ETHICS AND PUBLIC POLICY CENTER

July 15, 2026

Submitted via Federal eRulemaking Portal

Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: CMS "Request for Information, Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard," RIN 0938-AW02, file code CMS-9874-NC

Dear Secretary Kennedy:

We are scholars at the Ethics and Public Policy Center (EPPC), and we write to offer public comment in response to the Center for Medicare & Medicaid Services' (CMS) Request for Information, "Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard" (RFI).[1]

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The RFI "seeks public input to support CMS's comprehensive review of the Essential Health Benefits (EHB) framework and the requirement under the Patient Protection and Affordable Care Act (Affordable Care Act) that the scope of EHB be equal to the scope of benefits provided under a typical employer plan."[2] It provides seven topics related to EHB, each with subquestions. The responses CMS receives will be considered as it "develop[s] future regulatory proposals or future subregulatory policy guidance."[3] Our recommendations below identify those questions to which we believe our suggestions are most responsive.

We are grateful that CMS has asked for comment on proposed reforms to ensure the EHB system operates consistently with Congress' goals and with the explicit safeguards and guiderails

[1] 91 Fed. Reg. 35938 (June 15, 2026), https://www.federalregister.gov/d/2026-11994.

[2] *Id*. at 35938.

[3] *Id.*

that Congress established. Below, we offer recommendations responsive to some of the questions raised in the RFI.

Many of our recommendations reference the CMS Marketplace Integrity Rule issued in June of 2025. We believe that CMS did a good job thinking through many of the important questions related to this issue in that Rule. We urge CMS to take this opportunity to review the logic of that Rule and specific findings CMS made there and incorporate those findings into clear, broadly applicable determinations and rules for the EHB process.

Our final recommendation encourages CMS to consider its affirmative obligations under the Religious Freedom Restoration Act (RFRA). We encourage CMS to keep in mind that ACA regulations have been the source of enormous religious liberty problems and—as described below—how states like Colorado and California are using the EHB benchmark process to create new religious liberty problems. In light of this troubling history, we urge CMS to take this opportunity to develop appropriate safeguards to protect the religious liberty rights of religious employers.

I. New regulations and guidance are needed because the current system gives states too much freedom to create unpopular, expensive mandates.

To understand why we believe it is critical that CMS reform the EHB process, we begin with an overview that outlines why we believe that the current system gives states too much freedom and allows them to sidestep the EHB safeguards that Congress placed in the ACA.

The Affordable Care Act requires non-grandfathered individual and small-group market health insurance plans to cover "essential health benefits" (EHB), a set of items and services falling within ten statutory categories: (i) ambulatory patient services, (ii) emergency services, (iii) hospitalization, (iv) maternity and newborn care, (v) mental health/substance use disorder services, (vi) prescription drugs, (vii) rehabilitative and habilitative services, (viii) laboratory services, (ix) preventive and wellness services, and (x) pediatric services. 42 U.S.C. § 18022(b)(1). Congress directed the HHS Secretary to define EHB so that its scope is "equal to the scope of benefits provided under a typical employer plan," creating a federal floor that individual and small-group plans must meet. *Id*. at (b)(2)(A). Congress tightened this requirement further by requiring the Secretary to "submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in [42 U.S.C. § 18022(b)(2)]." *Id*. at (b)(2)(B).

Rather than write a single national list of covered items, HHS allows each state to select an "EHB-benchmark plan" from among several existing plan options, and whatever that benchmark plan covers becomes the enforceable EHB standard for ACA-compliant plans sold in that state. Crucially, EHB requirements do not apply to large-group or self-insured plans, only to plans in the individual and small-group markets.

The HHS Secretary's authority to determine what counts as an "essential health benefit" is rooted in Section 1302 of the ACA, 42 U.S.C. § 18022, where Congress gave the Secretary of

HHS the authority to "define the essential benefits" subject to certain limits as set out in that section.

One of the limitations that Congress set forth is that the "Secretary shall ensure that the scope of essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, *as determined by the Secretary*." 42 U.S.C. § 18022(b)(2)(A) (emphasis added). Congress only identified one source of information to "inform" the Secretary's "determination": a "survey of employer-sponsored coverage" performed by "the Secretary of Labor." *Id*.

A. Why the EHB is an attractive vehicle for mandate advocacy.

Because states can add benefits on top of the ten broad federal categories when picking or updating their benchmark plan, EHB designation has become an important lever advocacy groups use to force insurance coverage of specific, often controversial, procedures without needing a freestanding mandate in federal or state law. A few EHB structural features make this leverage especially strong:

- **No caps on covered benefits.** Once something qualifies as EHB, insurers cannot impose annual or lifetime dollar limits on it and must count it toward out-of-pocket maximums, making EHB designation far more valuable to advocates than a mere "allowed" benefit.[4]

    - *For example:* As TransEquality, a pro-gender ideology advocacy group, notes, "If a particular service is covered as an EHB, it is also subject to a whole host of consumer protections under the ACA, including no lifetime limits, cost-sharing, and additional protections against discrimination in benefit design."[5]

- **Broad, undefined categories create room for interpretation.** Some of the ten mandated EHB categories in 42 U.S.C. § 18022(b)(1)—especially "mental health services" and "preventive and wellness services"—are vague enough that advocates can argue a disputed procedure qualifies, even if the procedure is a physical intervention with only a mental-health rationale.

