C-TAC
COALITION TO TRANSFORM ADVANCED CARE

July 13, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Request for Information (RFI); Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard

Submitted electronically via www.regulations.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide input on this RFI regarding its effect on those living with serious illness.

C-TAC is a national, non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF). Serious illness also differs by geography. People living in rural areas are older, sicker, and lack access to the full range of health care, and we advocate for improved care for any with less access to it.

The RFI notes that the Affordable Care Act requires the Secretary to ensure that EHB are equal in scope to the benefits provided under a typical employer plan, while also requiring review of whether enrollees face difficulty accessing needed services because of coverage or cost and whether EHB should be updated to account for medical evidence and scientific advancement. Those statutory obligations are especially important for people with serious illness and their family caregivers, who rely on stable access to prescription drugs, behavioral health services, chronic disease management, rehabilitative services and devices, home-based supports, and clinically appropriate care coordination. It is with that perspective we provide the following input:

Affordability and cost

CTAC agrees that affordability must be central to this review. For people with serious illness, however, affordability cannot be reduced to premium levels alone. A plan is not affordable if it offers a relatively low premium but exposes enrollees to unaffordable deductibles, specialty-tier coinsurance, repeated utilization-management delays, out-of-network costs due to inadequate networks, or non-covered services that are integral to effective treatment.

CMS should explicitly recognize that cost-management tools can create substantial access barriers. The RFI asks how issuers manage EHB-related costs through benefit design, utilization management, network design, and payment approaches, and how those strategies affect enrollee access to medically necessary care. That question is critically important for those with serious illness. Prior authorization, step therapy, fail-first protocols, restrictive formularies, and narrow specialty networks can function as de facto exclusions even when a service is nominally covered.

CTAC also urges CMS to reject the premise that narrowing EHB is an appropriate or sustainable affordability strategy for high-need populations. In many cases, covering evidence-based services earlier and more comprehensively can avoid greater downstream costs, including emergency department use, hospitalizations, caregiver crisis, and preventable functional decline. In particular, coverage of behavioral health services, chronic disease management, and coordinated care can improve outcomes while reducing fragmentation over time, consistent with the RFI's focus on long-term affordability and market stability.

Scope of benefits included as EHB

People with serious illness often need access not only to broad benefit categories, but to specific services within those categories that are vulnerable to omission, narrowing, or restrictive medical management. Broad category labels, standing alone, are often insufficient. Coverage for "hospitalization," "prescription drugs," "behavioral health," or "chronic disease management" can vary dramatically in practice depending on sub-benefits, service definitions, limitations, and delivery modalities.

CTAC therefore recommends that CMS articulate clearer expectations for the scope of benefits within EHB categories that are especially important for serious illness care. These include:

- Prescription drugs, including coverage standards that support access to specialty drugs, infusion and injectable therapies, and drugs used for symptom management.
- Mental health and substance use disorder services, including integrated behavioral health care that is coordinated with treatment for serious physical illness.
- Rehabilitative and habilitative services and devices, including services needed to maintain function, reduce pain, and support activities of daily living.
- Preventive and wellness services and chronic disease management, interpreted broadly enough to include longitudinal care planning, care coordination, symptom monitoring, and other services that help avoid preventable deterioration.

- Ambulatory and home-based modalities, including telehealth where clinically appropriate, that enable people with serious illness to receive care in the least burdensome setting.
- Palliative care available from diagnosis on and hospice well before the last days of life.

CMS should consider whether services that support serious illness care and family caregiving are functionally necessary to achieve the goals of treatment and preserve quality of life, even if they have not historically been framed as core EHB components. The review should not freeze benefit design around outdated assumptions about where and how care is delivered.

The RFI also asks how to evaluate preventive and wellness services, behavioral health services, and chronic disease management in relation to long-term affordability and health outcomes. CTAC encourages CMS to take a long view. For people with serious illness, early behavioral health support, effective symptom management, coordinated care planning, palliative care, advance care planning, and sustained chronic disease management can reduce crises, improve adherence, and help family caregivers maintain stability. Those effects matter even when the immediate cost of coverage is visible and the downstream savings are harder to capture in a single-year premium model.

Updating EHB

CTAC recommends that CMS adopt a predictable review cycle, such as every three to five years, combined with the ability to conduct targeted interim reviews when emerging evidence shows material access problems for high-need populations. Specifically, CMS should require that any proposed EHB update be evaluated for its effect on people with complex, chronic, and serious conditions; out-of-pocket burden for high utilizers; continuity of treatment; and caregiver burden. A change should not be considered appropriate simply because it can be justified as typical if it predictably worsens access for populations with the greatest health needs.

Market stability and implementation

For people with serious illness, transition policy is not a technical afterthought. It is a core patient-protection issue. Any future EHB refinement should include strong transition safeguards, including:

- Protection for active courses of treatment so enrollees can continue medically necessary therapies for a defined transition period.
- Continuity-of-provider protections when network or coverage changes affect oncology, neurology, behavioral health, or other specialty care.
- Clear, plain-language notices describing changes in benefits, prior authorization rules, formularies, and appeal rights.
- Prospective review of how changes may affect people who rely on high-cost drugs, ongoing rehabilitation, home-based care, or frequent specialist visits.

The RFI asks what indicators should be monitored for market disruption and how to assess continuity of coverage and unintended consequences. In addition to enrollment, premiums, and issuer participation, CMS should monitor:

- Denials and prior authorization trends for serious illness-related services.
- Out-of-network utilization associated with inadequate specialty networks.
- Appeals and grievances.
- Consumer reports of delayed or foregone care.
- Mid-year treatment disruption.
- Measures of caregiver strain where available/possible

Thank you for the opportunity to provide input on this RFI. If you have any questions, please contact me at mgrant@thectac.org.

Sincerely,

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