Federation of American Hospitals

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President and CEO

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Via electronic submission at *http://www.regulations.gov*

The Honorable Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard; 91 Fed. Reg. 35,938 (June 15, 2026)

Dear Dr. Oz:

As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, the Federation of American Hospitals (FAH) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) regarding the *Essential Health Benefits (EHB) Framework and Typical Employer Plan Standard*. As CMS considers whether changes to the EHB framework are warranted, the agency should prioritize policies that preserve meaningful access to medically necessary care, promote stable insurance markets and maintain comprehensive coverage for consumers.

FAH urges CMS to evaluate any future changes to EHBs based on whether they improve patients' ability to obtain needed care, rather than focusing narrowly on premiums or benefit reductions. Comprehensive benefits, meaningful financial protection and appropriate federal oversight remain essential to ensuring that Marketplace coverage provides patients with access to medically necessary care when they need it.

Topic 3: Affordability and Costs

CMS seeks comments on how the scope of benefits included as EHB affects premiums, consumer affordability, and long-term market stability, as well as input on whether and how affordability considerations should inform assessments of the scope of EHB.

FAH appreciates CMS' leadership in ensuring that Marketplace coverage remains affordable for consumers. It is important to recognize that affordability encompasses many factors and is much more than monthly premiums. Patients experience affordability through their ability to obtain meaningful health care coverage and access medically necessary care, including the combined effects of premiums, deductibles, coinsurance, provider access and financial protection against significant medical expenses.

CMS should evaluate any future modifications to EHBs based on whether they improve or diminish meaningful access to medically necessary services. Policies that reduce covered benefits or increase patient cost sharing may reduce premiums in the short term, but frequently shift costs to patients, increase underinsurance and discourage timely access to care.

Equally important, affordability cannot be assessed solely by examining covered benefits while overlooking how those benefits are administered. **Even where services are technically covered as EHBs, health plan cost management strategies, such as prior authorization, downcoding, restrictive utilization management and inappropriate claim denials can significantly impede patients' access to medically necessary care. CMS should consider these strategies as part of any evaluation of whether consumers have appropriate access to meaningful health care coverage.** Patient affordability is enhanced when coverage provides meaningful access to care rather than nominal coverage that shifts costs onto patients.

FAH also encourages CMS to consider the downstream costs and adverse patient consequences associated with reduced benefits, which lead to delayed or forgone care. Patients who cannot obtain timely **care** often experience worsening health conditions that ultimately require more intensive and costly interventions. Comprehensive coverage that facilitates timely access to care improves health outcomes while reducing avoidable long-term costs.

Finally, the way patients experience health care affordability is most closely tied to whether the premiums they pay are actually used to support patient care. Congress established the medical loss ratio (MLR) to ensure that most premium dollars (generally 80–85 percent) are directed toward medical services rather than administrative costs or profits. Consumers reasonably expect that the premiums they pay will be used to support meaningful access to hospitals, physicians, and other essential services. However, vertical integration of insurers, providers and related entities has created ways for plans to technically comply with MLR standards while shifting premium revenue within affiliated corporate structures. Insurers that own provider entities, pharmacy benefit managers, and other subsidiaries inflate reported medical spending by directing care to their affiliates – often paying higher rates – while retaining the funds within the same corporate family.[1] Under the current regulatory framework, the opaque nature of these intra-corporate transfers makes it more difficult for regulators and consumers to determine whether an insurer's reported medical spending reflects genuine investment in patient care. This practice contributes to higher premiums for consumers and creates an uneven competitive landscape for providers. **Effective oversight of the MLR standard requires greater insurer transparency in how premium dollars are allocated across complex corporate structures, and we urge consideration of several targeted policy improvements:**

- **Require issuers to separately report payments counted as medical spending that are made to affiliated entities**, including provider organizations, pharmacy benefit managers, utilization management vendors and other subsidiaries.
- **Require issuers to disclose corporate relationships** between the insurer and entities receiving payments reported as medical claims so that regulators can evaluate the extent of vertically integrated spending.
- **Strengthen reporting requirements for quality improvement activities** to ensure that administrative functions performed by affiliated entities are not recharacterized as medical spending.
- **Expand public reporting of MLR data** to distinguish direct medical claims payments from other forms of reported medical spending, including quality improvement activities and payments to affiliated entities.
- **Incorporate review of vertically integrated payment arrangements into MLR audits and program integrity activities** to ensure that reported medical spending reflects genuine patient care rather than internal financial transfers.

[1] Arnold, D. R. & Fulton, B. D. (November 2025). UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers. Health Affairs, 44(11).https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00155

Topic 3.2: Issuer Cost Management Strategies

CMS asks how issuers, employers, and other interested parties manage costs associated with benefits included as EHB, including through benefit design, utilization management techniques, network design, or payment approaches.