    - *For example:* TransEquality has argued that sex-rejecting procedures count as EHBs, even where states have explicitly excluded it: "Unfortunately, most state EHB Benchmark plans have language that explicitly excludes trans care, but even that does not mean trans care isn't covered."[6] It claims that "trans health" is still covered as an EHB "because those services are included in the broad categories of medical care under an EHB. For example, hormones may be covered under the prescription drugs EHB, surgery may be covered under the inpatient or outpatient EHB, and seeing a

[4] *See* Ctrs. for Medicare & Medicaid Servs., *Information on Essential Health Benefits (EHB) Benchmark Plans*, https://www.cms.gov/marketplace/resources/data/essential-health-benefits (last visited July 15, 2026) ("The EHB-benchmark plans displayed may include annual and/or lifetime dollar limits; these limits cannot be applied to the essential health benefits.").

[5] TransEquality, *Understanding Essential Health Benefits*, https://transequality.org/resources/understanding-essential-health-benefits.

[6] *Id.*

therapist for a diagnosis of gender dysphoria is likely covered under the mental health EHB."[7]

- **Progressive states have used their state benchmark plans to create state-level insurance mandates.** Many states have taken advantage of loose CMS rules and oversight over the state benchmark process, updating their plans to include broad coverage for sex-rejecting procedures and "social infertility" (e.g., including IVF benefits for single people or people who do not have procreative sex). Lax CMS enforcement allows states to abuse federal law to create enormous state-level mandates for the individual and small-group market, placing onerous mandates on millions of enrollees and insurers.

- **Federal subsidy dollars follow the mandate.** It would be one thing if the EHB framework merely allowed states to create their own mandates. But because EHB coverage is subsidized through ACA premium tax credits, the EHB framework allows states to create state mandates that are funded with federal dollars. Once a procedure is deemed "essential," taxpayer subsidies flow to it automatically. This gives progressive advocates a strategic reason to fight for EHB inclusion rather than push for a standalone state mandate that lacks federal subsidization.

- **Federal EHB definitions ripple to Medicaid expansion too.** The EHB package also defines minimum coverage for the ACA's Medicaid expansion population, multiplying the reach of any single successful mandate push.[8]

- **EHB designation indirectly affects large-group and self-insured plans.** As noted above, the EHB requirement to offer coverage applies only to plans in the individual and small-group market.[9] But changes to the EHB definition also reach large-group and self-insured plans indirectly: federal law prohibits any group health plan—including large-group and self-insured plans—from imposing annual or lifetime dollar limits on whatever benefits qualify as EHB,[10] and separately requires that enrollee cost-sharing for EHB counts toward the plan's annual out-of-pocket maximum.[11] Because self-insured and large-group plans may adopt any state's EHB-benchmark definition for this purpose,[12] an

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[7] *Id.*

[8] 42 U.S.C. § 1396u-7(b)(2) (Medicaid's "Alternative Benefit Plans" (ABP) must provide benefits "consistent with" section 1302(b), the EHB provision). *See also* 42 C.F.R. § 440.347(a)-(b) (Alternative Benefit Plans "must contain essential health benefits coverage" in each of the ten categories, and :must include essential health benefits in one of the state options for establishing essential health benefits described in 45 CFR 156.100:)

[9] 42 U.S.C. § 18022(a)-(b); PHS Act § 2707(a), 42 U.S.C. § 300gg-6(a); 45 C.F.R. § 156.115(a).

[10] 42 U.S.C. § 300gg-11 (PHS Act § 2711); 45 C.F.R. § 147.126(a)-(b); *see also* U.S. Dep't of Labor, *FAQs About Affordable Care Act Implementation Part 66* (Apr. 1, 2024), https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-66.

[11] 42 U.S.C. § 18022(c) (ACA § 1302(c)); PHS Act § 2707(b), 42 U.S.C. § 300gg-6(b); 45 C.F.R. § 156.130; *see also* Ctrs. for Medicare & Medicaid Servs., *ACA Implementation FAQs, Set 18* (Oct. 8, 2024), https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/aca_implementation_faqs18.

[12] *See* Newfront, *ACA Essential Health Benefits* (Feb. 20, 2020), https://www.newfront.com/blog/aca-essential-health-benefits.

expansion in what counts as EHB—whether at the state benchmark level or through a change in CMS's federal EHB framework—correspondingly expands the scope of these no-dollar-limit and out-of-pocket-maximum protections across the employer-sponsored insurance market, not merely the ACA exchanges.

B. Colorado and California show why it is critical that CMS act now to rein in the EHB process.

These concerns are not theoretical. Colorado's and California's actions in recent years show how the EHB has been abused. CMS should study these examples to understand how the program must be reformed to bring it in line with the strictures that Congress has established.

