July 15, 2026

Submitted electronically via www.regulations.gov

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9874-NC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard [CMS-9874-NC]

Dear Administrator Oz:

Patients Rising is a national patient education and advocacy organization representing the thousands of Americans who live with chronic and life-threatening illness. Our community does not experience health policy as an abstraction. They experience it at the pharmacy counter, in the explanation of benefits they cannot decipher, and in the January deductible reset that determines whether they start the year on their medication or off of it.

We are proud to have joined the multi-organization comment letter led by the HIV+Hepatitis Policy Institute, and we incorporate its recommendations by reference. We write separately because we believe this comprehensive review is the right moment to state plainly the principle that should govern it.

The test every change should have to pass

Cost-sharing is a legitimate feature of insurance design. Patients Rising does not ask CMS to eliminate patient cost-sharing, and we do not pretend that anyone else can. What we ask is simpler and more demanding: every actor in this system — regulators, insurers, pharmacy benefit managers, employers, pharmaceutical companies, and

advocates like us — should be judged by whether we are lifting financial burden off the patient, and whether what remains is clear, predictable, and honest.

That yields a two-part test to urge CMS to apply to every idea this RFI generates. First, does the change lift financial burden from patients, or shift more of it onto them? Second, does it make the patient's obligation clearer — or does it add another layer of complexity that only sophisticated intermediaries can navigate and profit from? A benefit framework fails patients not only when it covers too little, but when it becomes so opaque that a patient cannot know, in advance, what a prescription will cost or whether the help they receive will count.

Measured against that test, the most urgent problems in the current EHB framework are not the statutory categories or the benchmark structure. They are the practices that have grown up around the framework to capture, for intermediaries, dollars that were intended to defray patients' costs.

1. Preserve the prescription drug framework; fix the enforcement

Responding to the RFI's questions on the scope of benefits and the frequency of EHB updates (Topics 4 and 5), we caution CMS against any change that would narrow prescription drug coverage or weaken the current standards, including the greater-of drug count requirement and the nondiscrimination protections.[1] The framework governing prescription drugs is generally working for patients. What is not working is enforcement. Before CMS considers rebuilding the house, it should start locking the doors that are standing open.

2. Copay assistance must count — because it belongs to the patient's burden, not the plan's revenue

Federal regulation defines cost sharing as any expenditure required "by or on behalf of" an enrollee for essential health benefits.[2] When a manufacturer, charity, church, or family member pays a patient's copay, that payment is made on behalf of the enrollee, and the only lawful reading of the regulation is that it counts toward the patient's deductible and out-of-pocket maximum. The United States District Court for the District of Columbia reached that conclusion nearly three years ago, striking down the 2021 rule that let issuers decide for themselves whether assistance would count.[3] Yet the federal government has neither enforced the decision nor issued a new rule, and copay

[1]See 45 C.F.R. § 156.122 (prescription drug benefit standards, including the greater-of count by United States Pharmacopeia category and class and pharmacy and therapeutics committee requirements).
[2]45 C.F.R. § 155.20 (defining "cost sharing" as "any expenditure required by or on behalf of an enrollee with respect to essential health benefits") (emphasis added).
[3]HIV & Hepatitis Policy Inst. v. U.S. Dep't of Health & Human Servs., No. 22-cv-2604 (D.D.C. Sept. 29, 2023).5

accumulator programs have continued to spread — they now appear in nearly 40 percent of ACA marketplace plans.[4]

The human arithmetic is not complicated. KFF Health News recently reported on a Florida marketplace enrollee who has relied on manufacturer assistance for sixteen years to afford a psoriatic arthritis medication that costs more than $7,700 a month. His insurer stopped counting that assistance toward his $10,600 out-of-pocket maximum — so the assistance was exhausted, the plan collected it, and then the plan collected his out-of-pocket maximum from him a second time.[5] That is the "double dip": the plan is paid twice for the same cost-sharing obligation, and the patient — the person all of this assistance was created for — is the only party in the transaction left worse off.

Twenty-six states, the District of Columbia, and Puerto Rico have already acted to require that assistance count. Patients should not need to win the geographic lottery to get the benefit of federal law. We urge CMS to state, through guidance and a new rule defining cost sharing consistent with the court's decision, that copay assistance counts toward cost-sharing limits, and to enforce that requirement in every market it regulates.

3. The arguments against counting assistance do not survive contact with the record

Because CMS will hear the opposing case from well-resourced commenters in this docket, we address it directly.

