CONSOLIDATED APPROPRIATIONS ACT (CAA) SECTION 204 MEDICAL AND PHARMACY REPORTING

Frequently Asked Questions – Updated December 9, 2022

This document provides answers to frequently asked questions from your clients about our support for Federal reporting required under CAA Section 204. (Excluding Shared Administration Repricing (SAR), Payer Solutions, Allegiance).

We continue to closely monitor the final rule making requirements and are dedicated to providing you and your clients with data that will support their compliance with the Consolidated Appropriations Act.

Here are some of the frequently asked questions, and how you can answer them.

1. **What is required under the Consolidated Appropriations Act, Title II, Section 204 Prescription Drug and Health Care Spending Report?**

   - The Medical and Rx Reporting provision (Section 204) requires health plans and payers to report information on plan medical costs and prescription drug spending to the Secretaries of Health and Human Services, Labor, and the Treasury, and the Office of Personnel Management (OPM) on an annual basis. This requirement applies to group health plans (including ASO plans, expatriate plans, and grandfathered plans) and health insurance issuers offering group or individual health insurance coverage, with the exception of church plans that are not subject to the Revenue Code.
   - On November 17, 2021, the departments released an interim final rule (IFR) with request for comments (IFC).
     - With the IFR, the Departments released reporting instructions that provided greater technical detail regarding each data element; the reporting instructions were updated on June 30, 2022.
     - The Departments are requiring plan/issuer submission of information based on the "reference year," defined as the "calendar year immediately preceding the calendar year in which the Section 204 data submissions are due."
   - On June 28, 2022, additional guidance and clarification was added regarding several key report elements, including:
     - Plan list dates, Spend Categories and Total Spending.
     - New Additional Categorization – Medical Benefit Known, Medical Benefit Estimated and Requirement to provide Premium Split between Member/Employer in the 2022 report.
   - FAQs have been published by CMS between August 2022 and November 2022 for various topics, including:
     - Reporting handling when multiple reporting entities are involved
     - Updated handling for vaccine National Drug Codes (NDCs)
     - Inclusion of wellness services in D2 (Spending by Category data file)

Together, all the way.®

Cigna®

2. **Does this provision apply to Grandfathered Plans and Expatriate Plans?**

   - Yes.

3. **What steps is Cigna taking to support clients in compliance with Section 204?**

   - Cigna will produce medical and pharmacy spend reporting annually for both fully insured and self-funded (ASO) clients.
   - Cigna will directly submit these reports to the U.S. Department of Health and Human Services, Department of Labor and Department of the Treasury, and OPM.
   - Reports for calendar year 2020 and 2021 will be delivered by 12/27/22. For calendar years beginning 2022, reports will be provided by 6/1 of the following year.
   - Reports we submit will contain information applicable to our collective set of clients and we do not plan to share reports submitted with clients.

4. **Will clients receive a confirmation when reports are submitted?**

   - Cigna will send an email to clients and brokers in December confirming we will submit reports by 12/27/22.
   - In early January, a follow-up email will be sent to clients and brokers to serve as a confirmation of report submission.

5. **How do the updated reporting instructions impact Cigna's work?**

   - The reports submitted by 12/27/22 will not incorporate any data from clients or other external parties nor any data that is not maintained by Cigna.
   - For December 2022, Cigna is not operationalized to provide underlying data feeds to clients, and will instead report on the client's behalf.
   - All Data reports we submit will be aggregated by Legal Entity, Situs State and Market Segment.
   - Federal guidance issued on 6/28/22 and subsequently through FAQs issued by CMS does not change our submission approach; client action is not required for reports submitted by 12/27/22. Additional communication regarding reports to be submitted annually beginning 6/1/23 will be provided at a later date.

6. **Will Cigna report on the data for a client that termed in the reference year?**

   - Yes, we will report client data within the reference year.

