Center on Budget and Policy Priorities

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February 25, 2014

To: Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

RE: Draft 2015 Letter to Issuers in the Federally Facilitated Marketplaces

Dear Sir or Madam:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on the draft 2015 letter to issuers operating in the federally facilitated marketplaces.

Sincerely,

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CHAPTER 1: CERTIFICATION PROCESS AND STANDARDS FOR QUALIFIED HEALTH PLANS

Section 1. FFM QHP Application and Certification Process

We support the proposal requiring FFM QHP issuers to submit a complete QHP application for the plans they wish to offer through the marketplaces in 2015. It is reasonable for CMS to provide issuers with additional time to view and modify their plan data during the 2015 certification cycle this calendar year.

While the FFM will not certify QHPs until October 17, about one month prior to the beginning of open enrollment, we urge CMS to provide as much preliminary plan information as possible to the public before October 17 such as premium rates, cost-sharing charges, and other key plan elements. This would help reduce confusion or misinformation about marketplace plan options that will be available prior to open enrollment, which would otherwise risk dampening consumers' interest in enrolling in Marketplace coverage.

Section 3. Review of Rates

i. Consideration of Rate Increases

We support CMS' efforts to take into account QHP rate increases as part of the certification process. For 2015, CMS should take a closer look at the rate review processes in place in FFM states, including those deemed to have effective rate review programs, in order to ensure they are, in fact, effective, including by being sufficiently transparent and providing opportunity for public input. We urge CMS to examine rate growth for plans offered inside and outside the Marketplaces, as required by the ACA, in 2014.

ii. Review of QHP Rates

We support the proposal to conduct an outlier analysis to identify QHP rates that are higher or lower relative to other QHPs in the same service area and to use this information to determine whether offering a particular QHP through the FFM would be in the best interest of consumers.

CHAPTER 2: QUALIFIED HEALTH PLAN AND STANDALONE DENTAL PLAN CERTIFICATION STANDARDS

Section 2. Service Area

CMS proposes to review requests for service areas that serve a geographic area smaller than a county in order to ensure such areas are not discriminatory. We support this type of review, which would help limit the risk that issuers may structure very small service areas may order to avoid enrollee populations with high risks or other characteristics. However, we want to ensure that the review is not limited to just sub-county service areas. Larger service areas could also be structured in ways that are discriminatory, such as those that are a collection of counties or parts of counties that, while contiguous, may exclude certain counties or parts of counties in discriminatory ways. CMS should ensure that issuers operating through the FFE are setting all of their service areas in a non-discriminatory manner.

We also support the proposal for establishing a formal process to review changes to service areas for 2015, which will help ensure that modifications are being made for legitimate reasons and are not discriminatory, while also minimizing disruption for people currently enrolled in such QHPs.

Section 3. Network Adequacy

We strongly support the proposal for more proactive review of QHP provider networks, under which CMS will review provider lists submitted by issuers to evaluate whether the provider networks meet a "reasonable access" standard. We support that the proposed review will focus on specific types of providers (such as hospital systems, mental health providers, oncology providers, and primary care providers) whose exclusion from some plans' provider networks have raised serious access to care concerns in the past. Additional provider types that CMS should evaluate include pediatric specialists, as well as specialists within in-network hospital systems (such as anesthesiologists and hospitalists), who may themselves not be in an issuer's network but nevertheless provide treatment to QHP enrollees who use in-network hospitals and expect to be charged in-network cost-sharing for hospital and other related professional services.

We also support future CMS rulemaking which would articulate specific time and distance standards, as well as creating a search engine function so that consumers can search for particular providers and provider types in QHPs offered through the FFM.

While it is likely that issuers will raise concerns about the potential burden and cost of a more robust network adequacy review by CMS, we believe that the proposed approach is a critical protection for consumers that will help ensure that the QHPs they purchase through the FFM provide an adequate level of access to health care providers.

