measure and evaluate the chemical famoxadone. *Contact:* RD.

• *PP 3E9082.* (EPA–HQ–OPP–2024–0155). Interregional Research Project Number 4 (IR–4), IR–4 Project Headquarters, North Carolina State University, 1730 Varsity Drive, Venture IV, Suite 210, Raleigh, NC 27606, requests to establish a tolerance in 40 CFR part 180.587 for residues of the fungicide famoxadone (3-anilino-5-methyl-5-(4-phenoxyphenyl)-1,3-oxazolidine-2,4-dione) in or on Arugula at 25 ppm; brassica, leafy greens subgroup 4–16B at 40 ppm; celtuce at 25 ppm; cress, garden at 25 ppm; cress, upland at 25 ppm; fennel, Florence at 25 ppm; leafy greens subgroup 4–16A, except spinach at 25 ppm; leaf petiole vegetable subgroup 22B at 25 ppm; mango at 0.9 ppm; pepper/eggplant subgroup 8–10B at 4 ppm; tomato subgroup 8–10A at 1 ppm; vegetable, root, except sugar beet, subgroup 1B at 0.6 ppm; vegetable, tuberous and corm, subgroup 1C at 0.02 ppm; and to establish a regional tolerance in 40 CFR 180.587 for residues of the fungicide famoxadone (3-anilino-5-methyl-5-(4-phenoxyphenyl)-1,3-oxazolidine-2,4-dione) in or on succulent shelled bean subgroup 6–22C (East of the Rocky Mountains) at 0.15 ppm. The gas-liquid chromatography (GC) with nitrogen phosphorus detection (NPD) is used to measure and evaluate the chemical famoxadone. *Contact:* RD.

• *PP 5E9166.* (EPA–HQ–OPP–2025–0126). Applicant: Bayer CropScience, 800 N Lindbergh Blvd., St. Louis, MO 63141. *Active ingredient:* Trifloxystrobin. *Product type:* Fungicide. Requests to establish import tolerances in 40 CFR part 180 for residues of the fungicide trifloxystrobin (benzeneacetic acid, (E,E)-α-(methoxyimino)-2-[[[[1-[3-(trifluoromethyl) phenyl]ethylidene]amino]oxy]methyl]-methyl ester) and the free form of its acid metabolite CGA–321113 ((*E,E*)-methoxyimino-[2-[1-(3-trifluoromethyl-phenyl)-ethylideneaminooxymethyl]-phenyl]acetic acid) in or on the raw agricultural commodities: Avocado at 0.5 ppm. A newer analytical method is available employing identical solvent mixtures and solvent to matrix ratio (as the first method), deuterated internal standards, and liquid chromatography/mass spectrometry-mass spectrometry (LC/MS–MS) with an electrospray interface, operated in the positive ion mode is used to measure and evaluate the chemical trifloxystrobin. *Contact:* RD.

• *PP 5F9177.* (EPA–HQ–OPP–2025–3824). Valent BioSciences, LLC, 1910 Innovation Way, Suite 100, Libertyville, IL 60048, requests to establish a tolerance in 40 CFR part 180 for residues of the insecticide fenpropathrin in or on all food/feed items (other than those covered by a higher tolerance as a result of use on growing crops) when fenpropathrin is used in food/feed handling establishments or as a wide-area mosquito adulticide at 0.9 ppm. The LC–MS/MS method is used to measure and evaluate chemical fenpropathrin. *Contact:* RD.

• *PP 5F9195.* (EPA–HQ–OPP–2025–2565). BASF Corporation, 26 Davis Drive, Research Triangle Park, NC 27709, requests to amend (increase) the existing afidopyropen tolerance established in 40 CFR part 180.700 in or on Orange, subgroup 10–10A from 0.15 ppm to 0.3 ppm. In their initial assessment of afidopyropen (DP No. 441491), EPA's HED indicated the existing methods and accompanying independent method validations were sufficient to support afidopyropen tolerances. EPA's ROCKS stated that the submitted analytical method for plant commodities can adequately detect parent afidopyropen (as well as its dimer M440I007) for the purposes of tolerance enforcement. *Contact:* RD.