Colorado: In 2021, Colorado submitted and CMS approved a new benchmark plan that asserted that a wide range of sex-rejecting procedures qualified as EHBs. The Colorado EHB plan notes that "[s]urgical services and hormone therapy for medically necessary gender-affirming care are EHB under this EHB-benchmark plan," and thus the plan design covers the following "gender-affirming" interventions, "at a minimum":

1. Blepharoplasty (eye and lid modification)
2. Face/forehead and/or neck tightening
3. Facial bone remodeling for facial feminization
4. Genioplasty (chin width reduction)
5. Rhytidectomy (cheek, chin, and neck)
6. Cheek, chin, and nose implants
7. Lip lift/augmentation
8. Mandibular angle augmentation/creation/reduction (jaw)
9. Orbital recontouring
10. Rhinoplasty (nose reshaping)
11. Laser or electrolysis hair removal
12. Breast/chest augmentation, reduction, construction[13]

In October 2021, CMS approved Colorado's EHB benchmark plan. CMS's press release lauded its approval as a "landmark" decision "aligned with the Biden-Harris Administration's efforts to address health care disparities by removing longstanding barriers and expanding access to care for transgender persons."[14] Colorado's own press release said that its benchmark plan showed that "Colorado continued to lead the nation in healthcare and health insurance reform."[15] Neither CMS nor Colorado even attempted to explain how a slate of sex-rejecting procedures

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[13] Colo. Div. of Ins., Colorado Essential Health Benefits Benchmark Plan, at 38 (2023), in Ctrs. for Medicare & Medicaid Servs., Information on Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/files/zip/co-ehb-benchmark.zip (listing "Gender Affirming Care" as a covered benefit).

[14] Press Release, *Biden-Harris Administration Greenlights Coverage of LGBTQ+ Care as an Essential Health Benefit in Colorado*, CMS (Oct. 12, 2021), https://www.cms.gov/newsroom/press-releases/biden-harris-administration-greenlights-coverage-lgbtq-care-essential-health-benefit-colorado.

[15] Press Release, *Benefits to Explicitly Include Services to Address Substance Use Disorder and Mental Health*, Colo. Dept. of Reg. Agencies (Oct. 12, 2021), https://doi.colorado.gov/news-releases-consumer-advisories/biden-administration-announces-approval-of-colorados-inclusive.

that they said "remov[ed] longstanding barriers" and "lead the nation" if they were part of the "typical employer plan"—a legal requirement for inclusion as EHB.

Progressives lauded what they called "The Colorado Way" as "a prime example of how states can use the benchmarking process for Essential Health Benefits (EHB) to address unmet needs."[16] One article celebrated that "more recent iterations of the federal EHB rules give states additional flexibility in EHB benchmark selection," and that Colorado had shown what could be done with this "flexibility."[17] The same article noted that while "Federal rules require states to provide notice and seek public comment on new benchmark selections," "most states have no formal process for benchmark selection."[18]

California: In May 2025, California submitted an application to CMS to update its benchmark plan. Its application proposed to add new services as EHB, including hearing aids and wheelchairs, beginning in 2027. California's press release said that its updates "will close coverage gaps for millions" which would seem impossible if the new proposed EHB were already part of the "typical employer plan."[19]

California's application to CMS, using OMB form No. 0938-1174 (exp. 11/30.2027), demonstrates important weaknesses in the current state benchmark application process.[20]

Question 2 on the form affirms that the proposed EHB-benchmark plan "must provide a scope of benefits that is equal to the scope benefits of a typical employer plan in the State." But the same question on the CMS form offers an incredible definition of a "typical employer plan":

> The scope of benefits in a typical employer plan in a State is any scope of benefits that is as or more generous than the scope of benefits in the least generous plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), and as or less generous than the scope of benefits in the most generous plan in the State (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), among the following the plans at § 156.111(b)(2)(ii)(A) and (B).

Given that definition, CMS asks states not to confirm that its proposed benchmark plan "is equal to the scope of benefits provided under a typical employer plan," but instead asks:

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[16] Wayne Turner, *The Colorado Way: Using the Essential Health Benefits benchmarking process to advance health equity*, Health Law, Oct. 18, 2021, https://healthlaw.org/the-colorado-way-using-the-essential-health-benefits-benchmarking-process-to-advance-health-equity/.

[17] *Id*.

[18] *Id*.

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

[20] California Application to CMS, Appendix B: Essential Health Benefits (EHB)-Benchmark Plan Actuarial Certificate Template (March 25, 2025), https://www.dmhc.ca.gov/Portals/0/Docs/DO/EHB/AppendixBEHBBMPCert.pdf.

> What plans did the state identify as the least and most generous plans among the plans at § 156.111(b)(2)(ii)(A) and (B)?

California was thus able to answer in a manner that completely side-stepped the critical requirement that Congress established:

> The Kaiser UC Plan was determined to be the most generous plan. The current benchmark plan was identified to be less rich than the proposed benchmark plan since benefits are being added (with no benefits being reduced).

These recent examples from Colorado and California show that the EHB system is broken and that states are taking advantage of weak CMS regulations and oversight. They are using the EHB system to impose new mandates on individuals and small employers, even as they openly celebrate that their new requirements had not been part of the typical employer plan. We hope that these practical examples demonstrate why it is critical for CMS to take this opportunity to reform EHB regulations and processes, and help CMS identify the reforms that need to be made.

II. CMS should initiate reforms to curtail states' ability to manipulate the EHB system to create unpopular, expensive insurance mandates.