Section 4. Essential Community Providers

The proposals to strengthen the standards related to QHP issuers' inclusion of Essential Community Providers (ECP) are welcome, but they will not necessarily ensure that there is sufficient access to ECPs in a given service area. For example, requiring QHPs to include 30 percent of a large group of ECPs may be sufficient to ensure access to needed care, particularly among low-income and vulnerable populations. But if an area has only 5 ECPs and ECPs play an outsized role in providing care in the community (like primary care), then including only 2 such ECPs in the network would meet the proposed threshold but likely leave the provider network wholly inadequate. CMS should therefore consider the relative number of ECPs available in a given service area and more closely scrutinize service areas where ECPs disproportionately provide services in the community (e.g. the services that are generally provided by the ECP category) above a certain threshold. If ECPs in a given service area have a disproportionately important role, then CMS would apply a higher percentage threshold than would apply generally. For 2015, we also urge CMS to ensure, if it finalizes the use of a threshold percentage, that the standard should be higher than 30 percent, such as 50 percent or more.

We also support the requirement that issuers must offer contracts in good faith to at least one ECP in each ECP category in each county in the service area where an ECP in that category is available, as well as to all available Indian health providers in the service area. But issuers should

also be required to actually contract with at least one ECP in each county of the plan service area, not just offer such a contract, in order to ensure there is a minimum level of access to ECPs for plan enrollees. Also, an issuer should not be permitted to avoid meeting the ECP standard by submitting a narrative justification. If the narrative justification exception is retained, issuers should be required to include in it information about all ECPs that an issuer has offered an contract to as well as specific information about how the issuer intends to ensure that specific populations (such as people with limited English proficiency, those with chronic or complex medical conditions, and children) would receive timely access to care.

CHAPTER 3: QUALIFIED HEALTH PLAN AND STANDALONE DENTAL PLAN DESIGN

Section 1. Discriminatory Benefit Design: 2015 Approach

i. EHB Discriminatory Benefit Design

We strongly urge CMS to take an active role in enforcing the prohibition against discriminatory benefit design in QHPs offered through not only the FFM but also in state-based marketplaces as well as outside the marketplaces. This includes requiring states to utilize the strategies CMS outlining in the issuer letter as ways to assess compliance with this standard. We support the proposal for future CMS rulemaking that would require a review of coverage of prescription drugs based on clinical appropriateness. While more details are needed to assess CMS's approach in this area, it appears that it would likely help create minimum and more consistent standards for what drugs would need to be covered under a state's essential health benefits standard to ensure that all issuers' formularies are non-discriminatory. However, such a standard should be required for states, not as an option for states. In general, any federal rules related to the essential health benefits should represent a minimum standard that applies market-wide and that must be adhered to in states, regardless of whether the marketplace in the state is operated by the state or the federal government or which regulator is enforcing the standard.

We support CMS assessing compliance with the EHB non-discrimination requirement through issuer monitoring and compliance reviews. However, we believe that solely relying on complaints and appeals would be insufficient to ensure that benefits covered under all plans in the individual and small-group markets are non-discriminatory. CMS should consider other ways to enforce this important standard, including by establishing practices that states and the federal government will be required to utilize in assessing and ensuring compliance with this standard.

ii. QHP Discriminatory Benefit Design

We support the proposal to perform an outlier analysis on QHP cost-sharing charges as part of the certification process, in order to ensure that plans are not discouraging the enrollment of individuals with significant health needs. This analysis, however, should examine the full array of cost-sharing charges under the QHP, especially the amount of plan deductibles and which services are and are not exempt from a plan's deductibles.

We support the proposal to examine cost-sharing charges on specific benefits, such as inpatient hospital stays and prescription drugs, which are likely to be particularly important to people with

significant health needs. We agree that the review of prescription drugs should identify plans that subject large numbers of drugs to preauthorization and/or impose step therapy requirements to particular drug categories and classes. We support the proposal to analyze information in the "explanations" and "exclusions" sections of the Plans and Benefits Template for discriminatory wording, which CMS defines as typically meaning the reduction in the generosity of a benefit in some manner for subsets of individuals for other than clinically indicated reasons. We note that when problems are found, issuers should be required to remedy not only the problematic wording in the Plans and Benefits Templates but also ensure that all other plan documents as well as the benefits being covered for enrollees are not discriminatory.

Section 2. Prescription Drugs

It is unclear, based on the draft letter, whether CMS is proposing a policy change that affects how drugs are counted for purposes of determining whether a QHP meets the essential health benefit standards. CMS should clarify whether drugs covered under a medical benefit counted as covered when comparing QHPs to the EHB benchmark in a state for 2014. For 2015, CMS should ensure that prescription drug coverage is adequate and that all QHPs meet consistent standards for the number of drugs that must be covered compared to a state's EHB benchmark.

