriers to necessary care that persist throughout the country. We refer HHS to a letter NHeLP submitted to Secretary Becerra in 2021 re: Advancing Health Equity Through Essential Health Benefits, where we outline improvements HHS can make to current coverage in various categories.[131] In that letter, we identified specific evidence-based services that have been proven effective and that are considered the standard of care for treating certain conditions.

In particular, we underscore the importance of establishing strong minimum coverage requirements in the areas of behavioral health services, rehabilitative and habilitative services, maternity care, and chronic disease management. With regards to behavioral health services, we emphasize that the current benchmarking approach that requires states to look at a comparison set of plans to establish an actuarial scope of benefits has enabled states to require coverage of important benefits as EHB. Many of these services are fundamental in states' fight against the overdose crisis. HHS should continue encouraging states to address the issue through EHB benchmarking, but we also urge the Department to require all states to ensure access to all medically necessary services using accepted standards of care and accepted medical necessity criteria.

Congress also expressly included "chronic disease management" among the ten EHB categories.[132] However, HHS has not defined "chronic disease management," which has led to a patchwork of private insurance coverage of important benefits and services that people living with chronic illness need. People with chronic illness also often struggle with high cost-sharing, with high deductibles, copays and coinsurance, and paying for services not covered by health plans.[133] Developing a comprehensive federal coverage standard for chronic disease management is challenging, given the unique, complex, and highly individualized requirements for treating and managing a wide array of chronic conditions. Moreover, insurers often seek to discourage persons with chronic conditions from enrolling in plans. Insurance companies have used many features of health plan benefits and delivery to unlawfully deny needed coverage or discourage people with significant health

[130] *Id.* 16–18.
[131] Wayne Turner, Héctor Hernández-Delgado & Fabiola Carrión, *supra* note 23.
[132] 42 U.S.C. §1802(b)(1)(I).
[133] Nicole Topay et al., The Third Way, *Chronic Care Cost Cap* (Dec. 19, 2022), https://www.thirdway.org/report/chronic-care-cost-cap.

needs from enrolling in their plans. These include exclusions, cost sharing, formularies and adverse medication tiering, visit limits, provider networks, prior authorization, and other utilization management that are arbitrary and not clinically based or appropriate.

With little guidance or enforcement from HHS or state regulators, it is often difficult to discern how insurers are implementing the EHB requirement to provide "chronic disease management." A survey of the state benchmark plans shows that in nine out of the ten state plans surveyed, the coverage requirement that might fulfill the chronic disease management EHB is a diabetes education or self-management program.[134] Such programs take a multidisciplinary approach to educating those with diabetes on how to manage their disease on their own.[135] Diabetes management programs often include a variety of out-patient care options, including medical nutritional therapy, psychological counseling, and education for family members or caregivers.[136] Utilizing a multitude of treatment options allows patients with diabetes to have better health outcomes by helping them to understand their disease and do more for their health than just take their medication.[137]

These programs also prevent these patients from taking on expensive medical bills or spending time in the hospital by encouraging self-sufficiency and medication compliance.[138] Guaranteeing coverage for coordinated and integrated care is great for the long-term health of diabetes patients.[139] However, limiting that coverage to patients with diabetes excludes other chronic disease groups from these benefits.

We urge HHS to engage with patient advocates and organizations to better identify the broad range of benefits and services that define "chronic disease management." We also emphasize that any chronic disease management benefit should be comprehensive, treating the whole person and should include reproductive and sexual health. By working

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[134] State benchmark plans surveyed include Oregon, Michigan, Pennsylvania, Minnesota, Missouri, New Hampshire, North Dakota, Oklahoma, Virginia, Wisconsin. *See* Ctrs. For Medicare & Medicaid Srvs., Information on Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/marketplace/resources/data/essential-health-benefits (last visited July 14, 2026)

[135] Ctrs. for Disease Control & Prevention, About Diabetes Self-Management Education and Support, https://www.cdc.gov/diabetes/education-support-programs/index.html#:~:text=Key%20points,find%20a%20program%20near%20you.

