

TRANSPARENCY IN COVERAGE & CONSOLIDATED APPROPRIATIONS ACT, 2021

Update for Cigna Shared Administration (SAR)
Clients, Consultants, and Plan Administrators

The information in this document is accurate as of May 1, 2022 and is subject to change.

Together, all the way.®



Cigna's position

At Cigna, we are committed to complying with all applicable laws, rules, and regulations. We are actively preparing for the upcoming requirements as part of the Transparency in Coverage rule and Consolidated Appropriations Act. We understand the implications and have established a rigorous compliance implementation program in connection with these requirements. The rulemaking process is likely to produce additional requirements prior to the scheduled effective dates and/or enforcement dates. We will be evaluating the anticipated rulemaking and will work to address the final requirements as they are issued.

In addition, Cigna understands the impact of the Transparency in Coverage rule and Consolidated Appropriations Act to our clients, and we are providing programs and tools to support you where appropriate.

To keep clients, consultants, and plan administrators informed and up to date on these requirements, this document summarizes information regarding provision requirements, Cigna's actions for SAR clients, client next steps and key dates.

Please contact your Cigna representative with any questions.

UPDATE: No new charges will apply for standard Transparency in Coverage and Consolidated Appropriations Act support on effective dates through the end of 2023, including delivery/hosting of machine readable files. Charges for 2024 effective dates will be evaluated at a later date.

DETAILED UPDATES BY PROVISION

The information in this document is accurate as of May 1, 2022 and is subject to change.

Transparency in Coverage Rule Updates

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Machine-readable file requirements (MRF)	Requires health plans or issuers to publish three separate machine-readable files (1) negotiated rates for all covered items and services between the plan or issuer and in-network providers; (2) historical payments to, and billed charges from, out-of-network providers; and (3) in-network negotiated rates and historical payment net prices for all covered prescription drugs at the pharmacy location level. Per the 8/20 announcement from the Tri-Agencies, the Departments will defer enforcement of the machine-readable files requirements until July 2022 for the in-network and out-of-network files, and pending further rulemaking for the prescription drug file.	Cigna will host the IN Medical file that we provide on the client's behalf and at no cost on cigna.com. If a client does not have their own public website, we will build a website with a link to the cigna.com MRF subpage at no cost to the client. Clients who choose to opt out of our standard offering can download applicable MRFs through cignaforemployers.com, customize with their EIN/Name, and post on their own website. Cigna will not be providing a service to intake MRFs provided by non-Cigna carriers. Cigna will not provide a hosting service for a clients' OON Medical MRF.	As required by Transparency in Coverage: • Clients who did not opt out of our standard MRF support will need to post a link on their public website to where their files are hosted. • Clients for whom Cigna has created a public website will need to make available the URL of that website when requested. • Clients who opt out of our standard delivery will need to download applicable MRFs through cignaforemployers.com, customize with their EIN/Name, and post on their own website. • Downloading the files is not necessary when Cigna is hosting the files on our clients' behalf. There are significant system requirements needed to download the files.	Enforcement deferred until July 2022 for the in-network and out-of-network files, and pending further rulemaking for the prescription drug file. Cigna will make the files available through Cignaforemployers.com on or before June 1, 2022. Files will be available to the general public as of July 1, 2022. Cigna provided system requirements to clients to assist their decision making regarding hosting their own files. This same information is also available to clients on CignaforEmployers.com.
Cost-share liability estimator tool requirements	Requires health plans or issuers to have an internet-based, self-service tool and paper(if required) that provides real-time, personalized, out-of-pocket cost information, based on the member's plan for covered items and services furnished by a particular provider	Cigna has allocated significant resources to expand our existing cost estimator tools/paper process and is actively working toward compliance with the self-service tool requirements, effective 2023 and 2024.	No action needed at this time.	For plan years beginning on or after 1/1/2023, plan/issuer must disclose cost-share information for 500 shoppable items and services identified within the rule. For plan years beginning on or after 1/1/2024, all covered items and services must be included in the cost-share tool.

