

July 15, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9874-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard (CMS-9874-NC)

Dear Administrator Oz:

On behalf of the American Hospital Association's (AHA's) nearly 5,000 member hospitals, health systems and other healthcare organizations, and our clinician partners who care for patients in communities across the country, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') request for information (RFI) on the Essential Health Benefits (EHB) framework and the Affordable Care Act's requirement that the scope of EHB be equal to the scope of benefits provided under a typical employer plan.

Hospitals and health systems understand firsthand how benefit design affects whether patients can access the care they need when they need it and without financial hardship. For that reason, the AHA believes the EHB framework must continue to serve its core purpose: ensuring that individual and small-group market enrollees have access to meaningful, comprehensive coverage, including services necessary to prevent illness, manage chronic conditions, respond to emergencies and acute healthcare needs, safely deliver babies, and treat behavioral health conditions.

As CMS undertakes this review, we urge the agency to approach any potential future policy changes with the understanding that affordability cannot be achieved by making coverage less adequate. Lower premiums are not the same as lower healthcare costs for patients if they are accompanied by reduced benefits, narrower coverage standards, higher deductibles, greater cost sharing or other changes



that increase households' financial exposure when care is needed. A benefit package that appears less expensive up front but leaves patients underinsured is not a sustainable affordability strategy; it simply shifts financial risk to patients and providers.

The AHA [remains concerned](#) that overly broad flexibility in EHB benchmark selection can create incentives for a race to the bottom in benefit design. When states have greater latitude to redefine benchmark plans or adopt benchmark components in ways that reduce benefits, plans may become less comprehensive while still nominally satisfying statutory requirements. Such an approach may generate short-term premium effects for some enrollees, but it also can increase out-of-pocket exposure, weaken access to medically necessary services and destabilize coverage for individuals with significant health needs.

At the same time, the AHA recognizes that the EHB framework should evolve to reflect advances in clinical evidence, changing patient needs and continued innovation in care delivery. Healthcare delivery has changed significantly since the framework was first developed, such as expanded access to virtual and home-based care. As new technologies emerge, including those enabled by artificial intelligence, the delivery system will continue to evolve. CMS should ensure that the EHB framework is flexible enough to account for these changes while preserving comprehensive coverage and protecting patients' access to medically necessary care. The AHA supports modernizing the EHB framework in ways that expand access to high-value care and better reflect how care is delivered today — not in ways that narrow benefits or shift costs to patients and providers.

Below we provide comments on certain topics included in the RFI.

Topic 1. Typical Employer Plans and Typicality

CMS should continue to prioritize meaningful, comprehensive coverage across the statutory benefit categories through an updated EHB framework with a “typical employer plan” standard that reflects the benefits ordinary working families reasonably expect their health coverage to include.

The AHA encourages CMS to preserve a robust, patient-centered interpretation of the 10 statutory EHB categories: hospitalization; emergency services; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; and pediatric services. The AHA also recommends that CMS evaluate plan affordability in a way that reflects how patients actually experience coverage. Patients do not experience affordability solely through monthly premiums; they also experience it through the totality of their coverage, including deductibles, cost sharing, exclusions, utilization management requirements, provider network limitations and whether medically necessary care is delayed or denied.

From the perspective of hospitals and health systems, underinsurance can be as significant as being uninsured. Patients with inadequate coverage often postpone care, forgo medication adherence, experience worse outcomes and present later in the course of illness — often in hospital emergency departments — when conditions are more severe and more expensive to treat. Any review of the “typical employer plan” standard should consider whether coverage provides meaningful financial protection and practical access to care.

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

The AHA supports state flexibility in selecting an EHB-benchmark plan insofar as it encourages innovation, but also recommends that CMS maintain a robust, standardized minimum benefit floor to avoid the gradual erosion of coverage or materially different levels of protection for core services across states. Patients should not face substantially different access to basic health benefits or financial protection because of where they live, rather than what their clinical needs require.