A. CMS should eliminate states' ability to bypass Congress' "typical employer plan" requirement by referencing large employer plans. [Topic 1, Question 1.1]

Question 1.1 in the RFI asks for comments related to the "current regulatory framework for identifying a 'typical employer plan' as reflected in the EHB-benchmark plan selection framework established under §§ 156.100 and 156.111(b)(2)," which concern the manner in which states select their benchmark plans.[21]

As described in the RFI, the "current regulatory framework for identifying a 'typical employer plan'" under §§ 156.100 and 156.111(b)(2) "includes the following plan types:

- Government employee plans (Federal and State);
- Small group plans;
- Large group plans; and
- Self-funded plans.[22]

CMS recognizes that "the statute does not specifically require CMS to use a reference plan approach when defining the EHB or ensuring typicality."[23]

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[21] 45 CFR 156.100 concerns benchmark plans for plan years beginning prior to January 1, 2020, and § 156.111(b)(2) concerns the scope of benefits for plan years beginning on or after January 1, 2020, through December 31, 2025.

[22] 91 Fed. Reg. 35940.

[23] 91 Fed. Reg. at 35940.

CMS then asks: "Are certain types of plans more representative of a typical employer plan than others?"[24] "When considering typicality, should CMS consider employer size?"[25] The answers are **yes** and **yes**. Large employer plans and government plans tell you nothing about what the typical employer plan is like because large employers and governmental entities are nothing like the typical employer in the United States.

This is common sense. Recognizing this reality, and adjusting EHB regulations accordingly, is the most important step CMS can make to reform the EHB system and bring it in line with Congress' clear instructions in Section 1302(b)(2).

1. As CMS has already correctly determined, what large employers cover is irrelevant to the "typical employer plan" required under section 1302(b)(2)(A).

As CMS notes, the current EHB-benchmark plan selection framework under §§ 156.100 and 156.111(b)(2) permits states to consider certain plan types, including "government employee plans" and "large group plans."

But neither large group plans or government employer plans have any bearing on the key legal constraint here: whether "the scope of the essential health benefits under [section 1302(b)(1)] is equal to the scope of benefits provided under a typical employer plan." Section 1302(b)(2). **CMS itself made this clear just last year, in its final rule, Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability.**[26] What remains is for CMS to adopt new EHB regulations that reflect this fact.

a. Large employer plans are not "typical employer plans."

The preamble to the Marketplace Integrity Rule responded to comments who contended that surveys of large employer health coverage were relevant to the "typical employer plan" inquiry under section 1302(b)(2). CMS disagreed, emphasizing the following:

- While "very large employers … represent a larger share of employees," "[t]he statute specifically references the typical employer and not the typical employee."[27]
- Congress intentionally focused on the "typical employer plan" "to restrain the EHB from reflecting the more generous and costly health plans offered by very large employers."[28]
- Additionally, when it comes to health care items that are favored by progressive activists, "very large employers … receive more pressure from advocacy organizations to cover"

[24] *Id*.

[25] 91 Fed. Reg. at 35941.

[26] 90 Fed. Reg. 27074 (June 25, 2025) ("Marketplace Integrity Rule").

[27] 90 Fed. Reg. at 27155.

[28] *Id*.

such procedures and, therefore, likely do not represent the typical employer to the degree a portion yield to this pressure."[29]

These conclusions from just last year are obviously correct. CMS should incorporate this clarity into EHB regulations and remove states' opportunity to sidestep the legal "typical employer plan" requirement by measuring their benchmark against a large employer plan.

b. Government employer plans are not "typical employer plans."

While CMS did not specifically address government employer plans in the Marketplace Integrity Rule, these same arguments apply with full force, as government employers are large employers by any measure, and are amplified by government employers' lack of incentive to contain costs when taxpayers are paying the bill.

The federal government alone employs approximately 2.9 million civilian workers, making it the single largest employer in the United States—larger than Walmart, Amazon, or McDonald's.[30] Federal employees, retirees, and their families receive coverage subsidized by taxpayers through the Federal Employees Health Benefits (FEHB) Program, which OPM itself describes as "the largest employer-sponsored group health insurance program in the world," covering over 8 million lives through a small number of nationwide or regional plan offerings.[31]

State governments exhibit the same pattern: California's state employee health plan alone covers more than 1 million employees and dependents, while New York's, Washington's, North Carolina's, and Georgia's state plans each cover between roughly 300,000 and 570,000 enrollees in a single, statewide plan.[32] These enrollment figures dwarf even the largest private employers CMS considered irrelevant in the Marketplace Integrity Rule.

If "very large employers" like Fortune 100 companies do not represent the "typical employer,"[33] then government employers—whose plans are, in effect, mega-plans covering hundreds of thousands or millions of enrollees through a single centralized benefit design not subject to market forces that would ordinarily balance the value of the benefits to employees against the costs to the employer—are the paradigmatic example of the non-typical employer Congress intended to exclude from the EHB calculus.

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[29] *Id*.

[30] Pew Research Center, *What the Data Says About Federal Workers* (Jan. 7, 2025), https://www.pewresearch.org/short-reads/2025/01/07/what-the-data-says-about-federal-workers/.

[31] U.S. Office of Personnel Management, FEHB Handbook, https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/fehb-handbook/.

[32] Becker's Payer Issues, *States With the Largest Employee Health Plans* (June 29, 2023), https://www.beckerspayer.com/payer/states-with-the-largest-employee-health-plans/.

