July 15, 2026

The Honorable Robert F. Kennedy, Jr
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9874-NC – Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard
91 Fed. Reg. 35938 (June 15, 2026)

Dear Secretary Kennedy and Administrator Oz:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the request for information related to a comprehensive review of the Essential Health Benefits (EHB) framework and typical employer plan standard. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

More than 2 million Americans will be diagnosed with cancer this year and more than 18.5 million Americans living today have a history of cancer.[1] At every education level, individuals with health insurance are more likely than those without it to have access to critical early detection cancer services.[2,3] Having health insurance coverage makes an individual more likely to survive cancer, and the effects of insurance coverage on cancer survival are even more pronounced in disadvantaged communities.[4]

We appreciate the opportunity to provide thoughts on the current EHB construct. Most of the patient protections provided under the Affordable Care Act (ACA) are tied to EHB services. For example, under the ACA plans are prohibited from imposing lifetime and annual dollar limits on EHB services.[5] These protections are vitally important to cancer patients, many of whom faced coverage limitations before the enactment of the ACA.

We offer comments on the following provisions of the RFI:

- *Question 2.2 (Benefits Associated With Variation Across States)*
- *Question 3.2 (Issuer Cost Management Strategies)*
- *Question 3.3 (Coverage and Affordability Tradeoffs)*
- *Question 3.4 (Measurement of Affordability and Cost)*

[1] American Cancer Society. *Cancer Facts & Figures 2026.* Atlanta: American Cancer Society; 2026.
[2] Zhao, J., Han, X., Nogueira, L., Fedewa, S.A., Jemal, A., Halpern, M.T. and Yabroff, K.R. (2022), Health insurance status and cancer stage at diagnosis and survival in the United States. CA A Cancer J Clin, 72: 542-560.
[3] Ward E, Halpern M, Schrag N, Cokkinides V, et al. Association of Insurance with Cancer Care Utilization and Outcomes. CA: A Cancer Journal for Clinicians, 2008;58: 9–31. doi:10.3322/CA.2007.0011.
[4] Abdelsattar ZM, Hendren S, Wong SL. The impact of health insurance on cancer care in disadvantaged communities. Cancer. November 14, 2016. https://onlinelibrary.wiley.com/doi/full/10.1002/cncr.30431.
[5] Affordable Care Act section 1302(b).

- *Question 3.5 (Emerging Costs and Future Trends)*
- *Question 4.2 (Factors Informing Scope of Benefits Included as EHB)*
- *Question 4.5 (Preventive and Wellness Services, Behavioral Health Services, Chronic Disease Management, and Health Outcomes)*
- *Question 5.2 (EHB Safeguards)*
- *Question 6.2 (EHB-Benchmark Plan Application Process Improvements)*
- *Question 7.5 (Monitoring and Evaluation Metrics)*

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

Question 2.2 (Benefits Associated With Variation Across States)

The Department of Health and Human Services (HHS) seeks comment on the advantages of State flexibility in defining the scope of EHB.

ACS CAN believes the EHB framework provides the foundation of minimum coverage on which individuals rely. The medically necessary services cancer patients need will not vary depending on geography, but will vary depending on the type of cancer and the stage at which the cancer was diagnosed (among other factors). It is imperative that HHS not weaken EHB services and, in fact, recommit to ensuring that EHB services provide sufficient minimum coverage for those with serious and complex illnesses, such as cancer, regardless of their state or location.

Topic 3: Affordability and Cost

Question 3.2 (Issuer Cost Management Strategies)

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

We note that a number of EHB benefits are subject to utilization management tools, including prior authorization and step therapy. Some forms of utilization management tools may be appropriate, but we are concerned about the increasing use of utilization management. These tools can make it more difficult for cancer patients to access the services and prescriptions they need, especially when frequent clinical visits or high-cost oncology drugs are needed. We urge HHS to require that plans that use these tools do so only if they are based on scientific evidence, are standardized and consumer friendly, and are not discriminatory in nature. Further, HHS should be resourced to provide extensive review of utilization management tools on EHB services to ensure the use of the tools does not result in delayed access to these vital services.