CAA Updates – Title I: No Surprises Act

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Sections 102 and 105: Medical Billing & Air Ambulance	Requires health plans or issuers to cover emergency services without prior authorization at the in-network benefit level, regardless of whether emergency services were rendered in-network or out-of-network. Individuals cannot be required to pay out-of-network cost sharing for certain services provided by an out-of-network provider at an in-network facility, unless the nonparticipating provider gives notice to the individual and the individual consents to out-of-network care.* When determining a member's cost share liability, insurers are required to apply the member's in-network benefits to a Median Contracted Rate meant to represent the typical in-network rate a provider would receive for that service.	Cigna will provide assistance to our clients for compliance with the CAA No Surprises – Surprise Billing requirements by identifying potential NSA claims and providing the plan administrator with the Qualifying Payment Amount (QPA) via the 837 file. The plan administrator will be responsible for validation of NSA eligibility, as well as benefit adjudication as directed in the interim final rules released on 7/1/2021.	Additional operational detail was emailed under a separate attachment in December 2021.	Effective upon renewal for plan years on or after 1/1/2022.
Section 103: Independent Dispute Resolution (IDR)	Requires health plans to implement an independent dispute resolution process which applies to emergency services rendered out-of-network or non-emergency services rendered by an out-of-network provider at an in-network facility, in a state that does not have an applicable specified state law that provides a method for determining the total amount payable for out-of-network services. After a 30 day negotiation period, if the Insurer and the Provider can't come to an agreement, then either can initiate the IDR process.	Cigna will provide these services thru MultiPlan to our Out-of-Network Savings Program clients as a standard part of the program. Cigna will provide these services thru MultiPlan to our NON Out-of-Network Savings Program clients at a fee per claim.	Clients should plan for identifying key employees who will be able to answer question during negotiation and/or IDR. Non OONSP Clients will have to intake the dispute and enter into system. Will also need designated contacts to answer questions during negotiation and/or IDR..	Effective upon renewal for plan years on or after 1/1/2022.

*For purposes of the balance billing prohibition for non-emergency services provided by a nonparticipating provider at a participating health facility, a participating health care facility is a hospital, hospital outpatient department, critical access hospital or ambulatory surgical center that has a direct or indirect contractual relationship with the health plan or health insurance issuer with respect to the item or service furnished.

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CAA Updates – Title I: No Surprises Act

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Section 106: Air Ambulance Reporting	Requires insurers to submit two years of claims data related to air ambulance services to the Secretary of HHS.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	Reporting required for 2022 and 2023 plan years (to be submitted by March 31, 2023 and March 30, 2024, respectively).
Section 107: ID Cards	Requires health plans to include the following on their plan or insurance IDs issued to enrollees: - Amount of the in-network and out-of-network deductibles - Out-of-pocket maximum limitations	Cigna is making enhancements to ID cards to include in-network and out of network deductibles and out-of-pocket maximums for those clients for which <i>Cigna performs ID card production services</i>. New Business - Effective Dates 1/1/22 & After: ID cards will be mailed to members with this new information. Renewing Business - Renewal Dates 1/1/22 & After: Updated cards will be printed and mailed on renewal only for a change of benefit, of election, a qualifying life event, or at an individual member's request. Fees will be consistent with the current client agreement. No new fees for standard ID card support are being instituted in conjunction with the CAA. When an ID card is requested to be mailed for a 1/1/22 effective date or later, the ID card will be updated to reflect the additional information.	Contact your account team with any questions regarding your members' ID cards.	Effective for plan years on or after 1/1/2022. Pending future rulemaking in 2022, plans and issuers are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law. Plans and issuers may design various, but reasonable, methods to comply with the law.

Cigna is also making other changes to its ID card processes, not related to the CAA. PCP information will no longer print or generate a reissued medical ID card. ID cards will not be mass reissued for this change. A myCigna.com activation sticker will be applied to medical ID cards based on the registration status of the customer. If the customer has not registered on myCigna.com, the sticker will be adhered to the card. These changes will go into effect at the end of October.

CAA Updates – Title I: No Surprises Act

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 110: External Review of Surprise Medical Bills	Allows for existing external review process to apply to determining whether surprise billing protections are applicable when there is an adverse determination by a health plan.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	Effective 1/1/2022.
Section 111: Advanced Explanation of Benefits (AEOB)	Requires group health plans or issuers offering individual or group coverage to automatically provide an AEOB upon receiving notification from a provider or facility that a participant or enrollee is scheduled to receive an item or service from a specific provider*.	We will share more information as rulemaking is provided.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022.
Section 112: Good Faith Estimate	Requires health care providers and facilities to verify, three days in advance of service and not later than one day after scheduling of service, what type of coverage the patient is enrolled in and provide notification of Good Faith Estimate whether or not patient has coverage.	We will share more information as rulemaking is provided.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022.

*No later than 1 business day after the plan receives notification from a provider or if the item or service is scheduled at least 10 days in advance, no later than 3 business days after the plan receives the notification (or request).