• *PP 6F9234.* (EPA–HQ–OPP–2025–3824). Valent BioSciences, LLC, 1910 Innovation Way, Suite 100, Libertyville, IL 60048, requests to establish a tolerance in 40 CFR part 180 for residues of the insecticide abamectin in or on all food/feed items (other than those covered by a higher tolerance as a result of use on growing crops) when abamectin is used in food/feed handling establishments or as a wide-area mosquito adulticide at 0.1 ppm. The LC–MS/MS method is used to measure and evaluate chemical abamectin. *Contact:* RD.

Authority: 21 U.S.C. 346a.

Dated: June 9, 2026.

Edward Messina,

Director, Office of Pesticide Programs.

[FR Doc. 2026–11942 Filed 6–12–26; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 156

[CMS–9874–NC]

RIN 0938–AW02

Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Request for information.

SUMMARY: This request for information (RFI) seeks public input to support CMS' 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. CMS seeks comment on current interpretations of EHB, State approaches to selecting and updating EHB-benchmark plans, and methodologies used to determine the scope of benefits included as EHB, as well as how these approaches relate to access and market stability under the Affordable Care Act. CMS also seeks comment on variation across States in the scope of benefits included as EHB, cost pressures affecting EHB, processes for updating State EHB-benchmark plans, limitations in available data used to evaluate EHB, and potential impacts of possible future policy changes. The information gathered will inform CMS' evaluation of whether revisions or additions to the current EHB regulations through future notice and comment rulemaking may be appropriate.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by July 15, 2026.

ADDRESSES: In commenting, refer to file code CMS–9874–NC.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://www.regulations.gov/docket/CMS-2026-2081.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention:

CMS–9874–NC, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9874–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: LeAnn Brodhead, (667) 290–8805.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received at *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Section 1301(a)(1)(B) of the Affordable Care Act [1] requires qualified health plans (QHPs) to cover the Essential Health Benefits (EHB) package described in section 1302(a) of the Affordable Care Act, which includes coverage of the services described in section 1302(b) of the Affordable Care Act. Section 2707(a) of the Public Health Service Act extends this requirement to non-grandfathered individual and small group health insurance coverage (hereinafter referred to as plans subject to EHB requirements) irrespective of whether such coverage is offered through an Exchange.

Section 1302(a) of the Affordable Care Act provides for the establishment of this EHB package to include coverage of the EHB (as defined by the Secretary of HHS (Secretary)), cost-sharing limits, and actuarial value (AV) requirements. Section 1302(b) of the Affordable Care Act directs the Secretary, in defining the EHB, to ensure that they are equal in scope to the benefits provided under a typical employer plan and that they include at least the following ten statutory benefit categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. In addition, section 1302(d) of the Affordable Care Act establishes AV standards for plan coverage. Section 1302(b)(4)(A) and section 1302(b)(4)(G)(i) of the Affordable Care Act further direct the Secretary to ensure that such EHB reflect an appropriate balance among the benefit categories so that benefits are not unduly weighted toward any category when defining EHB and to assess whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost when reviewing EHB, respectively. Sections 1302(b)(4)(G)(ii) and (iv) of the Affordable Care Act direct the Secretary to periodically review EHB to assess whether the EHB needs to be modified or updated to account for any changes in medical evidence or scientific advancement, and how benefit changes affect costs.

HHS initially outlined its intended regulatory approach to defining EHB, including a State benchmark-based approach, in a 2011 bulletin.[2] We subsequently finalized implementing regulations related to EHB in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation final rule, which appeared in the February 25, 2013 **Federal Register** (78 FR 12834) (EHB Rule). As set forth in the EHB Rule, for a non-grandfathered individual or small group market health plan to provide the required EHB package, the health plan must, among other things, provide the benefits in accordance with the State's EHB-benchmark plan, as described at 45 CFR 156.115. A State's EHB-benchmark plan serves as a reference plan for the benefits considered as EHB in the State. This State benchmark-based framework gives States flexibility in defining EHB in their respective States.

