



FACT SHEET

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Notice of Benefit and Payment Parameters for 2022 Final Rule Fact Sheet

The Notice of Benefit and Payment Parameters for 2022 final rule finalizes some of the standards included in the proposed rule for states, Exchanges, and issuers in the individual and small group markets. These changes further the Administration’s goals of lowering premiums, enhancing the consumer experience, and reducing regulatory burden. CMS anticipates issuing further rulemaking to address the Notice of Benefit and Payment Parameters for 2022 proposals that were included in the proposed Notice of Benefit and Payment Parameters for 2022 but were not included in this final rule.

Lowering Premiums

FFE and SBE-FP User Fees

For the 2022 benefit year, HHS is finalizing a user fee rate of 2.25 percent of premiums for issuers offering plans through a Federally-facilitated Exchange (FFE), and a user fee rate of 1.75 percent of premiums for issuers offering plans through State-based Exchanges on the Federal Platform (SBE-FP). These rates reflect a 0.75 percentage point decrease from the FFE and SBE-FP user fee rates HHS finalized for the 2021 benefit year. These rate decreases reflect cost-saving measures implemented over the last several years to reduce user fee burden on consumers and create downward pressure on premiums.

Enhancing the Consumer Experience

Establishment of the Exchange Direct Enrollment Option

HHS is finalizing the proposal to establish in regulation a new option by which a State Exchange, SBE-FP or FFE state may facilitate enrollment of qualified individuals into individual market qualified health plans (QHPs) primarily through approved private-sector, direct enrollment (DE) entities (such as QHP issuers and web brokers). Under this new “Exchange Direct Enrollment option” (DE option), instead of a single, Exchange enrollment website, an SBE, SBE-FP or FFE state that is approved by HHS to implement the DE option will approve DE entities to operate private-sector websites through which consumers can apply for and enroll

in QHP coverage offered through the Exchange, as well as receive a determination of eligibility for QHP coverage, advance premium tax credit (APTC) and cost-sharing reductions (CSRs) from the Exchange (if otherwise eligible).

Under the DE option, the Exchange will remain responsible for building and/or maintaining back-end eligibility and enrollment system functionality to which approved DE entities' consumer-facing websites will connect, providing standardized comparative QHP information, making eligibility determinations, and meeting all other applicable Exchange statutory and regulatory requirements. For SBE-FP and FFE states that are approved to implement the DE option, HealthCare.gov will continue to provide the same standardized comparative QHP information available today to assist consumers shopping for coverage. State Exchanges approved to implement the DE option must have at least one DE partner that can display and allow for enrollment in all QHPs available in the state, as well as meet other critical federal requirements for HHS approval to participate in the FFE DE program. State Exchanges may elect this option beginning with the 2022 plan year, and FFE and SBE-FP states may elect this option beginning with the 2023 plan year. For an FFE or SBE-FP state that elects and is approved by HHS to implement the DE option for the 2023 plan year, HHS will collect FFE-DE or SBE-FP-DE user fees from issuers participating in the Exchange at the rate of 1.5 percent of premiums charged. Additional programmatic guardrails and operational parameters may be expanded upon and addressed in more detail in future rule making, particularly those related to the consumer experience and ongoing oversight.

Individual Coverage Health Reimbursement Arrangements and Qualified Small Employer Health Reimbursement Arrangements

HHS is finalizing a proposal that will require individual market QHP issuers to accept payments made on behalf of an enrollee from an individual coverage health reimbursement arrangement (individual coverage HRA) or qualified small employer health reimbursement arrangement (QSEHRA) when such payments are made using any of the payment methods that QHP issuers are required to accept under existing rules. The finalized rule includes changes to the regulatory text to specify that, in addition to accepting direct payments from an individual coverage HRA or QSEHRA, QHP issuers must also accept premium payments that are made directly by enrollees who are enrolled in an individual coverage HRA or QSEHRA, and clarify that QHP issuers are required to accept payments from individual coverage HRAs or QSEHRAs only when such payments are made using a method that the QHP issuer is already required to accept.

Reducing Regulatory Burden

Section 1332 Application, Monitoring and Compliance, and Periodic Evaluations

HHS and the Department of the Treasury (collectively, the Departments) are finalizing a proposal, with modifications in response to comments, to codify many of the policies and interpretations outlined in the 2018 "State Relief and Empowerment Waivers" guidance (83 FR 53575) into section 1332 regulations.

These regulations govern section 1332 waiver application procedures, monitoring and compliance, and periodic evaluation requirements. The Departments believe this policy will give

states greater certainty regarding how the Departments will apply section 1332's statutory guardrails when determining whether a state's waiver proposal can receive and maintain approval. It will also mitigate risk that substantial state taxpayer funds and other state resources will be spent preparing and submitting incomplete waiver applications or proposals that are not approvable.

Network Adequacy

HHS is finalizing a revision to the QHP network adequacy regulation clarifying that a QHP that does not vary benefits based on whether a covered service is furnished by a provider with whom the QHP has a network participation agreement is not required to comply with the network adequacy standards to be certified as a QHP. This clarification that QHP network adequacy requirements do not apply to indemnity plans makes explicit what issuers commonly understood already. Thus, finalization of this clarification will not have a substantive impact on QHP certification requirements for these plans.

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