Question 3.3 (Coverage and Affordability Tradeoffs)

HHS asked what factors the Centers for Medicare & Medicaid Services (CMS) should consider when evaluating potential tradeoffs between the scope of benefits included as EHB and affordability for consumers, issuers, and Federal taxpayers.

Affordability: We applaud the Administration's goal to improve affordability of health insurance coverage. However, we would caution that a determination of affordability is not related solely to the premium. Premiums are only one piece of the financial obligation of insurance for patients, and when individuals ultimately need to

access care, the absence of comprehensive benefits will actually shift costs onto the enrollee. An affordability determination should also include cost sharing associated with the health plan and any health-related costs not covered by insurance. When individuals enroll in non-comprehensive coverage options, they are potentially exposed to significant out-of-pocket costs that may result in considerable medical debt, or they are forced to skip or delay treatment because they can't pay for it.

State Mandates: ACS CAN recognizes the need to ensure consistency of benefit design to ensure comprehensive access to products and services needed by cancer patients, survivors, and those at risk of developing the disease. Since 2012, ACS CAN has advocated for the enactment of many state laws that improve access to care for people with cancer and those who will be diagnosed in the future including laws that ensure coverage of biomarker testing, prostate cancer screening, and fertility preservation services. We were deeply disappointed that the plan year 2027 Notice of Benefit and Payment Parameters final rule required states to defray state mandates regardless of whether these benefits were included in the state's EHB benchmark plan.

We are concerned this policy would encourage states to eliminate these vitally important protections that in some cases can impact survival for individuals diagnosed with cancer. Without coverage for these services, individuals with cancer may face unaffordable costs that impact their treatment and survival. For example, access to biomarker testing is imperative because biomarker testing is often used to help determine the best treatment for a patient. Targeted therapies based on biomarker testing results lead to longer survival.[6,7]

We also note that to date HHS has not provided further guidance to states on the question of what state mandated benefits could be subject to defrayal. This is particularly concerning for state mandates that overlap with existing EHB categories – such as biomarker testing coverage (laboratory services) and prostate cancer screening (preventive services) – particularly in light of the fact that many of these state mandates – such as those related to the early detection of, and treatment for, cancer – provide life-saving health care benefits and can save patient and plan expenditures through earlier and targeted interventions.

We also note that many state EHB benchmark plans fail to provide sufficient detail regarding the specific tests covered under the category of laboratory services. Some state benchmark plans note coverage of "laboratory and pathology services" and/or "diagnostic tests" but fail to provide a schedule or additional information regarding specific tests that are covered, thus making it hard to determine if defrayal is necessary.

We are concerned that the general lack of clarity related to state defrayal may cause some states to repeal state laws or refuse to enact new legislation that ensures more individuals can afford to access the services they need to detect, treat, and survive cancer, leaving patients with higher costs or without access to needed care.

Question 3.4 (Measurement of Affordability and Cost)

HHS asked what research approaches CMS should 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.

While we are concerned about affordability and the long-term viability of markets, it is equally important that

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[6] Gutierrez, M. E., Choi, K., Lanman, R. B., Licitra, E. J., Skrzypczak, S. M., Pe Benito, R., Wu, T., Arunajadai, S., Kaur, S., Harper, H., Pecora, A. L., Schultz, E. V., & Goldberg, S. L. (2017). Genomic Profiling of Advanced Non-Small Cell Lung Cancer in Community Settings: Gaps and Opportunities. Clinical lung cancer, 18(6), 651–659. https://doi.org/10.1016/j.cllc.2017.04.004.