For plan years (PYs) 2014 through 2016, States were required to select—or default to—one of ten ''typical'' employer plans identified at § 156.100, all of which were based on 2012 plan designs, with any missing benefit categories supplemented as specified under § 156.110.[3] States were required to select base-benchmark plans (that is, the reference plan used to determine the specific items and services included as EHB in a State) from among the following four types of health plans: (1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market as defined in § 155.20; (2) any of the largest three State employee health benefit plans by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment that are open to Federal employees under 5 U.S.C. 8903; or (4) the largest insured commercial non-Medicaid HMO operating in the State.

For PYs 2017, 2018, and 2019, States retained these same base-benchmark plan options; however, the underlying reference plans were updated from 2012 plans to 2014 plan designs pursuant to revisions to the EHB regulations finalized in the HHS Notice of Benefit and Payment Parameters for 2017 final rule, which appeared in the March 8, 2016 **Federal Register** (81 FR 12204) (2017 Payment Notice). In most States, the EHB-benchmark plans from this period remain in effect today.

The HHS Notice of Benefit and Payment Parameters for 2019 final rule, which appeared in the April 17, 2018 **Federal Register** (83 FR 16930) (2019 Payment Notice), added § 156.111 to provide States with additional options from which to select an EHB-benchmark plan for PYs 2020 and beyond. In that final rule, we stated that we believe States should have additional choices with respect to benefits and affordable coverage, and we added § 156.111 to provide additional flexibility for States

[1] The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this RFI, the two statutes are referred to collectively as the ''Patient Protection and Affordable Care Act,'' or ''Affordable Care Act''.

[2] The HHS EHB bulletin is available on the CMS website at *https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.*

[3] As specified by § 156.100(c), for PYs beginning prior to January 1, 2020, if a State did not make an EHB-benchmark selection using the process described in the section, the State's EHB-benchmark defaulted to the largest plan by enrollment in the largest product by enrollment in the State's small group market.

to select new EHB-benchmark plans starting with the 2020 PY. Specifically, we expanded State flexibility by allowing States to update their EHB-benchmark plans using one of three approaches: (1) selecting the EHB-benchmark plan that another State used for the 2017 PY; (2) replacing one or more EHB categories of benefits in its EHB-benchmark plan used for the 2017 PY with the same category or categories of benefits from another State's EHB-benchmark plan used for the 2017 PY; or (3) otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.[4] We also established typicality and generosity standards requiring States to demonstrate that the total AV of their EHB is no more or less generous than the total AV in the State's most and least generous typical employer plans, reducing outliers while providing a consistent ceiling on the EHB that is specific and relative to each State. Typicality required that benefits be equal in scope to those of a typical employer plan, defined as one of the original ten base-benchmark plan options or the largest plan by enrollment among one of the five largest group products in the State, given other regulatory conditions were met, effectively giving States fifteen potential comparison plans.[5] The generosity standard required that updated benefits not be more generous than a comparison plan, defined as the benchmark plan used for PY 2017 or any of the base-benchmark options available for that PY.

In the HHS Notice of Benefit and Payment Parameters for 2025 final rule, which appeared in the April 15, 2024 **Federal Register** (89 FR 26218) (2025 Payment Notice), we finalized revisions to § 156.111 that eliminated the first two options for States to update their EHB-benchmark plans—adopting another State's EHB-benchmark plan in whole or replacing individual EHB categories—beginning in PY 2026 on the basis that they were subsets of the broader option to create a new EHB-benchmark plan. We also amended the typicality standard so that in demonstrating that a State's new EHB-benchmark plan provides a scope of benefits that is equal to the scope of benefits of a typical employer plan in the State, the scope of benefits of a typical employer plan in the State is defined as any scope of benefits that is as or more generous than the scope of benefits in the State's least generous typical employer plan, and as or less generous than the scope of benefits in the State's most generous typical employer plan, from a defined set of plans identified as typical employer plans. In addition, we removed the generosity standard.