7. **What do the data file indicators signify, e.g., D2?**

PHARMACY BENEFITS AND COSTS REPORTING DATA FILES KEY
Identifiers beginning with "P" (plan) refer to files for the 3 plan categories:
P1: Individual and Student Markets
P2: Group Health plans (most commercial business)
P3: FEHB plans
Identifiers beginning with a "D" (data) reference the 8 distinct data files required:
D1: Premium and Life Years
D2: Spending by Category
D3: Top 50 Most Frequent Brand Drugs
D4: Top 50 Most Costly Drugs
D5: Top 50 Drugs by Spending Increase
D6: Rx Totals
D7: Rx Rebates by Therapeutic Class
D8: Rx Rebates for the Top 25 Drugs

8. **What does the CAA Section 204 report entail?**

   The aggregated report by Legal Entity, Market Segment and Situs State includes Commercial, IFP, Cigna + Oscar and Cigna Global Health Benefits with reporting requirements across Pharmacy, Medical Spend, rebate, premium and plan structure data.

   Reporting for 2020 and 2021 plan years is due 12/27/22 with subsequent plan year reporting due annually each June 1.

   There are 11 reports in total. The intention is to show which drugs drive pharmacy spend/trend, rebate information and contribution to overall health care spend and premiums.

   The reports will show the top 50 drugs for Cigna's combined set of clients by frequency utilized, overall spend, and annual increase in spend aggregated by Legal Entity, Market Segment and State. The reports also contain high level premium information, total spend across medical/pharmacy by category, a list of Client Names/Tax IDs, rebate information by therapeutic class, and rebate information for the top 25 drugs aggregated by Legal Entity, Market Segment and State.

9. **Which files will Cigna submit to the government on behalf of clients?**

   - Unique to this report, the government separated the full Data report into eight different parts, so that medical carriers and PBMs can each submit the applicable medical or pharmacy data for a shared client. Accordingly, for both ASO and Fully Insured clients (excluding SAR, Payer Solutions, Allegiance), Cigna will submit the applicable files to a client's plan design, inclusive of applicable narrative responses. For example:

- For clients with both Medical and Pharmacy coverage integrated through Cigna HealthPlan, Cigna will submit the applicable Plan (P1, P2, or P3) and Data (D1-D8) files.
- For clients with only Medical coverage through Cigna HealthPlan, Cigna will submit the applicable Plan (P1, P2 or P3) and Data (D1-D2) files. Clients should work with their carve-out Pharmacy carriers for support on the pharmacy (D3-D8) files.

- Cigna is not requesting or intaking any additional information from clients, brokers, or other carriers for the initial December 2022 submission.
- For December 2022, Cigna is not operationalized to provide underlying data feeds to clients, and will instead report on the client's behalf.

10. How will Cigna coordinate with a client's other carriers to complete CAA Section 204 Reporting?

- Given that the Departments specifically set up submissions to allow multiple reporting entities to submit files on behalf of a plan, we are not requesting or intaking any additional information from clients, brokers, or other carriers for the initial December 2022 submission.
- While a client may use one or more medical carriers for its selection of plans, each specific plan must submit its report (whether directly or through the carrier, etc.) containing that plan's medical and pharmacy data. Cigna will submit medical and/or pharmacy files on behalf of clients using a Cigna plan.

11. Can clients opt out of Cigna's process of submitting CAA Section 204 reporting?

Given the complexity of the report and the extraordinary size of raw data, we are submitting the required reports directly to the Departments on our clients' behalf. This includes ASO and Fully Insured clients. At this time, for the initial December 2022 submission, we are unable to accommodate client opt out. We are actively working to evaluate future options.

Beyond the standard reporting submission we are providing, capacity for non-standard data requests from clients is limited and will be subject to additional charges. Clients can work with their CGHB Client Manager or Sales Representative to access the non-standard client reporting team.