As CMS evaluates policies affecting the individual market, it is important to consider how cost management strategies, such as benefit design, cost-sharing structures, and network practices affect whether coverage translates into meaningful access to care.

According to a recent KFF poll, about six in ten (61 percent) Marketplace enrollees report having difficulty affording out-of-pocket costs for medical care. Considering that 37 percent of all U.S. adults reported that they would not be able to cover a $400 expense with cash or its equivalent – an amount that represents only a small fraction of the typical deductible in Marketplace plans – many consumers in plans with high deductibles could find themselves scrambling to pay for health care when they need it.

Over the past decade, deductibles and other forms of cost sharing have increased significantly across private insurance markets. According to the Kaiser Family Foundation's Employer Health Benefits Survey, the average deductible for single coverage increased by more than 50 percent since 2013, and enrollment in high-deductible plans has grown steadily.[2] When deductibles and coinsurance obligations reach several thousand dollars, many patients effectively face the full cost of care until those thresholds are met. Research shows that higher cost sharing reduces utilization of both discretionary and necessary medical services, meaning many families with insurance coverage delay or forgo care because of cost.[3] For these patients, insurance coverage does not necessarily guarantee access to care when it is needed.

A shift in costs to patients often results in delayed care or decisions to forgo care, which, especially for those with chronic conditions, can then result in the need for more intensive and costly care over time. **Cost management strategies must be applied appropriately, or they can function as a mechanism that impedes timely access to needed care that is an EHB covered benefit, which counteracts the consumer protections inherent in the statutorily required EHB package.**

Additionally, the impact of cost management strategies on access to medically necessary care and affordability of that care is compounded by network design and provider directory accuracy. Narrow networks are increasingly common in the individual market and can make it difficult for enrollees to find participating providers with available appointments. At the same time, inaccurate or outdated provider directories can leave patients believing that care is available in network when, in practice, the listed providers are no longer participating. Studies have found that a significant share of providers listed in plan directories are either not accepting new patients or cannot be reached to confirm participation.[4]

Marketplace competition should not be driven by cost management strategies that result in less meaningful coverage. Products that provide "illusory" and limited benefits, including catastrophic plans, non-network plans and narrow networks, may appear less expensive while exposing consumers to substantial financial liability and reduced access to medically necessary services. Such products can create the appearance of affordability without providing meaningful coverage. **CMS should instead continue promoting benefit designs that support timely access to medically necessary care while minimizing unnecessary financial and administrative barriers.**

Topic 4: Scope of Benefits Included as EHBs

CMS seeks comment on how the agency should define the scope of benefits included as EHB. For purposes of this inquiry, CMS states that scope of benefits may include covered services, treatment

[2] Kaiser Family Foundation. 2024 Employer Health Benefits Survey.
[3] Zarek Brot-Goldberg et al., What Does a Deductible Do?, 112 Q.J. Econ. 1261 (2017).
[4] Haeder, Weimer, Mukamel. "Secret Shoppers Find Access to Providers and Network Accuracy Problems in Health Insurance Marketplace Plans." Health Affairs.

approaches, coverage limitations, medical management, and other design features that affect access to care and health outcomes. CMS specifically asks about (i) factors informing the scope of benefits included as EHB, such as the breadth of covered services within each EHB category, (ii) how the agency should evaluate the appropriate scope of benefits within the 10 EHB categories, and (iii) the level of detail for defining and analyzing EHB, such as for determining which sub-benefits should be considered within each of the 10 EHB categories. Throughout the RFI, CMS also inquires about the appropriate balance between Federal oversight and State flexibility.

As discussed above, comprehensive health benefits, including comprehensive hospital services, inpatient medical rehabilitation, behavioral health services, and post-acute care – and a robust network of providers for furnishing those services – are essential to ensuring patients have access to a wide spectrum of necessary health care. Working families need to be able to rely on their health care coverage to facilitate timely access to comprehensive services and providers. This is imperative for a healthy population and in alignment with the agency's goals for preventing and managing chronic conditions. Congress recognized the importance of a comprehensive set of covered services and network providers, including by statutorily requiring that EHBs include at least the 10 general EHB categories and the items and services covered within those categories.[5]

FAH strongly supports the broad inclusion of services under each of the statutorily required EHB categories. The designation of services as EHBs attaches critical consumer protections that do not apply to services that are not considered EHBs. Congress prohibited insurers from imposing lifetime and annual dollar limits under their coverage for services designated as EHBs; these consumer protections do not apply to benefits that are not considered EHBs, for example, "in addition to" EHBs. These protections ensure patients are protected from catastrophic medical costs. Also, importantly, those eligible for the ACA cost-sharing subsidies may use those subsidies only for EHBs. Therefore, ensuring broad inclusion of services under each of the EHB categories is integrally tied to, and a foundational element of, furthering affordability of and access to needed health care.