Since establishing a process by which States can apply to update their EHB-benchmark plans in the 2019 Payment Notice, 12 States have updated their EHB-benchmark plans, while the remaining States have continued to use the EHB-benchmark plans that became applicable in PY 2017.

II. Solicitation of Public Comments

In the HHS Notice of Benefit and Payment Parameters for 2027 final rule, which appeared in the May 20, 2026 **Federal Register** (91 FR 29526) (2027 Payment Notice), we noted that we paused review of State applications to modify their EHB-benchmark plans pursuant to 45 CFR 156.111 for PYs beginning on or after January 1, 2027. We also noted that we are conducting a comprehensive review of section 1302 of the Affordable Care Act and the Secretary's statutory responsibilities under that provision.

We are engaging in a renewed examination of the EHB framework in light of significant changes in the health insurance and health care landscape, including changes in employer-sponsored insurance coverage, advances in health care innovations and delivery, shifts in the utilization of services, and rising health care costs. These changes necessitate examination of whether existing approaches to defining EHB, methodologies used to determine whether benefits are ''typical'' of employer coverage, and scope of benefits included as EHB continue to reflect current market conditions and support the statutory goals of affordability and access to care under the Affordable Care Act. For purposes of this RFI, the term ''benefits'' refers to items and services, including medical services, treatments, procedures, and covered goods and is intended to encompass the full scope of covered health care services and products unless otherwise specified.

We request comments from all interested parties on several topics related to EHB, including the general EHB framework and the typicality standard. Collectively, these comments will assist CMS in identifying areas where further analysis or potential future rulemaking may be appropriate.

Commenters are encouraged to identify the specific section and question number(s) (for example, Topic 2, Question 2.1; Topic 4, Question 4.3) addressed in each portion of their submission and to organize comments consistent with the structure of this RFI. Where applicable, commenters are encouraged to provide supporting data, citations to relevant statutory or regulatory provisions, and quantitative analyses to substantiate their views.

Topic 1: Typical Employer Plans and Typicality

The following questions relate to the statutory requirement at section 1302(b)(2)(A) of the Affordable Care Act that the Secretary ensure the scope of EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. CMS recognizes that changes to the interpretation of ''typical employer plan'' and ''equal in scope'' could affect affordability, market stability, State flexibility, and access to services by influencing which benefits are required to be covered as EHB and the degree of variation permitted across State EHB-benchmark plans.

Question 1.1 (Typical Employer Plan)

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), includes the following plan types:

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

However, the statute does not specifically require CMS to use a reference plan approach when defining the EHB or ensuring typicality and there are many ways that typicality could be assessed. What considerations, including data availability, representativeness of typical employer plan coverage, and administrative feasibility, should CMS consider when evaluating whether it is appropriate to propose policy changes related to typicality and whether changes to the current framework of a ''typical employer plan'' are warranted? Are certain types of plans more representative of a typical employer plan than others? Are there other ways that CMS could define and/or assess typicality that are not based on a reference plan approach, such as through a survey of commonly covered benefits within the 10 categories of EHB

[4] Section 156.111(a).

[5] The ''typicality'' standard for EHB is codified in 45 CFR 156.111(b)(2). Under this provision, a State's EHB-benchmark plan must provide a scope of benefits equal to the scope of benefits provided under a typical employer plan; for PYs 2020 through 2025, this was defined either as one of the State's 10 base-benchmark plan options from § 156.100 or the largest large-group health plan by enrollment in the State. *https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-B/section-156.111.*

or a review of existing data sets (for example, commercial claims data or employer-sponsored coverage surveys)? When considering typicality, should CMS consider employer size? When selecting or designing an EHB-benchmark plan, States have overwhelmingly relied on small group plans as a reference. Is there something inherently more ''typical'' about these plans such that they are more readily selected, or is this due to factors such as data availability? Are self-funded plans, which cover more than half of people with employer-sponsored coverage, insufficiently represented, and if not, how could CMS use data related to self-funded plans to improve how typicality is defined?