CAA Updates – Title I: No Surprises Act

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 113: Continuity of Care (COC)	Requires health plans to provide continued coverage at an in-network cost for patients with complex care needs for up to a 90-day period if a provider changes network status due to: (1) the provider's contractual relationship is terminated; (2) benefits are no longer provided because of a change in the terms of network participation; or (3) a contract between a group health plan and a health insurance issuer is terminated, resulting in a loss of benefits provided under the plan with respect to such provider. The plan or issuer must notify continuing care patients on a timely basis of the termination and their right to elect continued transitional care from the provider. Individuals must also have an opportunity to notify the plan or issuer of their need for transitional care.	To assist our clients with the continuity of care requirements, Cigna will send a provider termination file to the plan administrator on a weekly basis. The provider term file will include the necessary information for provider terminations identified the previous week. Cigna expects that plans will identify their members that meet the CAA COC criteria, notify those members of the provider termination, as well as notification of the member's right to elect continued transitional care from the provider. Cigna expects that the plan will complete the Continuity of Care review and approval. Cigna also expects that the plan will notify Cigna when they receive a claim that is approved for CAA COC, is priced as non-par, and requires a pricing adjustment to the providers previously contracted rate.	Additional operational detail is included as a separate attachment within this communication.	Effective for plan years on or after 1/1/2022. The Departments do not intend to issue regulations addressing continuity of care requirements prior to the effective date. Any rulemaking will include a prospective applicability date that provides a reasonable amount of time to comply with new requirements, and plans and issuers are expected to use a good faith, reasonable interpretation of the statute.
Section 114: Cost Comparison Tool	Requires health plans to offer a price comparison tool for consumers and make information available by phone. The tool (to the extent practicable) must allow an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.	Cigna has allocated significant resources and is actively working toward compliance with the similar Transparency in Coverage cost-estimator tool requirements, effective 2023 and 2024.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022. Enforcement date is expected to be aligned with the 1/1/23 cost-estimator tool requirements outlined in the Transparency in Coverage rule.

CAA Updates – Title I: No Surprises Act

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Section 116: Provider Directory Information	Requires health plans to have up-to-date directories of their in-network providers, which shall be available to patients online, or within one business day of an inquiry. Plans must verify key data elements (name, address, telephone, specialty and digital contact information) every 90 days and have a process to suppress providers from the directory that do not respond. Data element updates must be displayed in the directory within 2 business days of validation. Requires plans to make publicly available and post on website and include on each EOB, information on prohibitions on balance billing, information related to the applicable state law, the requirements applied and information on contacting applicable State and Federal agencies. Requires health plans to respond to an individual who requests information on a provider's network status through a telephone call within 1 business day, in writing electronically or in print, per individual's request. If a patient provides documentation that they received incorrect information from an insurer about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount. Health plans must retain communication records related to network status inquiries for two years.	Provider digital contact fields (email and/or website) will be added to the directory and continue to be populated through the validation/suppression processes beginning in 2022. Surprise billing disclosure will be added to directory, Cigna.com and EOBs. We are assessing the 2 day turnaround requirement to understand impacts to our current processes. Cigna has a process in place for handling customer calls inquiring about a provider's network status. Cigna has created a letter to respond to the customers within the 1 day turnaround time as requested in writing electronically or in print, per individual's request. Cigna will update member cost share liability as required when notification of an incorrect directory network status is received. Cigna will be able to retain this information for 2 years as well as audit the responses.	No action needed at this time.	Effective for plan years on or after 1/1/2022. Pending future rulemaking in 2022 for some parts of this provision, plans and issuers are expected to implement the requirements using a good faith, reasonable interpretation of the law.

CAA Updates – Title II: Transparency

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 201: Removing Gag Clauses	Bans gag clauses in contracts between providers and health plans (includes network or association of providers, third-party administrator, or other service provider offering access to a network of providers) that prevent enrollees, plan sponsors, or referring providers from seeing provider-specific cost and quality data.	Cigna does not standardly enter into any contracts that would prohibit the disclosure of information contemplated by Section 201 of the Consolidated Appropriations Act, 2021 ("CAA"). In fact, Cigna's template contracts include compliance provisions that would render ineffective any language that would be non-compliant with the CAA. Cigna continues to review its nonstandard contracts. Such language, if any is identified, will be removed from the contract as soon as practicable.	No action needed.	Already effective as of 12/27/2020.
Section 202: Broker Compensation Reporting	Requires group health brokers and consultants to disclose to plan sponsors all direct and indirect compensation received from insurers and associated with selection of insurance products, benefits administration, wellness services, or other defined broker and consultant services.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	Effective 12/27/2021.

CAA Updates – Title II: Transparency

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 203: Parity NQTL Program	Requires that plans perform, and provide to a regulator or participant on request, a comparative analysis for any non-quantitative treatment limitation (NQTL) applied to mental health/substance use disorder (MH/SUD) benefits.	Cigna will be prepared to provide necessary information to SAR clients that is consistent with the information it develops for use in evidencing non-quantitative treatment limitations (NQTLs) compliance as an insurer. Cigna is not in a position to perform client-specific testing for NQTL compliance. The comparative analyses that Cigna shares with clients are those Cigna develops by assessing its group-client book of business and not any specific client.	Clients should plan accordingly. Future inquiries should be sent through your Cigna sales representative.	Already in effect as of 2/10/2021.
Section 204: Medical Cost and Drug Spend Reporting	Requires health plans to report information on plan medical costs and prescription drug spending to the Secretaries of HHS, Labor, and the Treasury.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	Enforcement of compliance expected by 12/27/2022 (for plan years 2020 & 2021) and by 6/1 annually thereafter. Rulemaking expected in 2022