[7] Mendelsohn, J., Lazar, V., & Kurzrock, R. (2015). Impact of Precision Medicine in Diverse Cancers: A Meta-Analysis of Phase II Clinical Trials. Journal of clinical oncology : official journal of the American Society of Clinical Oncology, 33(32), 3817–3825. https://doi.org/10.1200/JCO.2015.61.5997.

health insurance provide coverage of the products and services that people need – including needs that the enrollee is not aware of when they make their choices at the beginning of the plan year. Cancer care is a continuum, that includes prevention, screening, treatment, and monitoring; reducing coverage of any of these services will hinder the fight against cancer. When individuals ultimately need to access care, the absence of comprehensive benefits will actually shift costs onto the enrollee. In a 2024 ACS CAN survey of cancer patients and survivors, nearly half (47%) of cancer patients and survivors surveyed had medical debt related to their cancer and the plurality of those (49%) carried over $5,000 in medical debt.[8] Almost all of those surveyed (98%) were insured at the time the debt was incurred most of whom (34%) had a high deductible health plan (HDHP) without a health savings account. Medical debt hinders timely access to care. Those with medical debt were three times more likely to be behind on recommended cancer screenings and 25% reported they skipped or delayed care because of their medical debt. The impact of medical debt reaches far beyond healthcare. Twenty-seven percent of those with cancer-related medical debt reported going without adequate food, nearly half of respondents (49%) saw their credit scores decrease and 30% reported difficulty qualifying for loans.

Question 3.5 (Emerging Costs and Future Trends)

HHS asked whether there are emerging trends in healthcare delivery, utilization, or technology that may influence the affordability of benefits included as EHB in future plan years.

Increasingly the use of precision medicine has been a vital component to improving cancer outcomes. Research has resulted in the availability of targeted therapies that are designed to work in patients with very specific biomarkers.[9] In 2025, over two-thirds (69%) of newly approved cancer drugs were for targeted indications. More targeted cancer therapies are in the pipeline. To effectively use these targeted therapies, a cancer patient must have been tested for biomarkers. Unfortunately, medical advancements such as biomarker testing are not clearly included in all EHB benchmark plans, which can impede patients' access to these vital tests. As HHS considers updates to its EHB benchmark standards, we urge clarification that comprehensive biomarker testing be specifically included as a component of the EHB category of laboratory services.

Topic 4: Scope of Benefits Included as EHB

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

HHS seeks comment on what factors CMS should 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.

Current regulations provide that health plans are required to cover the greater of: (1) one drug in every United States Pharmacopeia (USP) category and class or (2) the same number of prescription drugs in each category and class as the EHB benchmark plan.[10] We are concerned this standard is insufficient to meet the needs of individuals with serious illnesses, like cancer, that often require access to innovative new therapies. There is no single oncology drug that is medically appropriate to treat all cancers. Cancer is not just one disease, but more than 200 diseases. Cancer tumors respond differently to prescription drugs depending on the type of cancer, stage of diagnosis, and other factors. As such, oncology drugs often have different indications, mechanisms of action and side effects – all of which need to be managed to fit the medical needs of an individual. We urge CMS

[8] American Cancer Society Cancer Action Network. Survivor Views on Medical Debt. April 2024. Available from https://www.fightcancer.org/sites/default/files/national_documents/sv_debt_summary_24.pdf.
[9] The term "biomarkers" refers to the biological molecules found in blood, tissues, or other bodily fluids that provide insight into the physiological process, medical conditions, or diseases.
[10] 45 C.F.R. § 156.122.

to revise the prescription drug EHB benchmark standard and require plans to cover at least two drugs per USP category and class, in line with Medicare Part D requirements.

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

HHS asked how CMS should 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.