Question 1.2 (Defining Scope of Plan Benefits)

Under current EHB policy, the scope of benefits of a typical employer plan is based on comparison to specific reference plans within the EHB-benchmark framework, rather than a standardized actuarial value-based definition. What advantages or drawbacks should CMS consider when considering whether to define the scope of benefits of a typical employer plan based on AV, as opposed to a definition based on a specific set of benefits or another alternative methodology? We seek comment on considerations such as transparency, data limitations, comparability across plans, and administrative feasibility.

Question 1.3 (Typical Employer Plan Selection Approach)

Under current EHB policy, States must select from specified subsets of typical employer plans when selecting or updating the State's EHB-benchmark plan. As discussed previously, some of these typical employer plan options are limited to plans that were available in the 2017 PY, while others are available in any PY after 2017. We seek comment on whether and how this approach, including the defined set of plan options and associated constraints, could be refined, as appropriate, to continue to reflect the statutory requirement that EHB be equal in scope to benefits provided under a typical employer plan. What additional or alternative limits, if any, would be reasonable to apply to the use of historical plans (for example, limiting selection to plans that were in effect more than a specified number of years prior; tied to the EHB-benchmark plan selection year, etc.)? Are there modifications to the types of plans included in the current set of options, or to how CMS selects the plan options available to States, that could further support representation of a typical employer plan? Are there alternative ways CMS could structure or refine the current approach, including the use of plan options or the current requirement that EHB-benchmark plans fall within the range of the least and most generous typical employer plans, to maintain consistency with the statutory standard? In responding, we request that commenters address considerations related to market evolution, medical or scientific advancements, data reliability, and consistency across States.

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

The current EHB framework allows States to select EHB-benchmark plans that reflect their health insurance markets and population needs. This State-based approach has resulted in variation in the scope of benefits included as EHB across the 51 current EHB-benchmark plans. For example, premium rates and coverage of different benefits vary from State to State. We seek to better understand how this State variation affects consumers, issuers, and State regulators.

Question 2.1 (Overall Impacts Associated with Variation Across States)

To what extent does variation in the scope of benefits included as EHB across States affect consumers, issuers, and State regulators? Please describe specific impacts on:

- Plan availability;
- Consumer education;
- Issuer operations;
- State regulation and enforcement; and
- Market competition.

Question 2.2 (Benefits Associated With Variation Across States)

What are the advantages of State flexibility in defining the scope of EHB? How does State flexibility facilitate:

- Responsiveness to State-specific population needs;
- Innovation in benefit design and coverage approaches; and
- Alignment with State regulations and market conditions?

Question 2.3 (Challenges Associated With Variation Across States)

What challenges result from variation across States in the scope of benefits included as EHB? For example, consider:

- Administrative or compliance burden on issuers; and
- Potential differences in access to EHB based on State of residence, and potential variation in specific benefit categories (for example, maternity and newborn care, rehabilitative and habilitative services and devices, etc.).

Question 2.4 (Evaluation of the Scope of Benefits Included as EHB Across States)

What methodologies, data sources, or metrics should CMS use to evaluate and compare the scope of benefits included as EHB across States and in relation to typical employer plans? In responding, commenters are encouraged to address claims-based measures, including how differences in prices, service use, and population health may affect comparisons of the scope of benefits included as EHB across States.

Question 2.5 (Variation Across Markets and Populations)

How should CMS interpret differences in health care costs and utilization when comparing the scope of benefits included as EHB across States or plan markets, given that claims data may reflect other factors such as differences in prices, cost of living, or population health?