CMS should also take steps to improve the transparency of QHPs' prescription drug coverage. We support the proposal requiring issuers to indicate to CMS whether a drug is a "medical drug" covered under a plan's medical benefit rather than a drug covered under the prescription benefit. We urge CMS to ensure such information is provided to consumers as well; when issuers submit information about covered "medical drugs" to CMS, CMS should ensure consumers have access to this information (including delineation of whether a drug is part of the medical or prescription benefit and what cost-sharing charges are for any drugs) when they compare QHPs. This may be most easily accomplished by requiring all medical drugs and relevant information about them to be part of the formulary information that QHP issuers must provide to consumers. Otherwise, it may not be clear which items (such as diabetes test strips or infused drugs) a QHP issuer may cover as drugs under the medical benefit which wouldn't otherwise appear in plan formularies. In addition, CMS should ensure that issuers specify in plan documents the prescription drugs that a QHP covers and to which categories and classes from the state's EHB benchmark the covered drugs belong.

We support the proposal to require issuers to provide consumers with a direct link to their plan formularies and other relevant information. We also support the proposal to require issuers to temporarily cover non-formulary drugs and lift restrictions such as prior authorization and step therapy on covered drugs during the first 30 days of a consumer's enrollment in a QHP. CMS should not limit this consumer protection only to the situation where the first day of coverage begins on January 1; people who start coverage later in the year (say through a special enrollment period) also should also be able to access this short-term protection. Nor should CMS limit this consumer protection only to people who previously were enrolled in QHP coverage or other health insurance coverage. For example, people who have been previously uninsured may have chronic conditions and take maintenance medications that they were paying for out-of-pocket or through safety net programs. They, too, will need sufficient transition time to adjust to the prescription drug coverage under their new QHP. In addition, it seems overly cumbersome to require issuers to apply their drug coverage rules differently based on the coverage a person had prior to enrolling in the new

QHP. Will issuers need to determine whether people who had prior non-QHP coverage in the individual market had drug coverage under such plans?

Without these limitations, under its transition policy for 30-day coverage of drugs, CMS can thus ensure that this policy helps reduce disruptions in new enrollees' medication regimens and provides a minimum amount of time for people to switch to other covered medications whenever possible.

We also urge CMS to institute policies, which the issuer letter indicates that CMS is now considering, to help new enrollees with other types of care transitions, such as continuity of access to specialists for people in the midst of cancer treatment. In general, consumers need adequate time to adjust to and understand the benefits and cost-sharing charges of a new plan, particularly those people who have serious health problems requiring ongoing treatment including but not limited to cancer.

Section 3. Supporting Informed Consumer Choice

We support the use of meaningful difference standards for QHPs in the FFM. The use of quantitative standards for what constitutes a meaningful difference in the amount of QHP deductibles and out-of-pocket maximums, as described in the letter, is very welcome. We continue to believe, however, that the list of plan characteristics that CMS will consider when assessing meaningful difference should not include premiums, as differences in premiums often reflect differences in plan characteristics already on the list of criteria in assessing meaningful difference, such as provider network or deductible amount. We urge CMS to continue to revisit and refine its approach to meaningful difference over time to ensure that the standards established for the FFM can effectively permit consumers to make informed choices.

Section 7. Coverage of Primary Care: 2015 Approach

We support the suggestion that future rulemaking may require all QHPs to cover at least three primary care office visits without requiring enrollees to meet the plan deductible. We also support CMS encouraging FFM issuers to provide such benefits for 2015. When a QHP has a very high deductible, it is likely to cause some consumers to forgo seeing their doctor. Applying this three-visit minimum as a requirement for all plans would help to ensure that people receive some primary care. Moreover, it would also foster a more consistent benefit design across QHPs by setting a standard on coverage of primary care, irrespective of deductible. Greater standardization across plans, along with other requirements like meaningful difference, makes it easier for consumers to understand and compare available QHPs and make informed choices.

CHAPTER 4: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

Section 2: QHP Issuer Compliance Monitoring Program

We support the proposal to require issuers to submit a compliance plan and organizational chart as part of the certification and recertification process. We support CMS' coordination with states on federal monitoring and enforcement actions to minimize any unnecessary duplication of oversight activities.