[136] *See, e.g.*, Pennsylvania Benchmark Plan, https://www.cms.gov/media/325511; *see also* New Hampshire Benchmark Plan, https://www.cms.gov/media/500031.

[137] Nazar, et al., *Effectiveness of diabetes education and awareness of diabetes mellitus in combating diabetes in the United Kingdom; a literature review*, 5(2) J NEPHROPHARMACOL. 110–15 (Sept. 9, 2015).

[138] *Id.*

[139] Benefits can include improved A1c levels, higher rates of medication adherence, fewer severe diabetes-related complications, and decreased health costs. New Hampshire Dep't of Health & Hum. Servs., *Diabetes Education and Support Program*, https://www.dhhs.nh.gov/programs-services/disease-prevention/diabetes/diabetes-education-and-support-program (last visited July 14, 2026).

with stakeholders representing a diverse array of conditions and including underserved and under-represented individuals, HHS should work towards a goal of establishing minimum coverage standards and ensuring that issuers meet those standards.

Finally, we ask HHS to use its authority to define EHBs to disavow the practice of allowing plans to substitute benefits within an EHB category as long as the resulting coverage is actuarially equivalent. This practice undermines HHS's (and by extension states') authority to define EHBs and address unmet health needs by permitting plans to exclude certain services already identified as necessary from coverage. Federal rules already ban plans from substituting between categories and within the prescription drug category. But some EHB categories can be defined by a wide range of services and plans should not be free to impose their judgment when it comes to determining which benefits within the category should be covered. In addition, plans typically do not categorize services within specific categories and some services may overlap between different categories. In practice, therefore, HHS and states have little ability to rein in substitution between categories.

Topic 5: Updating EHB

We have previously urged HHS to establish an open, transparent, and participatory process to periodically review and update EHB.[140] However, we remain highly skeptical that this Administration would undertake a good faith effort to review and update EHB as provided for by law.[141] HHS has taken multiple actions to undermine and weaken EHB coverage. Most recently in the 2027 NBPP, HHS prohibited issuers from offering routine, non-pediatric oral health services as EHB, reversing an earlier rulemaking which allowed states to include such services as part of their benchmark.[142] In 2025, HHS added many transition-related services provided as gender affirming care, which it called "specified sex trait modification procedures," to the EHB prohibition at § 156.115(d).[143] NHeLP has long maintained that these regulatory prohibitions of specified benefits are directly contrary to the ACA.[144]

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[140] Nat'l Health Law Prog. & Cmty. Catalyst, *Joint Letter to CCIIO Director, Ellen Montz, Re: Essential Health Benefits Review and Update Process* (Sept. 11, 2024), https://docs.google.com/document/d/1AKoB9ZXsfQW_ytfOSd1gqn4eqkjjj95VHToDLr3K1mg/edit?tab=t.0.

[141] 42 U.S.C. § 18022 (b)(4).

[142] U.S. Dept. of Health & Human Srvs., 91 Fed. Reg. 29526–29877, 29676 (May 20, 2026).

[143] U.S. Dept. of Health & Human Srvs., 90 Fed. Reg. 27074-27227 (June 25, 2025) (prohibiting "specified sex-trait modification procedures" as EHB).

[144] *See, e.g.*, NHeLP 2027 NBPP Comments, *supra* note 38; Mara Youdelman et al., Nat'l Health Law Prog., *NHeLP Comments on Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule* (Apr. 10, 2025), https://healthlaw.org/resource/nhelp-comments-on-notice-of-proposed-rulemaking-regarding-marketplaces/; Héctor Hernández-Delgado & Wayne Turner, Nat'l Health Law Prog., *NHeLP Letter to CCIIO on Legal Authorities and Regulatory Changes for Essential Health Benefits* (Sep. 13, 2023), https://healthlaw.org/resource/nhelp-letter-to-cciio-on-legal-authorities-and-regulatory-changes-for-essential-health-benefits/; Héctor Hernández-Delgado & Wayne Turner, Nat'l Health Law Prog., *NHeLP Comments on Essential Health Benefits (EHB) Request for Information (RFI)* (Jan. 31, 2023), https://healthlaw.org/resource/nhelp-