12. What Cigna Legal Entity Name, Cigna EIN, Client Name, Client EIN, and Group Health Plan Number will be used in completing Plan (P1-P3) reports?

- The Cigna Legal Entity Name and Cigna EIN for CGHB clients will be reported as follows:
  - Cigna Health and Life Insurance Company 59-1031071.
  - For clients with Cigna Pharmacy coverage, the above will also be used for the Pharmacy Benefit Manager (PBM) Name and PBM EIN.
- Reporting submitted for CAA Section 204 will reflect the Client Names and EINs contained within Cigna systems at the time data is pulled. Your CGHB Client Manager or Sales Representative can confirm the applicable Client Names and EINs being used for CAA section 204 reporting. If a Client would like to update their Client Name or Client EIN, the CGHB Client Manager or Sales Representative can utilize existing processes to update the Cigna source systems.
- The Group Health Plan number used in the reporting will be the client's policy number from the Cigna source systems.

13. What is Cigna's response to the premium contribution reporting requirement?

- The Departments recently released further guidance on the reporting of premium information to acknowledge the difficulty in obtaining this information and to defer enforcement of submitting employer vs employee premium contribution until the June 2023 submission. Specifically, the government included the following language on page 23 of the reporting instructions updated June 28, 2022:

  "What if I don't know the amount of premium paid by members versus employers? Average monthly premium paid by enrollees and average monthly premium paid by employers are data elements required by Section 204 of the CAA and the Prescription Drug and Health Care Spending interim final rules (86 FR 66662). Generally, if you are reporting on behalf of a group health plan or FEHB plan, you must obtain this information from the plan.

  For the 2020 and 2021 reference years only. If you have obtained the required information, you must report it. However, the Departments recognize there may be significant challenges to obtain information about employer premium contributions, especially when a contractual relationship began before the passage of the CAA. Accordingly, the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are reported in RxDC report for the 2022 reference year and all future reference years."

- Due to the fact that this is not information issuers/insurers currently collect, the department has deferred enforcement on the reporting of this employer vs employee premium contribution for the December 2022 reporting.

We currently are unable to collect employer vs employee premium contribution for the December reporting and are not instructing clients to submit it separately.

- We will provide additional information about our support for this portion of the report for the June 2023 submission at a later date.
- At this time, we are not collecting information from clients for the initial December 2022 submission.

14. What is Cigna's methodology for calculating Premium Equivalents or other data report metrics?

- For plans that do not use traditional premiums, we will calculate and submit the applicable premium equivalents using internal Cigna data sources, and in accordance with reporting instructions.
- For December 2022, premium equivalents and other metrics we submit will only reflect a client's Cigna coverage.
- We are not requesting or intaking additional information from clients to support the December 2022 submission.

15. How will Cigna be supporting clients with the D1 premium contribution file?

- The data elements required for this include average monthly premium paid by enrollee and average monthly premium paid by the employer. Generally, this information for group health plans or FEHB plans must be obtained from the plan itself.
- The Departments recognize there may be significant challenges to obtain information about employer premium contributions, especially when a contractual relationship began before the passage of the CAA. Accordingly, the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are reported in RxDC (shortened name of the Prescription Drug and Health Care Spend) report for the 2022 reference year and all future reference years.
- For December 2022 reporting, Cigna will be submitting the D1 report on behalf of our clients, but without the premium split information.

16. For fully and self-funded clients, will Cigna be submitting the applicable reports directly to CMS on behalf of the client?

- Yes.

17. How is Cigna planning to report the information – in aggregate at the entity level or at the client level broken out for each state and market segment?

