NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

July 15, 2026

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

Via Regulations.gov

To whom it may concern:

The National Association of Insurance Commissioners (NAIC), representing the chief insurance regulators in the states, the District of Columbia, and U.S. territories, submits the following comments on the request for information (RFI) entitled *Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard*.

NAIC members appreciate the opportunity to provide information in response to the RFI and expect continued engagement with federal officials as the process for defining EHB is evaluated and potentially revised. However, given the complex and important nature of the questions, and the fact that many of the regulators most knowledgeable in reviewing and responding to this RFI are in the middle of health insurance rate and plan filing season, the time allotted to reply to the RFI was insufficient to respond to its questions in detail. Further, states generally use outside actuarial firms to perform benefit analyses, prepare EHB benchmark applications, and for related actions, and thus do not have detailed data to respond to many of the questions posed in the RFI. We strongly encourage CMS to engage appropriate actuarial expertise to better understand the impacts of any potential changes to EHB and to share the resulting analysis with states and other stakeholders before policy changes are finalized.

Moreover, a number of states followed established processes to update their EHB, yet CMS has suspended consideration of these states' complete applications. We request that CMS collaborate with these states to complete EHB updates under existing rules. CMS' review of the EHB framework should not delay state EHB updates and new rules should not impact state applications that were submitted while the current rules are in place. States invested time and resources in applying for EHB updates so that covered health plans could better serve state residents. We urge CMS to end its unwarranted delay in acting on these applications. Other states have also invested significant resources and were in the final stages of developing an application to update their benchmarks; these states experienced similar impacts when CMS halted the process.

Topic 1: Typical Employer Plans and Typicality

The current approach for defining essential health benefits (EHB) allows states to select a set of benefits from existing employer plans within the constraints established by federal rules. This approach represents a reasonable balance among a range of important considerations. The benefits in EHB-covered plans should ideally provide coverage for the health services consumers need, limit plan costs,

reflect statutory requirements, and promote stable competition in insurance markets. Meeting these objectives often requires tradeoffs and the current approach achieves balance given the commonalities and differences across employer plans, the value of state flexibility, and the need for predictability for insurers and consumers.

CMS requests input on limits to the use of historical plans in developing the EHB. Any limits on the use of historical plans should weigh the burden on states of updating their EHB-benchmark plan selection against the benefits of using more updated plans. If selecting a new plan requires significant research and analysis by states, it is only worth it if the benefits change meaningfully and in a way consistent with state priorities. CMS should maintain a default option for states if some historic plans "expire" as potential EHB benchmarks. The default option should be one that matches the state's current benchmark as closely as possible.

To better support representation of a typical employer plans, CMS may wish to consider ways it can promote greater representation of self-funded employer plans offered by private employers. Self-funded plan options from state and federal employers are available as comparison plans for generosity, but not self-funded plans from private employers. Collecting data on a representative range of these plans may prove challenging, but allowing comparison to private self-funded plans could better reflect the full range of typical employer plans. However, since some are likely to be more generous and others less generous than the current options, state or federal policymakers would need to set bounds to assure the options remain typical of employer offerings.

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

The existing framework for defining EHB has been informed by input and choices among the states, which results in some variation in benefits from state to state. State officials possess detailed knowledge and understanding of local factors and are best suited to tailor coverage to the needs of their insurance markets. State variation in EHB is generally small, but meaningful. State variation avoids a one-size fits all approach across the nation, while still allowing consistency aligned with the state-by-state regulation of individual and small group markets. Variation allows states to balance state policymaker priorities with cost and market dynamics within the federal EHB framework. It allows EHB to better match the typical employer plan in each state. Because health coverage is part of employee benefit packages, employer plan design reflects the supply and demand of each state's labor market, as well as a state's priorities, in that order.

CMS asks for comments on methodologies such as claims-based measures for evaluating the scope of benefits included as EHB across states. Evaluating the scope of an insurance plan requires careful review of the plan's provisions as laid out in a policy or certificate of coverage, not only analysis of claims submitted under the plan. While claims-based measures can provide valuable insights into the use of services, they may not show the importance of coverage for rare conditions or treatments, particularly for smaller states. A lack of claims should not be interpreted as a lack of coverage of benefits in an employer plan or in EHB-covered plans. Insurance coverage benefits individuals by establishing what would be covered if it were medically necessary—the coverage itself provides important risk protection and peace of mind for enrollees. Examining claims data shows only what was covered and paid for, not necessarily the full range of protections offered by an insurance plan against rarely needed but necessary treatments.