Excessive variation among benchmark plans also may create unnecessary administrative complexity for issuers and providers, particularly those operating across multiple states. For these reasons, CMS should maintain meaningful federal guardrails around benchmark selection and updates to ensure that state flexibility does not result in substantial disparities in coverage adequacy or financial protection. Benchmark changes should not be approved if they reduce benefit comprehensiveness, substantially shift costs to patients or weaken access to critical services.

Topic 3. Affordability and Cost

The AHA urges CMS to take a holistic view of affordability and recognize that affordable coverage and adequate coverage are closely connected. A plan with low premiums but inadequate protection from high out-of-pocket costs, exclusions, denials or utilization barriers may not be truly affordable for patients.

Maintaining a robust and comprehensive EHB framework is essential to preserving affordability and access. Weakening EHB standards would not address the underlying drivers of healthcare cost growth. Instead, it would reduce premiums primarily by limiting the scope of covered benefits, shifting more financial burden to patients and providers, and increasing the risk that individuals delay or forgo needed care.

Although less comprehensive plans may appear more attractive to healthier enrollees because of lower premiums, they often provide less meaningful financial protection for individuals who develop serious or chronic conditions, leaving those individuals with greater out-of-pocket exposure and reduced access to essential services. Over time, this dynamic can lead to risk segmentation, as lower-risk enrollees gravitate toward

leaner plans while higher-risk individuals concentrate in more comprehensive coverage. This segmentation can drive premium increases in more protective plans, weaken risk pooling, and ultimately compromise market stability and the value of coverage for the people who need it most.

Weakening EHB protections also risks undermining other ACA consumer protections that rely on a defined scope of benefits, including limits on cost sharing for essential health benefits. Allowing erosion of the EHB baseline would create opportunities for plans to reduce financial protection in ways that are inconsistent with the statute's intent and could reintroduce coverage gaps the ACA was designed to eliminate.

The AHA recently released an [affordability blueprint](#) that calls for systemwide solutions and shared accountability across stakeholders to address health care affordability. As noted in the blueprint, comprehensive access to healthcare services, particularly primary and preventive care, is key to improving affordability. At the same time, benefit designs that expose patients to high out-of-pocket costs and unnecessary complexity can discourage patients from seeking appropriate care, ultimately increasing system costs and undermining affordability. Policies that weaken EHBs by reducing access to needed healthcare services and increasing patients' financial burden would move the system in the wrong direction and are unlikely to achieve the administration's affordability goals.

Topic 7. Market Stability and Considerations Related to Implementation of Potential Refinements to the EHB Framework

The AHA appreciates CMS' focus on how refinements to the EHB framework may affect continuity of coverage. As CMS evaluates potential changes, it is critical to recognize that even well-intentioned EHB updates can create significant disruptions for patients, particularly those with ongoing or complex medical needs, if appropriate transition protections are not in place.

Refinements to the EHB framework, including updates to benchmark plans or modifications to the scope of covered services, could alter coverage for specific items and services from one plan year to the next. Without safeguards, these changes could result in unintended coverage gaps, mid-treatment disruptions or increased financial exposure for patients receiving medically necessary care. These risks are especially acute for individuals undergoing active treatment (e.g., cancer care, behavioral health treatment, maternity care or post-acute rehabilitation), where even short interruptions in coverage can lead to adverse clinical outcomes and higher downstream costs.

To mitigate these risks, the AHA strongly supports clear continuity-of-care protections tied to EHB changes. At a minimum, CMS should consider requiring plans to ensure that enrollees who are actively receiving a course of treatment for serious or complex

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conditions can continue to access that care without interruption for a defined transition period, regardless of whether the service remains classified as an EHB under a revised benchmark.

We thank you for the opportunity to comment on this important topic. Please contact me with any questions, or have a member of your team contact Ariel Levin, AHA's director of coverage and state issues forum, at alevin@aha.org.

Sincerely,

/s/

Ashley Thompson

Senior Vice President, Public Policy

American Hospital Association