[33] 90 Fed. Reg. at 27155.

Again, CMS should incorporate this common sense into EHB regulations and prohibit states from sidestepping Congress' "typical employer plan" requirement by incorrectly referring to government employee plans as such.

2. By any reasonable measure, the "typical employer" is tiny, and the "typical employer plan" only slightly larger.

Under Question 1.1, CMS recognizes that states "have overwhelmingly relied on small plans as a reference" in "selecting or designing an EHB-benchmark plan."[34] CMS then asks, "Is there something inherently more 'typical' about these plans. . . ?"[35] The answer is **yes**. Small plans are more typical because the typical American employer is small. As shown below, we believe the evidence is overwhelming that a typical employer plan is a plan offered by a small employer, with around 20 employees.

Most employers look nothing like a Fortune 100 company, or even a Fortune 1000 company. According to the Small Business & Entrepreneurship Council, drawing on U.S. Census data, 98.1% of employers have less than 100 employees and 89% of employers have less than 20 employees.[36] Our review of the 2022 Statistics of U.S. Businesses (SUSB) dataset from the U.S. Census Bureau found that the median U.S. employer has 5 employees.[37]

While very small employers dominate the U.S. economy, not all small employers offer health benefits. Thus, the "typical employer plan" reflects a business with more employees than the median U.S. employer. According to the Kaiser Family Foundation's (KFF) 2024 Employer Health Benefits Survey, 94% of firms with 50 or more employees offer health coverage, compared to only about 39% of firms with 3–9 employees.[38] Based on these statistics, the "typical employer plan" is likely held by an employer with between 10 and 20 employees.

Thus to honor Congress' judgment that the EHB package should be "equal to the scope of benefits provided under a typical employer plan," CMS must look at available data and determine what a "typical employer plan" looks like. CMS should check our math with the best data available, make appropriate findings, and then create definitions that follow Congress' mandate: the Secretary of HHS "shall ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan."

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[34] 91 Fed. Reg. at 35941.

[35] *Id*.

[36] Small Business and Entrepreneurship Council, Facts & Data on Small Business and Entrepreneurship, https://sbecouncil.org/about-us/facts-and-data/ (last visited July 15, 2026).

[37] U.S. Census Bureau, 2022 Statistics of U.S. Businesses (SUSB) Annual Data Tables by Establishment Industry, tbl. "U.S., All Industries: Employment Size of Enterprise," https://www.census.gov/programs-surveys/susb/data.html (last visited July 15, 2026).

[38] Kaiser Family Foundation, 2024 Employer Health Benefits Survey (Oct. 8, 2024), https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/.

B. Data from multiple employers' plans trumps data from a single reference plan as "a useful picture of the coverage offered by a typical employer." [Topic 1, Question 1.1]

Question 1.1 also asks how CMS should "define and/or assess typicality" other than its "reference plan approach" and whether "a review of existing data sets" would be a better approach.[39] We agree that looking at data is better than the "reference plan approach." That seems to be what Congress intends in Section 1302 of the ACA and reflects CMS judgment in last year's Marketplace Integrity Rule.

We begin with Section 1302(b)(2)(A), which reads:

> The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

Congress clearly recognized that the collection of data by the federal government is necessary to ascertain the characteristics of a typical employer plan, and CMS should continue to rely on official data, rather than privately conducted surveys, to inform this process.

The only source of data specifically identified by Congress is a Department of Labor report. To our knowledge, the most recent report from the Secretary of Labor on this matter is the April 11, 2011, document, "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services."[40] This document should play an important role in any EHB conversation. If the Secretary of HHS believes that he or she needs better data on this front, HHS could make a specific request to Labor. Perhaps an avenue for making this request or a request that Labor renew this report on a reasonable interval could be incorporated into a standing requirement.

We also refer CMS back to last year's Marketplace Integrity Rule, where **CMS concluded that "utilization data from the EDGE limited data set offers a useful picture of the coverage offered by a typical employer**."[41] The "Enrollee-Level External Data Gathering Environment (EDGE) limited data set" was created by CMS in 2020.[42] CMS creates the EDGE limited data "on an annual basis . . . using masked enrollee-level data submitted to EDGE servers

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[39] 91 Fed. Reg. at 35940-41.

[40] U.S. Dep't of Labor, Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services (April 15, 2011), https://web.archive.org/web/20170528072852/https:/www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf.

[41] 90 Fed. Reg. at 27155.

[42] CMS, *Enrollee-Level External Data Gathering Environment (EDGE) Limited Data Set (LDS)*, https://www.cms.gov/data-research/cms-data/limited-data-set-lds-files/enrollee-level-external-data-gathering-environment-edge-limited-data-set-lds.

by issuers of risk adjustment covered plans in the individual and small group (including merged) markets."[43]

C. As CMS found last year, large employer data can be relevant to show what a typical employer plan does not cover. [Question 1.1]

We are aware that commenters have often pointed to large employer surveys, for example the Kaiser Family Foundation's Employer Health Benefits Survey, which claims to be "widely cited and considered perhaps the most reliable source of information on employer and employee healthcare costs and premiums."[44] For the reasons stated above, large employer surveys are not an accurate representation of what the typical employer plan covers. But this data can still be useful in *some* instances, particularly where large employer surveys show that a benefit in question isn't even covered by the average large employer.