If HHS decides to move forward with setting up an EHB review and updating process, we urge following the data-driven, evidence-based approach we describe in the EHB Review Principles and 2021 letter to Secretary Becerra cited herein. We urge HHS to refrain from repeating the debacle of the Advisory Committee on Immunization Practices (ACIP), where unqualified Administration appointees have undermined vaccine coverage and confidence with their pseudo-science approach.[145]

Topic 6: State Process for Updating EHB Benchmark Plans

Most states have not adopted a formal process for selecting and updating the state's EHB benchmark plan. Federal rules require states to post a notice on a relevant state website regarding the opportunity for public comment with associated information.[146] However, HHS declined to set minimum requirements for the public comment process, such as holding public hearings or specifying the length of the public comment period.[147] Instead, HHS prioritized retaining state flexibility, looking to states to "reasonably interpret" the public comment requirement.[148]

However, the reasonableness standard has proven too broad and vague to ensure stakeholder participation in the EHB benchmark updating process. Notably, in its 2024 update, the District of Columbia posted its solicitation of public comment for its EHB benchmark update just two working days before submitting its proposal to HHS on May 1, 2024.[149] NHeLP submitted a letter to CCIIO objecting to the truncated public comment process.[150] However, at the time, CCIIO dismissed our concerns.[151] We cannot determine from the public record if any comments were actually submitted by other stakeholders.

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comments-on-essential-health-benefits-ehb-request-for-information-rfi/; Wayne Turner, Héctor Hernández-Delgado & Alexis Robles-Fradet, Nat'l Health Law Prog., *NHeLP Letter to CCIIO Director, Ellen Montz, Re: Request for Modifications to the Federal Prescription Drug and Maternity Care Essential Health Benefit Standards* (Aug. 15, 2022), https://healthlaw.org/resource/nhelp-letter-to-cciio-director-ellen-montz-re-request-for-modifications-to-the-federal-prescription-drug-and-maternity-care-essential-health-benefit-standards/.

[145] See, *e.g.*, Wayne Turner, Nat'l Health Law Prog., *RFK Jr.'s New Regime Puts Vaccine Coverage for Low-Income Children in Jeopardy* (Sep. 30, 2025), https://healthlaw.org/rfk-jr-s-new-regime-puts-vaccine-coverage-for-low-income-children-in-jeopardy/.

[146] 45 C.F.R. § 156.111(c).

[147] U.S. Dep't Health & Hum. Servs., 83 Fed. Reg. 16930, 17017 (Apr. 17, 2018).

[148] *Id.*

[149] *See* Dep't of Ins., Securities and Banking & DC Health Benefits Exchange Authority, Announcement – Selection of EHB Benchmark Plan for 2026 (Apr. 26, 2024), https://disb.dc.gov/page/essential-health-benefits-and-selecting-new-benchmark-plan.

[150] Wayne Turner & Héctor Hernández-Delgado, Nat'l Health Law Program, *NHeLP Letter to CCIIO on DC EHB Procedural Defect* (July 10, 2024), https://healthlaw.org/resource/nhelp-letter-to-cciio-on-dc-ehb-procedural-defect/.

[151] Letter from Jeff Wu, Deputy Administrator and Acting Director, Center for Consumer Information and Insurance Oversight to Wayne Turner & Héctor Hernández-Delgado, Nat'l Health Law Program (July 30, 2024) (on file with NHeLP).

Irrespective of the policy HHS ultimately proposes, we believe robust stakeholder participation, transparency, and public accountability are crucial for ensuring the EHB definition process adequately addresses the needs and concerns of state residents. HHS should establish clear minimum requirements for public notice and comment for EHB benchmark updates.

