TRANSPARENCY IN COVERAGE & CONSOLIDATED APPROPRIATIONS ACT

Update for Cigna clients and producers

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

Together, all the way.®

Cigna®

Cigna's position

At Cigna, we are committed to complying with all applicable laws, rules, and regulations. We have implemented changes to address requirements which are already under enforcement and 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 continue. 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.

To keep clients and brokers informed and up to date on these requirements, this document summarizes information regarding provision requirements, Cigna's actions, 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 and independent dispute resolution/arbitration fees. Charges for 2024 effective dates will be evaluated at a later date. Capacity for custom reporting and data requested by clients is limited and will be subject to additional charges.

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Cigna Update on Transparency in Coverage and CAA – Future State Focus Areas

	Cigna Actions	Client Next Steps	Key Dates & Further Rulemaking
Transparency in Coverage rule			
Machine-readable files requirements	See pg. 7	To support Cigna medical clients, Cigna is providing detailed instructions and next steps in a communication to be distributed on May 16. This information is also being distributed to producers on May 13.	• Enforcement deferred until 7/1/22 for in-network and out-of-network. • Cigna hosted files will be posted by June 30, 2022. • Pharmacy file deferred indefinitely subject to further rulemaking.
Cost-share liability estimator tool requirements	See pg. 7	No action needed at this time.	• Plan years on/after 1/1/2023: 500 shoppable services • Plan years on/after 1/1/2024: all covered items and services must be included.
Consolidated Appropriations Act, 2021 - Title I: No Surprises Act			
Section 106: Air Ambulance Reporting	See pg. 8	No action needed at this time. Additional detail about client involvement in submitting reporting to HHS will be available closer to the effective date.	• Reporting required for 2022 and 2023 plan years (to be submitted by March 31, 2023 and March 30, 2024, respectively).
Consolidated Appropriations Act, 2021 - Title II: Transparency			
Section 204: Prescription Drug and Health Care Spending Report	See pg. 8	No action needed at this time.	• Enforcement date of 12/27/2022; further rulemaking expected.

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Cigna Update on Transparency in Coverage and CAA – Provisions Already in Effect

	Cigna Actions	Client Next Steps	Key Dates & Further Rulemaking
Consolidated Appropriations Act, 2021 - Title I: No Surprises Act			
Sections 102 and 105: Medical Billing & Air Ambulance	See pg. 10	No action needed at this time.	• Effective upon renewal for plan years on or after 1/1/2022.
Section 103: Independent Dispute Resolution	See pg. 10	No action needed for clients with Cigna's standard administrative support.	• Effective upon renewal for plan years on or after 1/1/2022.
Section 107: ID Cards	See pg. 11	Contact your account team with any questions regarding your employees' ID cards.	• Effective 1/1/2022 but subject to further rulemaking.
Section 110: External Review of Surprise Medical Bills	See pg. 11	No action needed at this time.	• Effective 1/1/2022.
Section 113: Continuity of Care (COC)	See pg. 12	Fully insured/minimum premium clients will need to notify impacted employees of the opportunity to elect continuity of care when the client's insurance coverage ends with Cigna.	• Effective for plan years on or after 1/1/2022.
Section 116: Provider Directory Information	See pg. 13	No action needed at this time.	• Effective 1/1/2022 but subject to further rulemaking.
Consolidated Appropriations Act, 2021 - Title II: Transparency			
Section 201: Removing Gag Clauses	See pg. 14	No action needed.	• Already in effect 12/27/2020.
Section 202: Broker Compensation Reporting	See pg. 14	No action needed.	• Effective 12/27/2021.
Section 203: Parity NQTL	See pg. 14	If a client should receive notice of a Department of Labor (DOL) audit which is requesting NQTL comparative analysis information, they should contact Cigna Sales immediately and provide a copy of the DOL letter. Cigna will assist in providing the documentation that is responsive to the specific issue(s) in the letter.	• In effect 2/10/2021.

Cigna Update on Transparency in Coverage and CAA – Provisions Subject to Further Rulemaking

	Cigna Actions	Client Next Steps	Key Dates & Further Rulemaking
Consolidated Appropriations Act, 2021 - Title I: No Surprises Act			
Section 111: Advanced Explanation of Benefits (AEOB)	See pg. 15	No action needed at this time.	• Enforcement deferred for further rulemaking in 2022.
Section 112: Good Faith Estimate	See pg. 15	No action needed at this time.	• Enforcement deferred.
Section 114: Cost Comparison Tool	See pg. 15	No action needed at this time.	• Expected alignment with 1/1/23 Transparency Coverage requirement 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	Client Next Steps	Key Dates & Further Rulemaking
Machine-readable files requirements (MRF)	Requires health plans or issuers (which includes clients who sponsor employee benefit plans) 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 indefinitely defer pending further rulemaking for the prescription drug file.	Cigna will host the MRFs we provide, on each client's behalf and at no cost to the client*, on cigna.com. This is the standard option for ASO and Fully Insured clients and will include in-network Medical and out-of-network Medical MRFs for applicable clients. This includes behavioral claims. 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. Cigna will not be providing a service to intake MRFs provided by non-Cigna carriers. Cigna's hosting approach applies to standard US Commercial clients and Taft Hartley SAR clients. Allegiance and Payer Solutions are excluded.	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 have opted to post their own files on their public website, or have a third party do so, have received detailed instructions and technical requirements to support them 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 indefinitely deferred 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**. ASO Clients who choose to host their own files can access their applicable MRFs through Cignaforemployers.com, customize with their EIN/Name, and post on their own public website. Cigna will host files for all Fully Insured clients. 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 requested) 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.

