July 15, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9874-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via Regulations.gov

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

Dear Administrator Oz:

The National Association of Benefits and Insurance Professionals (NABIP) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) Request for Information regarding 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.

NABIP represents more than 100,000 licensed health insurance agents, brokers, consultants, general agents, and benefits professionals who serve consumers, employers, and families in every state. NABIP members help individuals, families, and small employers evaluate coverage options, compare premiums and cost-sharing obligations, understand provider networks and prescription drug coverage, and select coverage that best meets their healthcare needs and financial circumstances.

CMS's review raises important questions about whether the current EHB framework remains aligned with the ACA's statutory standard, how state benchmark variation affects consumers and markets, how benefit requirements influence affordability, and how future updates to EHB should be evaluated. These questions have implications across the non-grandfathered individual and small group markets, including coverage offered through Federally facilitated Exchanges, State-Based Exchanges, and off-Exchange markets.

NABIP's comments focus on the areas where our members have direct, practical experience: consumer decision-making, affordability, benefit design, coverage transitions, state benchmark variation, and the operational effects of state and federal policy changes. NABIP appreciates CMS's decision to seek broad stakeholder input before proposing changes to the EHB framework and offers the following comments to support future policymaking that is evidence-based, transparent, and operationally workable.

NABIP supports a careful review of the EHB framework that preserves meaningful coverage, reflects contemporary employer-sponsored coverage, protects consumer understanding, and avoids changes that would create market disruption, adverse selection, or unexpected gaps in care.

NABIP Recommendations

NABIP respectfully encourages CMS to consider the following recommendations as it evaluates the future of the EHB framework.

1. Preserve the Affordable Care Act's statutory typical employer plan standard as the foundation of the EHB framework.

CMS should evaluate whether current EHB benchmark plans remain properly calibrated to contemporary employer-sponsored coverage and should avoid allowing the framework to drift from the statute's core standard. The Affordable Care Act (ACA) ties the scope of EHB to the benefits provided under a typical employer plan, which remains an important guardrail for balancing comprehensive coverage, affordability, consumer protection, and market stability.

NABIP supports CMS's effort to assess whether current benchmark plans continue to reflect that standard. Since the original EHB benchmarks were established, healthcare delivery, prescription drug utilization, behavioral health needs, telehealth, chronic disease management, and employer benefit design have changed substantially. CMS should rely on current employer-sponsored coverage data, actuarial analysis, and stakeholder input, while being cautious about importing self-funded plan flexibility into the individual and small group markets without accounting for consumer protections, guaranteed issue rules, rating requirements, and operational differences.

2. Evaluate affordability as a core component of access, while recognizing that affordability is not measured by premiums alone.

NABIP members work with consumers every day as they weigh monthly premiums against deductibles, provider networks, prescription drug coverage, anticipated healthcare needs, and total financial exposure. For many individuals and families, affordability determines whether coverage is accessible in practical terms, not merely whether a plan is technically available. CMS should evaluate whether existing cumulative benefit requirements remain consistent with the Affordable Care Act and advance the goals of healthcare access, quality, and affordability, while recognizing that reducing required benefits may shift costs to consumers rather than reduce the underlying cost of care.

Affordability should not be measured only by monthly premium amounts. A lower-premium plan may still be unaffordable if deductibles, copayments, coinsurance, prescription drug costs, out-of-pocket maximums, or uncovered services leave consumers unable to afford care when they need it.

Narrowing benefit requirements may reduce plan design costs in some cases, but it does not directly address the underlying cost of care, including provider prices, prescription drug costs, utilization trends, market concentration, and broader healthcare inflation. If benefit requirements are reduced without addressing these broader cost drivers, consumers may face higher out-of-pocket exposure, more uncovered services, or unexpected benefit gaps.

Any recalibration of EHB should therefore be evidence-based and should preserve meaningful coverage, informed consumer choice, and protection against unexpected costs. NABIP supports flexibility and consumer choice, but choice is only meaningful when consumers can clearly understand and compare their options, including what is covered, what is excluded, what cost-sharing applies, and what financial risks they may face. Additionally, any changes to EHB should be given sufficient implementation time, measured in years, not months, to allow the market to adjust to significant changes affecting the entire

individual and small group markets. Unlike other adjustments, these policy changes could result in some consumers delaying or forgoing care.

3. Preserve appropriate state flexibility while maintaining clear federal guardrails and transparency across state benchmark updates.

States should retain the ability to respond to local healthcare needs, provider availability, market conditions, and population health priorities. NABIP recognizes the value of state flexibility and does not recommend eliminating the state benchmark approach. However, CMS should examine whether variation across state EHB benchmark plans has created unintended consequences.

Significant variation across state benchmarks can create consumer confusion, issuer compliance challenges, operational complexity for agents and brokers, and uneven coverage expectations across states. CMS should maintain clear federal guardrails to ensure benchmark updates remain consistent with the ACA's typical employer plan standard and should require transparent analysis of premium impact, cost-sharing impact, consumer need, employer-market comparability, actuarial value, operational feasibility, and market stability.