Federal rules require states to provide a "reasonable public notice" of the state's proposed update to the state's EHB benchmark plan by posting the notice on a "relevant" state website.[152] However, federal rules provide no specifics beyond this general requirement. Notice should be posted on a website that is easily accessible to the general public, such as the state department of insurance or state-based Marketplace website. It is more likely that a wider range of stakeholders will view the notice if it is on a high-traffic website rather than one that is limited to administrative or policy-change information, such as the state equivalent of the Federal Register.

Federal rules also require a "reasonable" public comment period, but do not say how long a state's public comment period must be. It is important for states to give the public sufficient time to study the proposal, formulate opinions, and communicate those ideas back to the state. For example, in 2018, Alabama proposed significant changes to its EHB benchmark, but provided only a two-week public comment period.[153] Advocates objected, arguing that two weeks is not a reasonable length of time to allow for meaningful public review and comment.[154] Unlike DC, Alabama ultimately withdrew its proposal in part because of the lack of opportunity for stakeholder input.[155]

HHS should establish minimum regulatory standards for EHB public commenting that mirror those specified by HHS for states requesting waivers through § 1115 of the Medicaid Act. Those standards require states to issue a public notice that contains a "comprehensive description" of the application and "a sufficient level of detail to ensure meaningful input from the public."[156] In addition, states seeking a § 1115 waiver are required to give stakeholders at least thirty days to submit comments.[157] Through regulation, HHS should

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[152] 45 C.F.R. § 156.111(c).
[153] Alabama Dep't of Ins,, EHB Benchmark Plan Revisions (July 19, 2018), https://www.aldoi.gov/currentnewsitem.aspx?ID=1008.
[154] Hayley Penan, Nat'l. Health Law Program, *Letter to Yada Horace, Insurance Rate Analyst, Alabama Department of Insurance, Re: Alabama PY 2020 EHB Benchmark Plan* (Aug, 2, 2020), https://healthlaw.org/resource/nhelp-comments-re-alabama-py-2020-ehb-benchmark-plan/.
[155] Alabama DoI, *supra* note 154.
[156] 42 C.F.R. § 431.408(a)(1)(i).
[157] 42 C.F.R. § 431.408(a). For additional information about the notice and comment process for states submitting § 1115 waiver applications, see Catherine McKee & Jane Perkins, Nat'l Health Law Prog., *Section 1115 Waiver Requirements: Transparency and Opportunity for Public Comment* (2017), https://healthlaw.org/resource/sec-1115-waiver-requests-transparency-opportunity-for-public-comment/.

require states to publicly post all relevant documents, including the actuarial report, the proposed benchmark plan summary of benefits covered, actuarial certifications required by HHS, and stakeholder comments received, to ensure greater transparency in the EHB benchmark updating process. Absent availability of these documents, stakeholders would be deprived from submitting informed feedback, rendering the current rule requiring a public comment process meaningless.

There are often competing priorities and interests seeking to add or improve benefits in EHB benchmark plans. Given actuarial and other limitations, states cannot add benefits all benefits they may want to as EHBs. In our view, decisions on what benefits to add, improve, or remove should be based upon a broader consideration of unmet health care needs and addressing longstanding inequities; not the concerns of the most well-resourced or politically connected proponents of a specific benefit.

HHS can help level the playing field of EHB benchmark selection by requiring a robust public process including stakeholder engagement, public notice and comment period, and full transparency.[158]

Conclusion

Thank you for the opportunity to submit feedback on this RFI and for considering our comments. We are available to further discuss our comments. If you have any questions or to coordinate a meeting, please contact Héctor Hernández-Delgado at hernandez-delgado@healthlaw.org or Wayne Turner at turner@healthlaw.org.

Sincerely,

Héctor Hernández-Delgado
Director, Services Practice Area
National Health Law Program

[158] *See* Wayne Turner & Héctor Hernández-Delgado, Nat'l Health Law Program, *Essential Health Benefits: Best Practices in Benchmark Selection* (July 26, 2022), https://healthlaw.org/resource/essential-health-benefits-best-practices-in-benchmark-selection/.