- All our reports are Aggregated by Legal Entity, Situs State and Market Segment, as required for aggregated reports.
- Plan (P1-P3) reports will contain a list of applicable clients and high level client identifiers (Client Name, Client EIN, plan start date/end date, number of members, etc.).
- All information in the D reports will be aggregated for Cigna's combined set of clients by market segment and State.
- The required market segments are as follows:
  - Individual market.
  - Student market.
  - Small group market.
  - Large group market.
  - Self-Funded small employer plans.
  - Self-Funded large employer plans.
  - Federal Employee Health Benefit plans.
- Under aggregation rules, by aggregating the D2 file, plans will have the flexibility to submit (either by themselves or through a third party or vendor) the remaining D files (D1 and D3-D8) as either aggregated files or separate (not aggregated) files. If the D2 file is submitted as a separate file and not aggregated, plans will not have the option of aggregating any of the other D files. Note that Cigna will be submitting D2 as aggregated.

18. For ASO carve-out clients, will Cigna be submitting the D2 file on behalf of the client directly to CMS?

- Yes.

19. For client plans where Cigna is doing the D2 report (aggregated), is it possible that other carriers are reporting for the same client plan?

- Yes, to alleviate reporting burdens, the Departments are allowing multiple entities to report on behalf of a plan, and the overall report is separated into distinct D files to facilitate multiple submissions. This would allow a plan with medical benefits through one insurer to have their medical spending files submitted by that insurer, while the plan's separate PBM can submit the pharmacy files on behalf of the plan.
- If a Client offers multiple plans through different insurers, each insurer will likely submit the report for the applicable plan offered through that insurer. Because each D file submission must be accompanied by the applicable P file, detailing the plan's information, the submissions will be appropriately tied back to the correct plan and client.

20. How will Cigna be handling assisting clients with the narrative response? What sections will you be supporting based on lines of business?

- Cigna intends to complete each narrative section with any D file that Cigna is submitting on behalf of the client.
- Narrative responses we submit will apply to our book of business (aggregation of clients) rather than applying to a specific client.
- Due to the broad applicability, we are not making draft or final versions of narrative responses available to clients.

21. What is Cigna's reporting for clients who have pharmacy benefits carved out to another PBM?

- Cigna will submit the relevant Plan file and D1-D2 files for clients who have medical with Cigna, but Pharmacy carved out to another carrier.
- Clients should reach out to their PBM for D3-D8 reports, as applicable.

22. Will the reports include specialty pharmacy benefits that are covered under the medical benefit?

Pharmacy benefits that are covered under the medical benefit will be reported in the medical spending file (D2), as required.

23. Is there additional detail about the specifics within the required reports?

For details on what is required within the medical and Rx spending report, please see:
Prescription Drug Data Collection (RxDC) | CMS

24. What Plan Names/Numbers will Cigna submit in the P2 report?

- Plan Names/Numbers we submit will be unique to the client's coverage with Cigna, not something that would match to what another carrier for the same client would submit for the separate coverage.
- Other carriers and the client should work together to determine what client identifiers to use for their non-Cigna reporting.

25. What does the government intend to do with this reporting?

The primary intent of the data collection is to provide valuable information to policy makers about competition and market concentration in the pharmaceutical and health care industries. The collected data will be used in a report published on the HHS website 18 months after initial data submission, and then every two years thereafter; the report will offer information on prescription drug pricing trends and employer contributions to health insurance premiums.

26. Is there standard language in the contract between Cigna and the client that acknowledges that Cigna will submit the required CAA Section 204 report on the client's behalf?

CGHB will be adding language to our fully insured Certificate documents in mid-2023, which aligns with our annual language filing schedule. This language cannot be modified, as it is part of our filing with the state. The filed language will appear in the Certificate as follows:

- Subject to change based on government guidance for CAA Section 204, Cigna will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D2) for and Employer without integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.
- ASO clients should reach out to their CGHB Client Manager for questions regarding contract language.

27. Are there other details we should know?

- Multiple types of reporting entities will be allowed to submit the required information to provide plans/issuers with flexibility and to reduce administrative burden.
- The Office of Personnel Management is extending the reporting requirements and applicability dates to Federal Employees Health Benefit carriers.

Together, all the way.®

Cigna®