We strongly caution against any policy changes that would narrow the scope of EHBs. **Narrowing the scope of benefits included as EHBs would not only shift costs to enrollees but would unduly impose costs on States as well, likely further reducing access to needed health care.** This is especially a concern when analyzed together with the recently finalized State defrayal policy (for "in addition to" EHBs) that will take effect January 1, 2028. Under that finalized policy, State-mandated services and treatments applicable to the small group or individual health insurance markets, even if those benefits are included in the State benchmark plan, will be considered "in addition to" services and the ACA consumer protections will not apply to those services, if the mandate was required by a State action after 2011 that was not for purposes of complying with Federal requirements. The preamble of the 2027 Notice of Benefit and Payment Parameters final rule provides that if a State begins defraying costs associated with a State-required benefit and making payments to QHP issuers, those issuers will have to update their plan filings accordingly beginning with PY 2028 "to reflect that the benefit is no longer covered as an EHB and should not be included in the percentage of premium attributable to coverage of EHB for the purpose of calculating APTCs."[6] Benefits that are federally required (e.g., those that are included under the statutorily required EHBs) can be State mandated and would continue to count as EHBs for which enrollees will continue to be able to rely on the ACA-provided consumer protections.

FAH therefore supports States having explicit flexibility to mandate inclusion of any services that fall under one of the 10 statutorily required EHB categories and for those services to be considered federally required and therefore EHB. We further urge CMS to clarify for States, that as long as a service falls under any of the 10 federally mandated EHB categories, the service constitutes an EHB and is not therefore treated as "in addition to" EHB.

[5] 42 U.S.C. § 18022.
[6] HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program; 91 FR 29580.

Further, FAH urges the agency to recognize that the scope of EHBs offered, access to services, and health outcomes are all integrally affected by utilization management tools used by plans. As discussed above, inappropriate use of utilization management for services and treatments results in denials and delays of needed care, often deterring the patient from pursuing medically necessary treatments and services, which can be detrimental to the health outcomes for the patient. These plan practices can therefore equate to the plan not effectively providing coverage of treatments and services included as federally required EHBs. **We urge CMS to work with States and enhance oversight of plan use of utilization management, and believe such oversight is vital to ensuring that EHB requirements are upheld by plans.**

FAH continues to have significant concerns about plans that seem compliant on paper with EHB requirements but use utilization management to effectively limit access to those EHBs. For example, many plans use highly restrictive criteria to keep patients out of inpatient rehabilitation facilities and inpatient long term acute care hospitals. Some plans rely heavily on algorithms that lead to prior authorization and claims payment denials – often after the care has been provided. The use of these algorithms can have the opposite impact from what CMS would hope to achieve in addressing care disparities. To the extent these algorithms are based on historic biases, appropriate patient care could be in jeopardy and disparities continued. Some plans also deny emergency department visits for mental health or behavioral health emergencies because prior authorization was not received in advance of receiving care.

FAH members continue to observe aggressive utilization management practices that we have consistently raised with CMS over the past several years, such as plan abuse of prior authorization requirements, maintenance of inadequate provider networks, use of extended observation care, retroactive reclassification of patient status, improper downcoding of claims, inappropriate pre- and post-payment denial policies, and denial of claims for previously authorized services. **All of these tools are used by plans to reduce or delay access to medically necessary services. These plan activities must be effectively monitored as a key component of oversight to ensure that the services within each EHB category are appropriately reflected in plans.**

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

Stable insurance markets depend on comprehensive benefits, meaningful consumer protections and balanced risk pools. FAH is concerned that policies encouraging enrollment in plans with more limited benefits may increase adverse selection by attracting healthier individuals while leaving those with chronic or complex conditions enrolled in more comprehensive products. Over time, this dynamic places upward pressure on premiums and undermines Marketplace stability.

Coverage erosion prevents patients from accessing timely coverage for medically necessary services or causes them to delay care because of financial barriers, leading to increased uncompensated care for hospitals, with patients frequently requiring more costly and complex treatment later. These effects are particularly significant for rural hospitals and providers serving medically underserved communities, many of which operate with limited financial margins and have fewer opportunities to offset increases in uncompensated care.

Given the significant individual and small group marketplace changes recently finalized through the 2027 *Notice of Benefit and Payment Parameters* final rule, FAH also encourages CMS to provide sufficient time to evaluate the impact of those policies before pursuing additional substantial revisions to the EHB framework.

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FAH appreciates CMS' thoughtful review of the EHB framework and encourages the agency to preserve comprehensive benefits, meaningful consumer protections and stable insurance markets. We also appreciate the opportunity to address these critical issues and look forward to collaborating with CMS to ensure a robust market for affordable, high-quality insurance coverage through the individual and small group marketplace. If you have any questions or would like to discuss further, please do not hesitate to contact Katie Tenoever, SVP, General Counsel at ktenoever@fah.org.

Sincerely,
/s/
Charlene MacDonald
President and CEO