Consider last year, when CMS used the Kaiser Family Foundation's Employer Health Benefits Survey to conclude that sex-rejecting procedures were not covered in the typical employer plan and therefore were not eligible for recognition as an EHB:

- CMS noted that "according to the KFF 2024 Employer Health Benefits Survey, which was cited by commenters, only 24 percent of employers with 200 or more employees responded that they cover gender-affirming hormone therapy."[45]

- CMS noted "that large employers tend to have more financial resources to provide a more generous benefit set."[46]

Using this KFF data together with its observation about the general relationship between large and small employer benefits, CMS reasoned that the fact that sex-rejecting hormone therapy was not covered by the typical *large* employer plan meant that the broader category of sex-rejecting procedures was not covered by the typical employer plan. We believe this inferential logic is strong and that CMS should allow itself and states to use large employer data for this limited purpose.

D. CMS should formally commit to issuing the EHB report mandated in section 1302(b)(4)(G) on a regular basis. [Topic 5, Question 5.1]

Question 5.1 in the RFI asks, "How frequently should CMS review EHB coverage, consistent with section 1302(b)(4)(G) of the Affordable Care Act, and consider whether updates

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[43] *Id*.; *see also* 90 Fed. Reg. at 27153 n.194.

[44] Peter Wehrwein, *Premiums for Employer-based Health Insurance Increased by 7% in 2024, Says KFF Report*, Managed Healthcare Exec. (Oct. 9, 2024), https://www.managedhealthcareexecutive.com/view/premiums-for-employer-based-health-insurance-increased-by-7-in-2024-says-kff-report.

[45] 90 Fed. Reg. at 27155.

[46] *Id*.

to regulations implementing EHB may be appropriate?" "Should there be a regular review cycle (for example, every 3-5 years)?"[47]

This statutory provision requires that the Secretary "review the essential health benefits" "periodically," not occasionally. The same provision also requires the Secretary to "periodically ... provide a report to Congress and the public" addressing specified questions related to the EHB program.

Surprisingly, **we have not been able to find *any* HHS reports to Congress or the public pursuant to this command in section 1302(b)(4)(G).** Every Federal Register preamble that touches the essential health benefits provisions—from the 2012 EHB data collection rule,[48] to the 2013 EHB and actuarial value final rule,[49] through the current 2026 RFI[50]—restates the Secretary's duty to periodically review the EHB and report the findings to Congress and the public, but none of them cites an actual completed report as having been transmitted. Nor does the broader compliance record fill the gap: GAO's public output on HHS/CMS ACA rulemaking consists of routine Congressional Review Act submissions certifying procedural compliance with individual payment-notice rules,[51] not any substantive assessment of the § 1302(b)(4)(G) reporting duty itself.

The clearest signal of the gap comes from HHS's own silence: the Department's December 2022 RFI was described by outside observers as the first time HHS had solicited comment on updating the EHB since the requirement took effect in 2014.[52] The current 2026 RFI likewise invokes §§ 1302(b)(4)(G)(ii) and (iv) only as the legal basis for asking new questions, without referencing any prior report's findings.[53]

We encourage CMS to use this opportunity to fix this gap and take its responsibility under section 1302(b)(4)(G) seriously. CMS should commit to issuing a section 1302(b)(4)(G) report as soon as practicable. CMS should also establish a regular cycle of reporting. A regular

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[47] 91 Fed. Reg. at 35942-43.

[48] Patient Protection and Affordable Care Act; Data Collection To Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42658, 42658–59 (July 20, 2012).

[49] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12842–43 (Feb. 25, 2013).

[50] 91 Fed. Reg. at 35939.

[51] *See, e.g.*, U.S. Gov't Accountability Off., GAO-17-336R, Department of Health and Human Services: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program (2016); U.S. Gov't Accountability Off., GAO-15-451R, Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (2015); U.S. Gov't Accountability Off., B-332198, Department of Health and Human Services, Centers for Medicare & Medicaid Services: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans (2020).

[52] Commonwealth Fund, *HHS Considers Updating the Essential Health Benefits* (Jan. 11, 2023), https://www.commonwealthfund.org/blog/2023/hhs-considers-updating-essential-health-benefits.

[53] 91 Fed. Reg. at 35939.

reporting cycle would do more than satisfy the statute—it would impose discipline on the entire EHB system. States would no longer be free to select outdated benchmark-year plans or add new benefits piecemeal without CMS's periodic assessment catching and addressing the change; instead, every state benchmark decision would eventually be measured against a public, recurring federal review.

E. CMS should formalize and give structure to the Secretary's authority to exclude identified services from EHB under 45 CFR 156.115(d). [Topic 5, Question 5.2]

Question 5.2 in the RFI asks:

> What, if any, mechanisms or safeguards should be in place to ensure that EHB updates maintain consistency with the statutory requirement that the scope of the EHB be equal to the scope of benefits provided under a typical employer plan pursuant to section 1302(b)(2)(A) of the Affordable Care Act?[54]

We suggest that CMS should take this opportunity to formalize and give structure to the Secretary's authority to exclude identified services from EHB under 45 CFR 156.115(d).