Topic 3: Affordability and Cost

Since the implementation of EHB requirements under section 1302 of the Affordable Care Act and implementing regulations beginning in 2014, health care delivery models, utilization patterns, and clinical practices have evolved, and overall health care spending has increased.[8] [9] We seek comment on how the scope of benefits included as EHB affects premiums, consumer affordability, and long-term market stability. Additionally, we seek input on whether and how affordability considerations should inform assessments of whether the scope of EHB is equal in scope to benefits provided under a typical employer plan, consistent with section 1302(b)(2)(A) of the Affordable Care Act.

Question 3.1 (EHB-Related Premium Drivers)

What specific aspects of EHB most significantly influence premium levels in the individual and small group markets? In responding, commenters are encouraged to identify specific EHB categories, services, or coverage features that contribute to cost growth, such as high-cost therapies, utilization-intensive

[8] Centers for Medicare & Medicaid Services, Office of the Actuary, *National Health Expenditure Data;* Agency for Healthcare Research and Quality, *National Healthcare Quality and Disparities Report,* available at *https://www.ahrq.gov/research/findings/nhqrdr/index.html.*

[9] Centers for Disease Control and Prevention, *Health, United States,* available at *https://www.cdc.gov/nchs/hus/index.htm.*

services, or coverage parameters (for example, limits on services or duration of treatment). To what extent does the scope or breadth of coverage within specific EHB categories contribute to premium increases? Are there specific EHB categories, services, or coverage features that do not contribute to cost growth? Have employer plans, especially self-funded plans, implemented changes to plan design features to mitigate cost growth that would lower premiums for plans subject to EHB requirements?

Question 3.2 (Issuer Cost Management Strategies)

How do 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? To what extent do current EHB requirements influence or constrain these cost-management strategies, including how such tools affect affordability and enrollee access to medically necessary care?

Question 3.3 (Coverage and Affordability Tradeoffs)

What factors should CMS consider when evaluating potential tradeoffs between the scope of benefits included as EHB and affordability for consumers, issuers, and Federal taxpayers? In responding, commenters are encouraged to address:

- How State regulators currently evaluate such tradeoffs when designing or regulating EHB coverage;
- How mismatches between EHB and benefits covered by a typical employer plan might introduce adverse selection risks between individual and group plans;
- To what extent CMS should consider that the generosity of EHB affects Federal expenditures through premium tax credits and cost-sharing reductions, in evaluating the appropriate scope of benefits included as EHB; and
- What data or empirical evidence should inform assessments of tradeoffs between an expanded scope of benefits and potential offsets elsewhere in plan design (for example, changes in cost-sharing or coverage limitations) relative to a typical employer plan.

Question 3.4 (Measurement of Affordability and Cost)

What data sources, analytic methods, or research approaches should CMS rely on to evaluate the relationship between the scope of benefits included as EHB, premiums, consumer affordability, and long-term stability of the individual and small group markets?

Question 3.5 (Emerging Costs and Future Trends)

Are there emerging trends in health care delivery, utilization, or technology that interested parties believe may influence the affordability of benefits included as EHB in future PYs? If so, how should CMS consider these trends when periodically reviewing EHB as required by section 1302(b)(4)(G) of the Affordable Care Act?

Topic 4. Scope of Benefits Included as EHB

We seek comment on how CMS should define and evaluate the scope of EHB, including methodological approaches, employer-sponsored coverage patterns, and how considerations such as clinical effectiveness, preventive services, and population health outcomes may inform which services are reflected in the scope of benefits included as EHB. For purposes of this section, the scope of benefits may include covered services, treatment approaches, coverage limitations, medical management, and other benefit design features that affect access to care and health outcomes.

Question 4.1 (Employer-Sponsored Plan Coverage Outside EHB)

Do employer-sponsored plans routinely cover benefits that are not EHB? What are the most commonly covered benefits by employer-sponsored plans that are not EHB?