Section 3: QHP Issuer Compliance Reviews

We support the proposal to use a variety of methods and sources of information to review the compliance and evaluate the performance of issuers, including complaint data, issuer reporting of problems, customer service and satisfaction information, health care quality outcomes, issuer operations, and network adequacy. We support the proposal for CMS to conduct routine monitoring of QHPs in FFMs and to perform at least a limited number of compliance reviews to address issues or non-compliance with standards. With the emphasis CMS is placing on the use of complaint data to conduct its reviews and monitoring, we urge the agency to ensure that consumers and consumer advocates have clear information about where within CMS complaints related to QHPs can be submitted. CMS should also provide information to the public, in the form of reports provided no less frequently than yearly, to describe the QHP complaints received at the federal level and how they were addressed.

Section 4. FFM Oversight of Agents/Brokers

The letter indicates that CMS "strongly suggests that agents and brokers not use 'Marketplace' or 'Exchange' in the name of their businesses or websites." We urge CMS to identify the full extent of federal enforcement authority to prevent such confusion and use that authority to fully prohibit the use of such terms if possible. Such a prohibition would ensure that only the Marketplace operating in the state could use these important terms.

Section 5. Monitoring of Marketing Activities

We support CMS monitoring marketing materials for compliance with the non-discrimination requirements of the ACA in FFM states where there is no or minimal review of issuer compliance with these standards. In addition, CMS should ensure that, when it is relying on a state to review marketing materials, that the state review is, in fact, adequate to ensure FFM issuers are meeting the requirements of §156.200(e) and §156.225(b). We also support the non-discrimination clause which would be included in all issuer agreements with agents and brokers and marketing materials distributed to enrollees and prospective enrollees. CMS, however, should also ensure that consumers and their advocates understand where within the agency they can submit complaints related to possible violations of the non-discrimination requirements. It is reasonable for CMS to coordinate with a state to investigate complaints about marketing activities lodged against an issuer, broker, agent, or web broker, provided that CMS moves to conduct its own investigation if the state does not do so, or if the state's efforts are incomplete or otherwise inadequate. We support that CMS would take any enforcement action it deems necessary based on such an investigation.

CHAPTER 5: EMPLOYEE CHOICE AND PREMIUM AGGREGATION SERVICES IN FF-SHOPS

Section 2. Single Bill, Single Payment under Premium Aggregation

We support the instructions to issuers that they must be ready to accept initial FF-SHOP enrollments and payments as early as November 15, 2014 and initiate coverage as soon as January 1, 2015 for groups enrolling through the FF-SHOP during the 2014 open enrollment period. We understand that for plan year 2014, the FF-SHOP has had limited functionality and relied heavily on issuers to perform premium billing and collection as well as enrollment of qualified employers. But

with the FF-SHOP taking on the premium aggregation and billing functions for plan year 2015, issuers must be prepared to handle these transactions no later November of 2014.

We support the clarification that, to maintain coverage, qualified employers will meet their obligation for submitting payment before the end of a grace period when that payment has reached the FF-SHOP, not based on when it is transferred by the FF-SHOP to the applicable issuers. We further support the requirement that issuers cannot terminate a qualified employer whose payment has been received by the FF-SHOP before the end of the grace period, and can only terminate an employer if notified by the FF-SHOP to do so because of lack of timely payment. Because employers are required to receive bills from and make payments to the FF-SHOP and not to issuers, the employer's grace period status should be based on timing of payments to the FF-SHOP and not be affected by the timing or process involved with funds being transferred from the FF-SHOP to issuers.

Section 3. FF-SHOP Enrollment and Payment Portals

We support the FF-SHOP providing a payment system portal available through the "MyAccount" feature of Healthcare.gov, which would enable employers to manage their payment activities. We also support that qualified employers must be directed by issuers' websites to the FF-SHOP for all payment related issues.

Section 6. Initial Payments for New Group Coverage and Frequency of Issuer Payments

We support that the FF-SHOP will allow new employers signing up for coverage to make payments via check as well as over the phone through the Employer Contact Center, in addition to the default online mechanism available on the "MyAccount" feature.

Section 8. Terminations for and Reinstatements after Non-payment of Premiums

We support the clarification that beginning in 2015, issuers cannot terminate coverage for non-payment of premiums unless instructed to do so by the FF-SHOP, which will be responsible for collecting premiums and monitoring premium compliance.

We support the provision that allows qualified employers to have coverage reinstated after they've failed to make payment during the grace period as long as they make full payment within 30 days of being terminated after the end of the grace period.