As CMS noted last year, the Secretary's authority to exclude identified services from EHB under 45 CFR 156.115(d) is rooted in section 1302 of the ACA, where Congress gave the Secretary of HHS the authority to "define the essential benefits" subject to certain limits as set out in that section.[55] Section 156.115(d) was created in the original 2013 EHB/Actuarial Value final rule,[56] which established the initial exclusion list: routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia. HHS's stated rationale at the time was that these four categories, while sometimes included in state benchmark plans, are not typically covered in a "typical employer plan" and therefore shouldn't be treated as EHB even where a state's benchmark plan happens to include them.

Last year's Marketplace Integrity Rule added sex-rejecting procedures to section 156.115(d)'s list of excluded services for the same reason. Some states have added sex-rejecting procedures to their benchmark plans, but these services are not covered in the "typical employer plan" and therefore don't qualify as EHB.

Section 156.115(d) is an important safeguard that helps the Secretary rein in state benchmark plans and exercise his responsibility under section 1302 of the ACA to "ensure" that only services "provided under a typical employer plan" are designated as EHB.

We recommend CMS formalize this authority in three ways.

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[54] 91 Fed. Reg. at 35943.

[55] 90 Fed. Reg. 12942, 12946 (Mar. 19, 2025), https://www.federalregister.gov/d/2025-04083.

[56] 78 Fed. Reg. 12,834 (Feb. 25, 2013).

First, CMS should codify a standing legal test for future additions to § 156.115(d), rather than continuing to evaluate each candidate exclusion on an ad hoc basis. We propose the following two-part test: a service should be excluded from EHB if (1) it is not medically necessary to treat, cure, or manage a physical illness, injury, or congenital defect—and (2) its claimed justification for coverage rests on a mental-health or psychosocial rationale rather than an independent physical-health indication. This test supports the exclusion of sex-rejecting procedures, and would give CMS a consistent, principled basis for evaluating future candidates such as coverage of assisted suicide, non-therapeutic sterilization, or expanded fertility treatments like IVF that raise religious liberty, moral, and medical concerns.

Second, CMS should establish a recurring review cycle for the § 156.115(d) exclusion list, tied to the periodic report to Congress required under section 1302(b)(4)(G) discussed above. Rather than amending § 156.115(d) reactively through individual rulemakings—as CMS has done seven times since 2013—the Secretary should commit to formally revisiting the exclusion list on a fixed schedule (for example, every three to five years, consistent with CMS's suggested cadence in Question 5.1) and publishing the Secretary's reasoning for any additions, removals, or decisions not to act.

Third, CMS should require that any state benchmark plan proposing to add an excludable service undergo a mandatory typicality review before approval, rather than placing the burden on CMS to identify problematic state additions after the fact through a separate rulemaking. This would shift the current dynamic—in which a single state's benchmark decision (like Colorado's 2021 sex-rejecting procedure mandate) can operate for years before CMS acts—to one in which CMS screens new state additions against the § 156.115(d) framework at the point of state benchmark submission.

Taken together, these reforms would transform § 156.115(d) from a piecemeal, reactive tool into a structured mechanism that better reflects Congress' instruction when it directed the Secretary to "ensure" that EHB remain equal in scope to a typical employer plan.

F. CMS should develop safeguards and certifications to curtail CMS's and state's ability to use the EHB to substantially burden religious liberty. [Topic 5, Question 5.2]

As President Trump and HHS are well aware, HHS regulations under the Affordable Care Act have been at the center of some of the biggest religious liberty battles over the last 15 years.

- **HHS Contraception Mandate:** In 2011, HHS under President Obama used the Women's Health Amendment to the ACA to try to force all covered employers—even churches and religious orders—to provide their employees with free contraceptives.[57] Thousands of religious employers filed over a hundred lawsuit seeking to vindicate their rights under RFRA. **Over fifteen years later**, and after

[57] *See* Becket, *The History of the HHS Mandate Cases*, https://s3.amazonaws.com/becketnewsite/HHS-Mandate-History-v14.pdf.

multiple successful trips to the Supreme Court, **the Little Sisters of the Poor are still in court** trying to protect their right to exclude mandated contraceptives from their health plan.[58]

- **HHS Sex-Rejecting Procedures Mandate:** In 2016, HHS under President Obama used Section 1557 of the ACA to try to force covered employers to cover sex-rejecting procedures, claiming such procedures were "medically necessary" and claiming that categorical exclusions were inherently discriminatory and unlawful. Within the year, the Fifth Circuit in *Franciscan Alliance v. Burwell* preliminarily enjoined the mandate, and HHS under President Trump revoked the sex-rejecting procedures mandate in 2020. In 2024, under President Biden, HHS issued another final rule under Section 1557 aimed at resurrecting the sex-rejecting procedures mandate in the wake of *Bostock v. Clayton County*.

Given this history and the manner in which states like Colorado and California have abused the EHB process to try to force onerous mandates on religious employers, we urge CMS to pursue rulemaking to create safeguards to protect religious employers' rights under RFRA. Our recommendation aligns with the Trump Administration's priorities and strong actions to protect and promote religious liberty.[59]

CMS should keep in mind that federal agencies have to do more than merely obey court orders interpreting RFRA; rather, they have an affirmative obligation to honor Americans' religious liberty rights. A 2017 memorandum from the Trump Department of Justice (DOJ), which remained in effect throughout the Biden presidency and to today, states that "In formulating rules, regulations, and policies, administrative agencies should … proactively consider potential burdens on the exercise of religion and possible accommodations of those burdens."[60] The memorandum reminds federal agencies that they "must pay keen attention" to "principles of religious liberty" "in everything they do."[61] That affirmative obligation warrants proactive steps to address religious liberty issues where, as here, religious liberty conflicts are so easily foreseeable.