4. Implement the plan year 2028 state defrayal policy through clear, timely, and operationally workable guidance.

CMS has already acted through recent rulemaking to restore clearer fiscal accountability for state-mandated benefits that exceed EHB. The ACA establishes a framework under which states are responsible for defraying the cost of certain state-mandated benefits that are in addition to EHB. In its recent rulemaking, CMS finalized the policy requiring states to defray the cost of any post-2011 mandate, even if it was successfully added to the state's EHB benchmark plan. CMS's next priority should be the policy's clear implementation. CMS should provide clear guidance no later than fall 2026 (well before plan year 2028), so states, issuers, regulators, enrollment platforms, agents, brokers, employers, and consumers understand how the policy will operate. This guidance should clarify which state-mandated benefits are considered "in addition to EHB", how the costs of those benefits should be calculated, how defrayal obligations interact with rate filings, premium tax credit calculations, and plan certification, and how consumers should be informed of related benefit or premium changes. CMS should also work closely with state legislators, regulators, issuers, and stakeholders over the next 12 months so states can make informed decisions about existing and future mandates.

5. Adopt a transparent, evidence-based process for evaluating future additions or modifications to EHB.

CMS should avoid ad hoc benefit-by-benefit decision-making and instead establish a durable framework for evaluating future EHB changes. New technologies, prescription drugs, emerging treatments, behavioral health services, chronic disease management, preventive care, telehealth, and evolving standards of care should be evaluated using clear and consistent criteria. Because policymakers and the public sometimes discuss EHB, preventive services, chronic disease management, and broader benefit

mandates interchangeably, CMS should use disciplined line-drawing to determine which services and benefits appropriately belong within the EHB coverage floor.

NABIP encourages CMS to consider whether a proposed EHB addition or modification is supported by credible clinical evidence, is commonly covered in contemporary employer-sponsored coverage, addresses a demonstrated consumer need, has a measurable effect on premiums or cost sharing, affects federal premium tax credit expenditures, can be operationalized by issuers, and can be clearly explained to consumers.

6. Consider operational predictability and market stability in any future changes to the EHB framework.

Any significant change to the EHB framework will have operational consequences across the individual and small group markets. States may need to take legislative or regulatory action. Issuers may need to redesign products, update actuarial assumptions, adjust formularies and provider networks, revise plan documents, and prepare rate filings. Enrollment platforms may need to update plan displays and benefit comparison tools. Agents and brokers will need training and clear guidance to help consumers understand changes.

CMS should align future policy changes with state legislative calendars, rate filing deadlines, plan certification timelines, consumer education needs, and agent/broker training. CMS should consider phased implementation when changes are significant or when states need time to respond, and should monitor indicators such as issuer exits, reduced plan offerings, premium volatility, changes in actuarial value or metal-level pricing, consumer complaints, post-enrollment coverage disputes, provider access concerns, and increased confusion during open enrollment.

7. Continue engaging licensed insurance professionals as a source of real-world operational experience.

Agents and brokers provide a distinct perspective that should inform CMS's evaluation of EHB policy. They help consumers and small employers understand plan options, compare benefits, evaluate affordability, assess provider and prescription drug access, and navigate coverage transitions. Their experience complements the perspectives of actuaries, issuers, providers, state regulators, and consumer advocates.

This perspective is especially important if CMS is considering whether greater benefit flexibility could support lower premiums. Consumers may welcome lower premiums, but they may not understand what reduced benefit requirements, greater state variation, or greater plan variation mean in practice. NABIP encourages CMS to include licensed insurance professionals in future stakeholder engagement related to EHB reforms and to collect structured feedback regarding consumer confusion, benefit gaps, affordability concerns, provider network issues, prescription drug access, plan comparison challenges, post-enrollment coverage disputes, and coverage transitions.

Conclusion

NABIP appreciates CMS's decision to seek stakeholder input before proposing changes to the Essential Health Benefits framework. CMS's review raises important questions about statutory alignment, affordability, state flexibility, state fiscal accountability, benefit design, market stability, and consumer understanding.

NABIP supports a careful, evidence-based review of the EHB framework. However, CMS should not equate lower premiums with better consumer outcomes if lower premiums are achieved through confusing, unstable, or inadequate coverage. A future EHB framework should preserve meaningful benefits, support informed consumer choice, maintain state fiscal accountability, avoid unintended market segmentation, and remain operationally workable for states, issuers, enrollment platforms, employers, consumers, and licensed insurance professionals.

The objective should be neither broader benefits nor lower premiums in isolation, but a stable framework that balances statutory compliance, affordability, meaningful access, consumer understanding, and market predictability.

NABIP looks forward to continuing to work with CMS to ensure consumers have access to affordable, meaningful, and understandable health coverage.

Respectfully submitted,

Mychal Walker

President

National Association of Benefits and Insurance Professionals