Topic 3: Affordability and Cost

CMS asks what aspects of EHB influence premium levels. In general terms, a broader scope of benefits contributes to higher premium costs. For instance, premiums may increase due to the disallowance of age limits for some services, such as hearing aids. Covering other benefits, though, may reduce overall costs. Maintaining EHB coverage of preventative care services or rehabilitative and habilitative services

can avoid costly diseases, prevent conditions from worsening, or maintain function that would otherwise be lost. Covered treatments can thus prevent the need for more expensive interventions.

We also note that plan features other than the scope of benefits can be used to manage costs. Medical necessity determinations and other utilization management techniques, when properly applied, can help ensure that covered benefits are used only when appropriate. Eliminating *inappropriate* use of benefits may be a better way to balance the breadth of coverage with cost than disallowing EHB coverage of a benefit entirely.

In seeking to improve affordability, CMS should consider that reducing the scope of covered benefits reduces the insurance value of health coverage. Benefit reductions can shift costs from premiums to out-of-pocket spending; consumers whose medical needs are not covered by their plan must pay out-of-pocket for services. Consumers must bear these costs on their own rather than pooling the risk with other enrollees. Reducing the scope of benefits shifts costs from the pool of enrollees and taxpayers to individuals who have health needs.

Topic 4. Scope of Benefits Included as EHB

CMS seeks suggestions on the factors it should consider when evaluating benefits, providing as examples AV and cost-sharing levels, breadth of covered services within EHB categories, alignment with clinical guidelines, consistency with employer-sponsored coverage, and impact on premium affordability. State regulators support consideration of all these factors and stress that policymakers should seek to reach an appropriate balance among them. Maintaining a state-focused process for defining EHB allows for fine-tuning of this balance in accordance with the preferences and priorities of each state and for better match with the typical employer plan in each individual state. To date, the EHB process has not explicitly focused on alignment with generally accepted standards of care and evidence-based practices, and we encourage greater use of such standards and practices in any revised EHB policies, while maintaining balance with the other named factors.

Topic 5. Updating EHB

CMS requests comment on how frequently EHB should be updated. State insurance regulators recommend that EHB updates continue to occur when an application is developed and submitted by a state. A regular review cycle could lead to increased burden on states and disruption for insurers by forcing a review and change of benefits when no change is warranted. States must weigh whether the benefits of an update outweigh the burden of pursuing the change. Employer plan benefits typically change little from year to year, though over several years benefits may be added and refined. Each state is best positioned to determine when sufficient changes have occurred to update EHB.

Topic 6. State Processes for Updating EHB-Benchmark Plans

State insurance regulators appreciate technical assistance from CMS during the application process for updating EHB benchmarks. If the application process is revised, enhanced technical assistance would help states meet new requirements. Clear guidance and feedback assists states in making necessary changes to their proposed benchmark plans and aids in the process being completed in a timely manner.

The impact of changes to the application requirements or CMS review process would depend on the specific changes proposed by CMS, and the latitude allowed to the states when incorporating them. Generally, states will need time to fully understand and effectively comply with new requirements and/or a new process. Expansive changes would likely increase the amount of time needed. As noted above,

states rely on contracted actuarial analysis to complete their applications—the more such analysis is required, the greater the burden on state resources in terms of time and cost.

In balancing federal oversight with state flexibility, CMS should prioritize compliance determinations rather than benefit-by-benefit review and analysis. CMS should review whether a proposed set of EHB meets statutory and regulatory requirements, such as being non-discriminatory, while allowing states to determine the scope of their own EHB benchmark plans.

State regulators value the opportunity to provide comments on the RFI. We look forward to continued collaboration to define EHB in ways that protect consumers and maintain stable health insurance markets.

Sincerely,

Scott White
NAIC President
Commissioner
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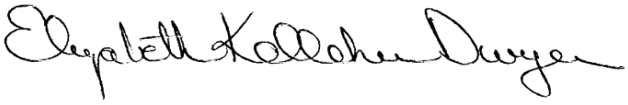

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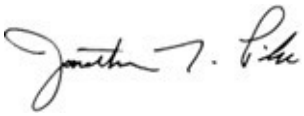

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