Section 13. Minimum Participation rates and Renewals during November 15-December 15

We continue to believe that minimum participation rates are no longer relevant or necessary in the small group market after 2014 including within the FF-SHOP, considering all the reforms to the small group market that have taken effect. We recognize that a minimum participation requirement *could* help encourage employers to provide larger premium contributions in order to increase employee enrollment, thus making it more likely that workers will be able to afford coverage. However, if HHS is interested in ensuring adequate employer contributions, it could instead require a minimum employer contribution level as a condition of enrolling through the FF-SHOP.

That being said, we support the provision waiving the minimum participation requirement for employers applying for coverage between November 15 and December 15 of the year preceding their intended coverage year. We further agree that there should be no reason to distinguish between groups renewing during this period and those that are newly applying for coverage through the FF-SHOP; this exception should be applied to all employers apply for or renewing FF-SHOP coverage during this time period for plans that take effect on January 1 of the following year.

CHAPTER 6: CONSUMER SUPPORT AND RELATED ISSUES

Section 1. Provider Directory

We support the requirement that QHP issuers provide direct links to their provider directories so that consumers will have increased access to this important information and will not have to first log on or enter plan-specific information on the issuer's web site. CMS should also ensure that issuers' provider directories are as accurate and up-to-date as possible, such as by reviewing the accuracy (such as through a "secret shopper" program), setting specific timeline requirements for issuer updates of provider directories (such as updates at least every two weeks), requiring QHP issuers to set up a system for consumers to report inaccuracies in provider directories (such as via a dedicated email address or web comment box at the issuer web site), and making relevant and timely updated based on that reporting. We also strongly support the creation of a centralized search engine function so that consumers will eventually be able to search for provider information directly on the FFM portal. CMS should ensure such a search engine would allow timely updates and ensure accuracy for consumers.

Section 4. Meaningful Access – Shelby

We support the letter referencing the Enhanced National CLAS Standards, the non-discrimination protections of Title VI of the Civil Rights Act of 1964, and section 1557 of the ACA. We believe these standards and laws provide important consumer protections and help ensure equal access to benefits. However, we are concerned that the letter does not provide clear standards for issuers offering QHPs to meet the language needs of individuals with limited English proficiency.

We recommend that CMS establish specific standards and examples on how QHP issuers can satisfy meaningful access standards. For example, with regard to language access, the letter should be revised to include a section such as the following:

> *To assist QHP issuers in complying with the standards established in 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, we have outlined the following measures, which are evidence of compliance with the regulatory requirements established by 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250.*
>
> *Language Access:*
>
> - *Applications and notices, as described in the list below, produced or used by QHP issuers should be available in the languages spoken by the state's top ten largest LEP groups or spoken by 10,000 persons or greater, whichever yields the greater number of languages. These applications and notices should also include taglines*

in the top 30 non-English languages in the state indicating the availability of free language assistance services through a QHP issuer's call center.

- *QHP issuers should offer oral interpretation, such as through telephonic interpreter services via a call center, in 150 languages, for notices and applications.*

- *QHP issuer Websites that contain information about QHPs, including applications and notices, should have taglines in the top 15 non-English languages in the state indicating the availability of free language assistance services through a QHP issuer's call center. Websites with content in English should be translated into Spanish, and applications and notices appearing on issuer Websites should meet the standards above.*

The draft issuer letter includes a minimum list of forms and notices, including the single streamlined application, as essential documents that need to be translated to ensure meaningful access. While this list is a good start, in order to meet meaningful access requirements under Title VI, federal recipient are obligated to translate *all* vital documents. Although the letter refers to these as *essential* documents, it provides a non-exhaustive list of the sort of document that would fall into this category.[1] HHS also recognizes that vital documents include not just those used during the receipt of medical care but also materials that raise "[a]wareness of rights or services" such that "where a recipient is engaged in community outreach activities, it should regularly assess the needs of the populations frequently encountered or affected by the program or activity to determine whether certain critical outreach materials may be the most useful to translate."[2] When the consequence of information is a person's access to a program or activity, whether through awareness or actual application, these materials should be considered vital documents and translated to ensure meaningful access.