Question 4.2 (Factors Informing Scope of Benefits Included as EHB)

What factors should CMS consider when evaluating benefits included as EHB considering the evolution of health care delivery, clinical standards of care, and statutory requirements related to a typical employer plan? For example, should CMS consider:

- AV and cost-sharing levels (for example, whether the scope of benefits allows plans to meet AV requirements and how the scope of benefits affects consumer out-of-pocket costs);
- Breadth of covered services within each EHB category;
- Alignment with clinical guidelines and evidence-based practices;
- Consistency with employer-sponsored coverage; and
- Impact on premium affordability?

Question 4.3 (Defining Scope Within Select EHB Categories)

How should CMS evaluate the appropriate scope of benefits within the 10 EHB categories, specifically with regard to behavioral health, preventive care, and chronic disease management, to ensure coverage remains clinically appropriate and consistent with statutory requirements?

Question 4.4 (Level of Detail for Defining and Analyzing EHB)

Section 1302(b)(1) of the Affordable Care Act provides that EHB must include ''at least the following general categories and the items and services covered within the categories,'' as further described in the statute. At what level of detail and using what analytical methods should EHB coverage be defined in EHB-benchmark plans? For example, coverage for ''inpatient hospital services'' may include many more specific ''sub-benefits'' and without additional detail, there can be ambiguity in which of the specific ''sub-benefits'' should be considered covered within ''inpatient hospital services.'' How should CMS or States ensure that the items and services within each EHB category are appropriately reflected in EHB-benchmark plans?

Question 4.5 (Preventive and Wellness Services, Behavioral Health Services, Chronic Disease Management, and Health Outcomes)

How do current EHB policies support coverage of preventive and wellness services, behavioral health services, and chronic disease management and how should CMS or States evaluate the role of such services in improving health outcomes and influencing long-term affordability when determining the scope of benefits included as EHB?

Topic 5. Updating EHB

Section 1302(b)(4)(G)(i), (ii), and (iv) of the Affordable Care Act direct the Secretary to periodically review EHB to assess whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost, whether the EHB needs to be modified or updated to account for any changes in medical evidence or scientific advancement, and the potential of additional or expanded benefits to increase costs, respectively. The following questions address the frequency and criteria for EHB reviews, safeguards to ensure consistency with typical employer plan coverage, and how the EHB framework can accommodate changes over time.

Question 5.1 (Frequency of EHB Coverage Review)

How frequently should CMS review EHB coverage, consistent with section 1302(b)(4)(G) of the Affordable Care Act, and consider whether updates to

regulations implementing EHB may be appropriate?

- Should there be a regular review cycle (for example, every 3–5 years)?
- Should EHB reviews be event-driven based on specific triggers or indicators? If event-driven, what factors should prompt CMS to initiate a review (for example, significant changes in medical practices and clinical guidelines, new technological innovations, shifts in employer coverage patterns, identified gaps in consumer coverage, public health emergencies, etc.), and what data source(s) (such as for covered employer benefits) would be relevant to determine when the threshold has been met to prompt such review?
- What are the advantages and disadvantages of implementing a formal review schedule versus maintaining flexibility to conduct reviews of EHB coverage as needed? Do States have the resources to support such reviews?

Question 5.2 (EHB Safeguards)

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 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?

Question 5.3 (EHB Framework Adaptability)

How could the EHB framework more effectively support innovation and adapt to:

- Changes in medical advancements or clinical guidelines;
- Emerging health care delivery models (for example, telehealth, value-based care);
- Regional variations in health care needs and priorities; and
- Promotion of both stability and flexibility in benefit design?

Topic 6. State Processes for Updating EHB-Benchmark Plans

Since establishing an application process for States to update their EHB-benchmark plans in the 2019 Payment Notice, 12 States have updated their EHB-benchmark plans.[10] As part of this process, States submit proposed updates for review, consistent with applicable statutory and regulatory standards, including the requirement that the scope of benefits be equal to the scope of benefits provided under a typical employer plan as required by section 1302(b)(2)(A) of the Affordable Care Act. We seek comment on considerations related to the structure and operation of the EHB-benchmark plan update process, including the respective roles of CMS and States, and how this process functions in practice while preserving State flexibility.