"Copay assistance raises premiums." If accumulator programs were producing consumer savings, insurers could show premium reductions in the states that permit them versus the twenty-six states that do not. They have not, because the diverted assistance functions as plan revenue, not as premium relief. Indeed, the share of commercial plan sponsors who describe manufacturer copay assistance as "a good way to help plan sponsors save money" has more than doubled since 2018, to 62 percent.[6] That is a candid admission of what these programs are: a transfer from patient assistance to plan accounts.

"Assistance steers patients away from generics." This concern is already answered by existing policy: the 2020 Payment Parameters rule, which the court restored, permits plans to decline to count assistance for a brand drug when a medically appropriate generic equivalent is available. The medicines actually targeted by accumulators and

[4]KFF Health News, "Copay Assistance Is Meant To Defray Patient Drug Costs. Some Insurers Keep It Instead." (July 7, 2026), https://kffhealthnews.org/health-care-costs/copay-accumulator-adjustment-programs-patient-assistance-insurance-pharma-drugs/.
[5]Id.
[6]Drug Channels Institute, "Copay Accumulators and Maximizers in 2025: Popular, Profitable, and Problematic" (Feb. 2026), https://www.drugchannels.net/2026/02/copay-accumulators-and-maximizers-in.html.

maximizers are overwhelmingly specialty drugs with no generic alternative — which is precisely why one in four cancer patients taking brand medicines faced an accumulator in 2024.[7] A patient with no lower-cost option cannot be "steered"; she can only be charged more.

"Patients need skin in the game." Patients with chronic illness have skin in the game in a way no other actor in this system does: their skin is the game. They already face deductibles and out-of-pocket maximums at record levels, and the well-documented consequence of unaffordable cost exposure is not smarter shopping — it is prescription abandonment, non-adherence, and more expensive downstream care. A policy that causes a patient to leave a prescription at the counter does not manage costs. It relocates them to the emergency room.

4. Close the loopholes that turn patient assistance into a business model

The same test condemns the newer schemes. Copay maximizer arrangements designate covered drugs — in one vendor's case, more than 500 of them — as "non-essential health benefits" in order to escape the ACA's cost-sharing limits and harvest the maximum available assistance, while counting none of it toward the patient's obligation. Alternative funding programs go further, steering patients out of their own insurance entirely and toward charity programs or foreign drug importation, with the patient bearing full cost if they refuse to comply. It is difficult to imagine arrangements more corrosive to the clarity and honesty patients deserve: the plan's own documents cannot tell a patient what is covered, what counts, or what anything costs.

CMS took a good first step in the 2025 Payment Parameters rule by confirming that drugs covered in excess of a state's benchmark are EHB in the individual and small group markets.[8] We urge CMS to finish the job: issue a rule clarifying that all covered prescription drugs are essential health benefits subject to EHB protections in all markets, including large group and self-funded plans, and work with the Department of Labor to investigate and prohibit alternative funding programs.

5. A caution on the "typical employer plan" standard

Finally, as CMS considers whether self-funded and large employer plans should inform the definition of a typical employer plan (Topic 1), we offer one caution grounded in everything above: typicality must not become a vehicle for importing loopholes into the benefit floor. The practices described in this letter — accumulators, maximizer carve-outs, non-EHB designations, alternative funding programs — are most prevalent

[7]Id.
[8]Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025, Final Rule, 89 Fed. Reg. 26218 (Apr. 15, 2024).

precisely in the self-funded market. If “typical” is defined by what the least-regulated plans do, then the EHB floor will be set by the very schemes that federal law was written to prevent. A typical employer plan standard should reflect the benefits typical employers cover, not the extraction techniques their vendors sell them.

Recommendations

1. Apply a patient-centered test to every change considered under this RFI: does it lift financial burden from patients, and does it make their costs clearer and more predictable?
2. Preserve the current prescription drug EHB framework and standards; do not narrow coverage.
3. Issue guidance and a new cost-sharing rule consistent with the 2023 court decision, requiring copay assistance to count toward deductibles and out-of-pocket maximums, and enforce it.
4. Clarify by rule that all covered prescription drugs are EHB, in all markets, ending “non-EHB” drug designations and maximizer carve-outs.
5. Investigate and prohibit alternative funding programs that push patients out of their own coverage.
6. Ensure the typical employer plan standard reflects benefits typically covered — not cost-shifting schemes — and give state regulators the tools and mandate to enforce existing EHB protections.

Patients Rising and the patients we serve want a system in which financial burden is lifted where it can be lifted, and stated plainly where it cannot. Every recommendation above serves that end. We thank CMS for undertaking this review and would welcome the opportunity to bring patient voices directly into it.

Sincerely,

Terry Wilcox

Terry Wilcox
Co-Founder & Chief Executive Officer
Patients Rising
terry@patientsrising.org