Section 5. Summary of Benefits and Coverage

The Summary of Benefits and Coverage form (or SBC) was intended to provide consumers with accurate and simple information that would allow them to compare different plans based on important elements, especially cost-sharing charges. Both the form and the manner in which issuers fill it out require significant improvements in order for the SBC to fulfill its intended role for consumers. We thus urge CMS to ensure that issuers in the FFM take immediate steps to improve consumers' ability to rely on the information contained in these forms.

For example, CMS should require that FFM issuers correctly and consistently identify to which benefits a QHP's annual deductible applies, and which are exempt from the deductible and require other cost-sharing charges (such as a copayment) instead. In some cases, the 2014 SBCs have not been clear in this area, leaving consumers to believe that a very high deductible applies to all or most

[1] HHS LEP Guidance, 68 Fed. Reg. at 47,318; LEP.gov, Frequently Asked Questions (listing as vital documents: "applications, consent and complaint forms; notices of rights and disciplinary action; notices advising LEP persons of the availability of free language assistance; prison rulebooks; written tests that do not assess English language competency, but rather competency for a particular license, job, or skill for which English competency is not required; and letters or notices that require a response from the beneficiary or client"); HHS LEP Guidance, 68 Fed. Reg. at 47,319 (listing as possible vital written materials: consent and complaint forms; intake forms; notices, written tests that do not assess English language competency; applications to participate in a recipient's programs or activities; hospital menus; third party documents, forms, or pamphlets; government documents and forms; and general information)
[2] HHS LEP Guidance, 68 Fed. Reg. at 47,318.

benefits, when in reality a number of items and services (such as physician visits or prescription drugs) do not require payment of the deductible first. It is well understood that high upfront cost-sharing charges can deter people from seeking needed care or care that would help ward off more expensive health problems. If QHPs are achieving higher actuarial values for very high deductible plans (such as $6,000 deductibles in the silver level) by exempting certain benefits from the deductible, it is crucial to make this clear on the SBC so that consumers can understand which plan meets their needs and how to attain the full value of the coverage they decide to purchase. While we acknowledge that CMS may be unable to modify the SBC form itself in the near-term, CMS should, at minimum, specify for issuers how to make clear on the existing SBC form to which services the deductible does and does not apply. The simplest solution may be to instruct issuers to specify for each of the "services you may need" on the SBC whether the deductible does or does not apply to a particular service, as well as what other cost-sharing charges would apply instead of the deductible or after the deductible is met.

A related issue arises in the Coverage Facts section of the SBC. Apparently the HHS Coverage Facts calculator does not account for plan designs in which the deductible does not apply to all services. Therefore, a plan's Coverage Examples will make it look like sample enrollees having a baby or managing type 2 diabetes would pay far more out of pocket than they would in reality under the plan. Not only does this have the potential to mislead consumers, it also raises the concern that the information being provided by issuers is likely to discourage enrollment by people with significant health needs, in violation of federal law.

While we welcome CMS encouraging issuers to provide separate SBCs for each of the cost-sharing reduction variations of the silver Marketplace plans, this falls far short of what consumers need. It is clear from preliminary data on Marketplace enrollment that the large majority of consumers gaining coverage are eligible for subsidies, and many of them likely are eligible for cost-sharing reductions in addition to advance premium tax credits. For the 2014 plan year, it was extremely difficult to find information about the cost-sharing reduction variations of issuers' plans. Initially, it was often not available at all, and even now it is quite difficult (and perhaps impossible) for the average consumer or someone assisting consumers to understand how cost-sharing charges might be reduced unless a consumer completes the eligibility determination process at the web site first.

This creates a situation where people who might be eligible for cost-sharing reductions — as well as the public, the media, and people assisting consumers — may not realize the benefits of cost-sharing reductions or how much they can lower their out-of-pocket costs and greatly increase the comprehensiveness of coverage available through the Marketplace for many people. Consumers who could be eligible for cost-sharing reductions may therefore be discouraged from enrolling in a QHP at all, believing the deductibles and other costs are simply too high, or they may mistakenly avoid silver plans without realizing they are giving up an important subsidy. Therefore, we urge CMS to require QHP issuers to supply separate SBCs for each cost-sharing reduction variation in time for the next open enrollment period. Some issuers have already done this. And because the differences between a base silver plan and the cost-sharing reduction variations are likely to be minimal -- outside of deductibles, coinsurance, copayments, and out-of-pocket limits for in-network care -- we do not think this would be overly burdensome for the issuers, while providing substantial benefit to consumers in assessing their plan options in the marketplace.