Question 6.1 (Experience With the EHB-Benchmark Plan Application Process)

Based on your experience with the current EHB-benchmark plan application process, please describe:

- Aspects of the process that work well and should be maintained; and
- Challenges or limitations encountered during the application process.

Question 6.2 (EHB-Benchmark Plan Application Process Improvements)

What improvements to the EHB-benchmark plan application process would you recommend? Please provide specific suggestions regarding:

- Application requirements, documentation, or submission process that could be clarified, simplified, or streamlined;
- Technical assistance from CMS during the EHB-benchmark plan application process, and what resources or support would be most helpful to States and other interested parties;
- The timing of State applications for EHB-benchmark plan updates (for example, the time required for States to research and submit applications and for CMS to review applications, particularly in relation to when the new EHB-benchmark plan would be effective); and
- Any other aspects of the application process that could be improved to address current challenges or limitations encountered during the process.

Question 6.3 (Impacts of Changes to EHB-Benchmark Plan Application Requirements and Review Process)

How might changes to EHB-benchmark plan application requirements or CMS review processes impact:

- Application preparation and documentation requirements;
- Timeline for CMS review of EHB-benchmark plan applications; and
- Interested parties' engagement?

Question 6.4 (Balancing Federal Oversight and State Flexibility)

How could CMS balance Federal oversight with State flexibility in the EHB-benchmark plan selection process? What level of CMS involvement in benefit-by-benefit analysis would be appropriate?

For example:

- Should CMS review be limited to ensuring overall compliance with statutory and regulatory requirements?

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

We recognize that potential changes to how EHB are defined, interpreted, or updated may create short-term transition and operational challenges. While other sections of this RFI address affordability, State variation, typicality, and the scope of benefits included as EHB, this section focuses specifically on implementation of any future proposed changes, including timing, transition safeguards, and minimizing unintended market and coverage disruptions. We seek public comments on the following questions:

Question 7.1 (Market Stability Impacts)

If CMS were to refine how EHB are defined, interpreted, or updated, what short-term market disruption risks should CMS consider?

- What indicators (for example, enrollment volatility, premium fluctuations, plan withdrawals) would signal market disruption?
- How should CMS distinguish between temporary transition effects and longer-term structural market instability?

Question 7.2 (Implementation and Operational Considerations)

What implementation sequencing and operational readiness considerations should CMS evaluate when considering refining EHB policy?

- What lead time would States and issuers require to operationalize changes and how might that timing vary depending on the type, scope, or complexity of such changes?
- How should CMS account for rate filing timelines, plan certification cycles, and product development processes?
- Are phased or staggered implementation approaches preferred? If so, how do the potential advantages of these approaches outweigh the potential disadvantages?

Question 7.3 (Consumer Access and Coverage Stability)

How might potential refinements to the EHB framework affect consumer continuity of coverage during transition periods?

- What safeguards could minimize consumer confusion or unintended loss

[10] Centers for Medicare & Medicaid Services (CMS), *Information on Essential Health Benefits (EHB) Benchmark Plans,* available at *https://www.cms.gov/marketplace/resources/data/essential-health-benefits.*

of coverage for medically necessary items and services?

- What communication or transition protections should CMS consider?

Question 7.4 (Transitional Implementation Guardrails)

- What temporary guardrails or monitoring thresholds should CMS consider during initial implementation of potential future EHB refinements to mitigate unintended consequences?
- What corrective tools should be available if unintended operational or market effects emerge?

Question 7.5 (Monitoring and Evaluation Metrics)

- Following implementation of any future EHB refinements, what targeted monitoring framework should CMS use to assess market impacts over time without duplicating broader affordability and data analyses addressed elsewhere in this RFI?

III. Collection of Information Requirements

This is a request for information (RFI) only. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), this general solicitation is exempt from the PRA. Facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA.

This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This RFI does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. We note that not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this RFI.

We will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. We may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this RFI. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. In addition, we may publicly post the public comments received, or a summary of those public comments.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on June 11, 2026.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

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