ACS CAN strongly supports section 2713 of the Public Health Service Act, which requires most health plans to cover in-network evidence-based preventive services without cost sharing to the enrollee. Plans are required to cover services that are rated "A" and "B" by the U.S. Preventive Services Task Force (USPSTF) and recommendations from the Advisory Committee on Immunization Practices (ACIP) and Health Resources and Services Administration (HRSA)-supported Guidelines for Women. However, USPSTF provides clinical recommendations and there often is the lack of clarity in translating the recommendations into coverage determinations. For example, the American Cancer Society believes that cancer screening is a continuum, which cannot always be defined as one individual test.[11] The Tri-Agencies have since clarified that plans must cover colonoscopies following an abnormal non-invasive colorectal cancer screening test[12] and the HRSA's Women's Preventive Services Guidelines have clarified that plans must provide follow-up imaging for breast cancer and screening and testing for cervical cancer.[13] While this clarification is helpful, there is still a concern that lack of consistent clarification of clinical recommendations into coverage determinations could lead to access problems. Moreover, there has yet to be any clarification regarding follow-up testing for lung cancer screening, which means that patients face cost sharing obligations for any follow-up lung cancer screening, which can be a barrier to patients completing the screening process.

ACS CAN has also frequently requested that HHS specifically require plans complying with the coverage of preventive services to cover all forms of evidence-based tobacco cessation treatment, including in-person individual, in-person group, and telephone-based individual counseling as well as all tobacco cessation medications approved by the U.S. Food and Drug Administration for that purpose, with no cost sharing and prior authorization. We encourage HHS to make these clarifications to strengthen the preventive service category of EHB services and to do so in regulations, not in sub-regulatory FAQs, which do not have the same force of law as regulations.

Topic 5: Updating EHB

Question 5.2 (EHB Safeguards)

HHS seeks comment on what 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.

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[11] American Cancer Society. ACS Position Statement on Patient Cost-Sharing for Cancer Screening & Follow-up Tests. Feb. 23, 2023. Available from https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/overview/acs-position-on-cost-sharing-for-screening-and-follow-up.html.

[12] Department of Labor. FAQS About Affordable Care Act Implementation Part 51, Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation. Jan. 10, 2022. Available from https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf.

[13] Health Resources & Services Administration. Women's Preventive Services Guidelines. Available from https://www.hrsa.gov/womens-guidelines.

While current regulations allow states to replace one or more categories of EHBs in the State's EHB-benchmark plan with the same category of EHB from the EHB-benchmark plan used by another state,[14] states who choose this option should be required to perform additional oversight functions to ensure that the EHB-benchmark plan as a whole continues to meet the statutory requirements of coverage.

Topic 6: State Processes for Updating EHB-Benchmark Plans

Question 6.2 (EHB-Benchmark Plan Application Process Improvements)

HHS seeks comment on improvements to the EHB-benchmark plan application process.

ACS CAN strongly urges HHS to require that any change to a state benchmark should be subject to a public notice and adequate amount of time for comment at the state level so that all stakeholders have an opportunity to provide relevant feedback. This will ensure that impacted members of the public – particularly those who would be impacted by the EHB benchmark update – will have adequate opportunity to review and offer comments on any benchmark change. This public comment opportunity should be available as a state is considering any EHB benchmark changes and also at the federal level.

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

Question 7.5 (Monitoring and Evaluation Metrics)

HHS seeks comment on what targeted monitoring framework CMS should use to assess market impacts over time.

An EHB benchmark standard is only helpful to consumers if the protections are enforced. States are primarily responsible for implementing enforcement over issuers to ensure compliance with the EHB requirements. As a result, enforcement of EHB protections will vary from state to state with some states being more proactive about enforcing EHB protections. CMS has the authority to step in and enforce health insurance market reforms, like EHB standards, if CMS determines the state is not substantially enforcing these requirements. We urge HHS to require CMS to engage in robust oversight (including market conduct examinations) to determine the extent to which consumers have unimpeded access to EHB services, regardless of their state of residence.

CONCLUSION

Thank you for the opportunity to comment on the Request for Information related to a comprehensive review of the Essential Health Benefits framework. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Vice President, Public Policy Advocacy at Anna.Howard@cancer.org.

Sincerely,

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network

[14] 45 C.F.R. § 156.111(a)(1)(ii).