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[58] Press Release, *Little Sisters of the Poor Look to Hand Government Another Loss in Federal Court*, Becket (July 7, 2026, https://becketfund.org/media/little-sisters-of-the-poor-look-to-hand-government-another-loss-in-federal-court/.

[59] *See, e.g.*, Exec. Order 14188, Additional Measures to Combat Anti-Semitism (Jan. 29, 2025), https://www.federalregister.gov/d/2025-02230; Exec. Order 14190, Eradicating Anti-Christian Bias, 90 Fed. Reg. 9365 (Feb. 6, 2025), https://www.federalregister.gov/d/2025-02611; Exec. Order 14205, Establishment of the White House Faith Office, 90 Fed. Reg. 9499 (Feb. 12, 2025), https://www.federalregister.gov/d/2025-02635; Press Release, EEOC, 200 Days of EEOC Action to Protect Religious Freedom at Work (Aug. 22, 2025), https://www.eeoc.gov/newsroom/200-days-eeoc-action-protect-religious-freedom-work; DOJ, Eradicating Anti-Christian Bias within the Federal Government (Apr. 30, 2026), https://www.justice.gov/opa/media/1438506/dl?inline; Press Release, President Trump's Religious Liberty Commission Delivers Historic Report Draft (June 26, 2026), https://www.justice.gov/opa/pr/president-trumps-religious-liberty-commission-delivers-historic-report-draft.

[60] U.S. Attorney General, Federal Law Protections for Religious Liberty, at 7 (2017), https://www.justice.gov/crt/page/file/1006786/dl.

[61] *Id*.

CMS's EHB framework raises clear RFRA concerns: when a state benchmark plan (or a future CMS rule) designates a service as EHB, it can force religious employers and insurers—including religious nonprofits, ministries, and closely-held religious businesses—to fund coverage for procedures that violate their sincerely held beliefs, on pain of ACA-mandated penalties for noncompliance.

In carrying out this affirmative obligation, CMS should keep in mind that every substantial burden the EHB program places on religious employers is illegal. As a general rule, once a RFRA plaintiff demonstrates a substantial burden on religious exercise, the government may mount a defense by satisfying strict scrutiny—showing that the challenged action advances a compelling governmental interest that the government cannot advance in a way that is less restrictive of religious liberty.

But under binding Supreme Court precedent, no health-care insurance mandate can pass strict scrutiny because it would *always* be less restrictive of religious liberty for the government to provide objectionable services itself. "This would certainly be less restrictive of [religious employers'] religious liberty," so the government *necessarily* loses on strict scrutiny.[62]

The Supreme Court's logic in *Hobby Lobby* applies with full force to any EHB mandate: the government could always create an alternative funding mechanism, direct subsidy, or public program to provide any given health service, without forcing religious employers, insurers, or issuers to underwrite it through their own health plans. Because a less restrictive alternative is by definition always available, no EHB designation compelling coverage of a religiously objectionable procedure can survive RFRA's strict scrutiny test.

CMS should account for this reality by taking the following concrete steps:

First, CMS should require any state seeking to add a new benefit to its EHB-benchmark plan to certify, as part of its benchmark submission, that the state has considered whether the proposed benefit is likely to impose a substantial burden on religious exercise under RFRA, and if so that the state has evaluated less restrictive alternatives to a coverage mandate before proceeding. This certification requirement would not itself resolve RFRA questions but would force states to build a record demonstrating they considered religious-liberty impacts before CMS approval, rather than treating those impacts as an afterthought to be litigated only after the mandate takes effect.

Second, CMS should establish a formal administrative process through which employers, issuers, and other stakeholders can raise religious-liberty objections to a specific EHB designation and request an exemption or accommodation, modeled on the religious-exemption request processes CMS and other agencies have adopted in analogous contexts. This process should include a defined timeline for CMS review, a clear standard for evaluating requests consistent with RFRA's substantial-burden and least-restrictive-means framework, and a mechanism for CMS to grant either an individualized exemption or a categorical carve-out from the EHB designation for religious objectors, without requiring objecting parties to litigate the

[62] *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 728 (2014).

question in federal court. CMS can consult with HHS's Office for Civil Rights, which have experts on federal laws protecting religious liberty and conscience rights in health care.

Third, CMS should commit, as a matter of policy, to independently reviewing any newly designated EHB category for RFRA compliance before finalizing its inclusion, rather than waiting for affected parties to raise the issue often through expensive and time-consuming litigation. Given that the government can always satisfy its coverage-access interests through means other than compelling religious objectors to fund a given service, CMS should treat this RFRA analysis as a standing, non-discretionary component of any EHB rulemaking or benchmark-plan approval, not an optional consideration.

CONCLUSION

Thank you for the opportunity to provide public comment and for the Department's review of the EHB process. We urge CMS to adopt the above recommendations.

Sincerely,

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