*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 and independent dispute resolution/arbitration fees. Charges for 2024 effective dates will be evaluated at a later date.

CAA Updates

	Provision Requirements	Cigna's Actions	Client Next Steps	Key Dates & Further Rulemaking
Consolidated Appropriations Act, 2021 - Title I: No Surprises Act				
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's regulatory team is currently assessing the recent guidance from the Tri-Agencies on this provision.	No action needed at this time. Additional detail about client involvement in submitting reporting to HHS will be available closer to the effective date.	Reporting required for 2022 and 2023 plan years (to be submitted by March 31, 2023 and March 30, 2024, respectively).
Consolidated Appropriations Act, 2021 - Title II: Transparency				
Section 204: Prescription Drug and Health Care Spending Report	Requires health plans to report information on plan medical costs and prescription drug spending to the Secretaries of HHS, Labor, the Treasury and the Director of the Office of Personnel Management.	The health plan team will be producing and submitting the final required medical and pharmacy spend reporting directly to the federal government on behalf of our clients for all US Commercial products (Medical / Behavioral / Pharmacy integrated), Oscar, and US Global.	Cigna is producing and submitting the final required reporting directly on behalf of clients. No action needed by clients at this time.	Enforcement of compliance expected by 12/27/2022 (for plan years 2020 & 2021) and by 6/1 annually thereafter. Rulemaking expected in 2022

APPENDIX:
DETAILED UPDATES BY PROVISIONS ALREADY IN EFFECT OR SUBJECT TO FURTHER RULEMAKING

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

CAA Updates by Provisions Already in Effect – Title I: No Surprises Act

	Provision Requirements	Cigna's Actions	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.	For claims that qualify as no surprises claims, Cigna will calculate and apply the customer's cost share at the in-network benefit level and reimburse providers as directed in the interim final rules released on 7/1/2021. Cigna's MRC2+ solution will be retired on renewal for all clients beginning with clients renewing on 1/1/2022. Impacted clients will be contacted by their account teams with details. Customer plan booklets are being updated with the following changes: • Replaced ACA Emergency Services language with No Surprises Act language • Included Air Ambulance as a new category within the schedule • Revised schedule to ensure cost-share rules for NSA services align with expectations of the No Surprises Act New language will be updated in customer booklets or rider upon renewal or as soon as possible thereafter, depending on state filing approvals.	No action needed at this time.	**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 implement the independent dispute resolution process as directed by law.	No action needed for clients with Cigna's standard administrative support.	**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.

CAA Updates by Provisions Already in Effect – Title I: No Surprises Act

	Provision Requirements	Cigna's Actions	Client Next Steps	Key Dates & Further Rulemaking
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. **New Business** - Effective Dates 1/1/22 & After: ID cards will be mailed to customers with this new information and it will also be displayed on myCigna. **Renewing Business** - Renewal Dates 1/1/22 & After: Updated cards will be printed and mailed on renewal only for a change of benefit or election or a qualifying life event or at an individual customer'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 a physical card is requested to be mailed for a 1/1/22 effective date or later, both the physical card and digital image on MyCigna will be updated in tandem to reflect the additional information.	Contact your account team with any questions regarding your employees' 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.
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 follow established external review processes as applicable by funding type, when external appeal is requested.	No action needed at this time.	**Effective 1/1/2022.**

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 unless the product requires a PCP election and unless a state mandate requires the PCP to appear on the 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 went into effect at the end of October.

CAA Updates by Provisions Already in Effect – Title I: No Surprises Act

	Provision Requirements	Cigna's Actions	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.	Cigna has updated its processes to meet the requirements of the law. New language will be updated in client policies and certificates upon renewal or as soon as possible thereafter, depending on state filing approvals.	Fully insured/minimum premium clients will need to notify impacted employees of the opportunity to elect continuity of care when the client's insurance coverage ends with Cigna.	**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.

CAA Updates by Provisions Already in Effect – Title I: No Surprises Act

	Provision Requirements	Cigna's Actions	Client Next Steps	Key Dates & Further Rulemaking
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. 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 by Provisions Already in Effect – Title II: Transparency

	Provision Requirements	Cigna's Actions	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 already provides certain broker compensation information to brokers and clients. Information can be found on the ERISA form 5500, 1099 form and through Cigna's Paid Compensation statements.	No action needed.	**Effective 12/27/2021.**
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.	To the extent Cigna administers the MH/SUD and medical benefits in a benefit classification in which an NQTL is applied and the design and application of the NQTL aligns with Cigna's standard product features, Cigna will provide to clients a comparative analysis for that NQTL that is consistent with the analysis Cigna uses to evidence compliance for its insured business.*	If a client should receive notice of a Department of Labor (DOL) audit which is requesting NQTL comparative analysis information, they should contact Cigna Sales immediately and provide a copy of the DOL letter. Cigna will assist in providing the documentation that is responsive to the specific issue(s) in the letter.	**Already in effect as of 2/10/2021.**

*Cigna is not in a position to perform client-specific testing for NQTL compliance for clients that do not apply Cigna standard NQTL administration.

CAA Updates by Provisions Subject to Further Rulemaking – Title I: No Surprises Act

	Provision Requirements	Cigna's Actions	Client Next Steps	Key Dates & Further Rulemaking
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 are continuing our development of the underlying cost estimate systems needed to produce an advanced explanation of benefits. 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.
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.	We will share more information as rulemaking is provided. 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.

*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).