Instruction to Complete the Consolidated Appropriations Act (CAA)

Section 204 Pharmacy Reporting Survey

Important Reporting Requirement for Group Health Plans and Insurance Issuers

As required by Section 204 of the Consolidated Appropriations Act (CAA), group health plans and health insurance issuers must submit annual data to the federal government. To fulfill this requirement, we kindly request that you **complete an online survey by March 15th, 2025**. The submitted data will be compiled and sent to the Centers for Medicare and Medicaid Services (CMS) by June 1st, 2025.

To facilitate this process, we have created three distinct surveys tailored to your specific group type: Fully Insured, MPP, and ASO/Self-Insured groups. You will receive an email with a unique link to access your designated survey. The survey will contain pre-populated information that we ask you to review and confirm. If any information is incorrect, you will have the opportunity to update it with the correct details.

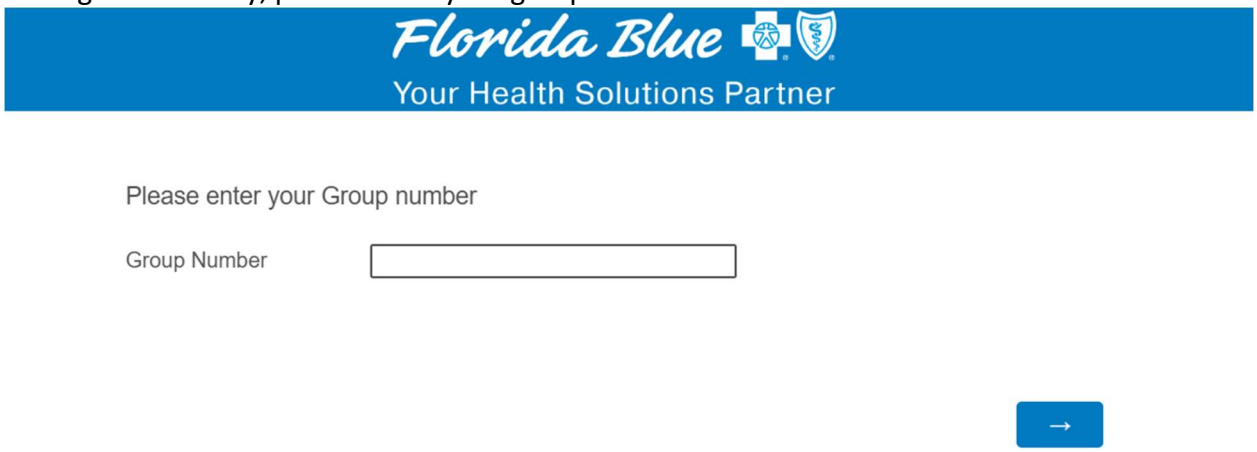
The instructions for completing the survey are below:

Fully Insured Group or MPP Group

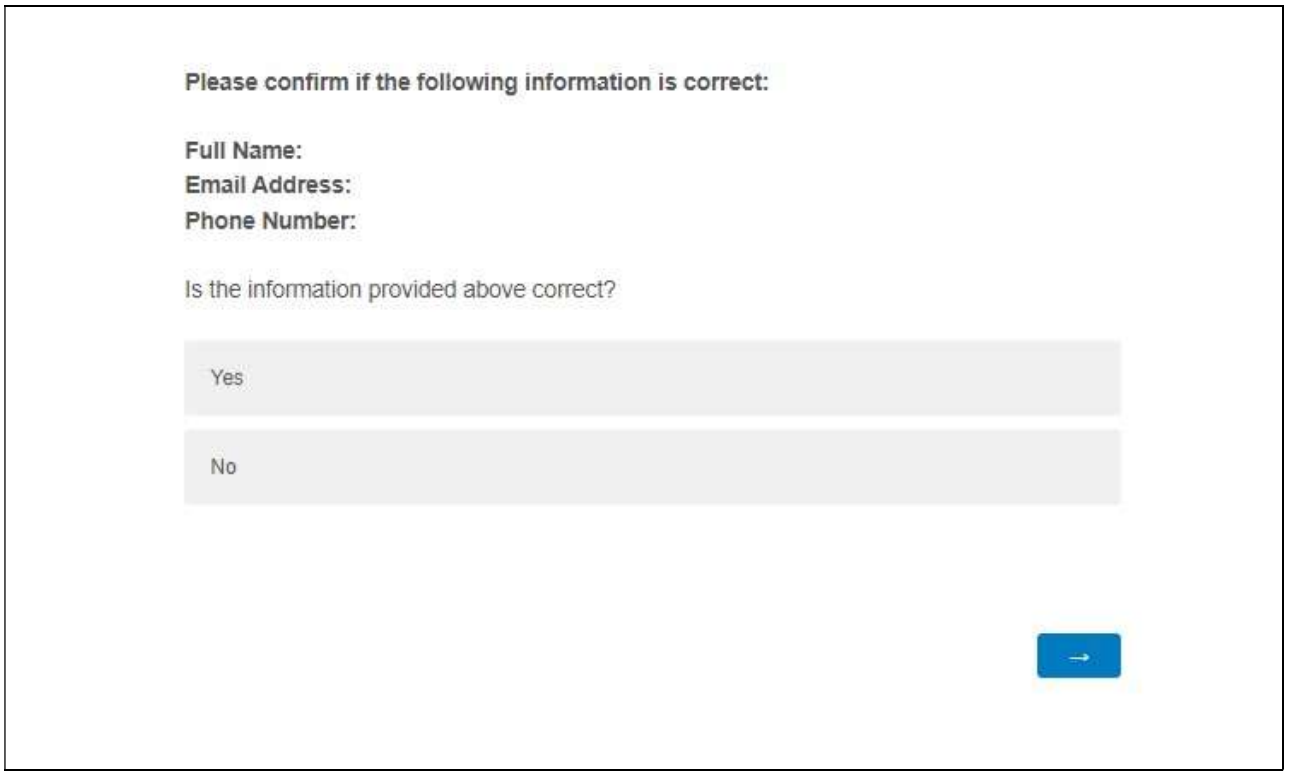
If you have a **Fully Insured Group or a MPP Group**, you will receive an email containing a unique link to your designated survey. Simply click on this link to access the first page of your survey, where you can begin the reporting process.

Completing the Survey:

1. To begin the survey, please enter your group number.

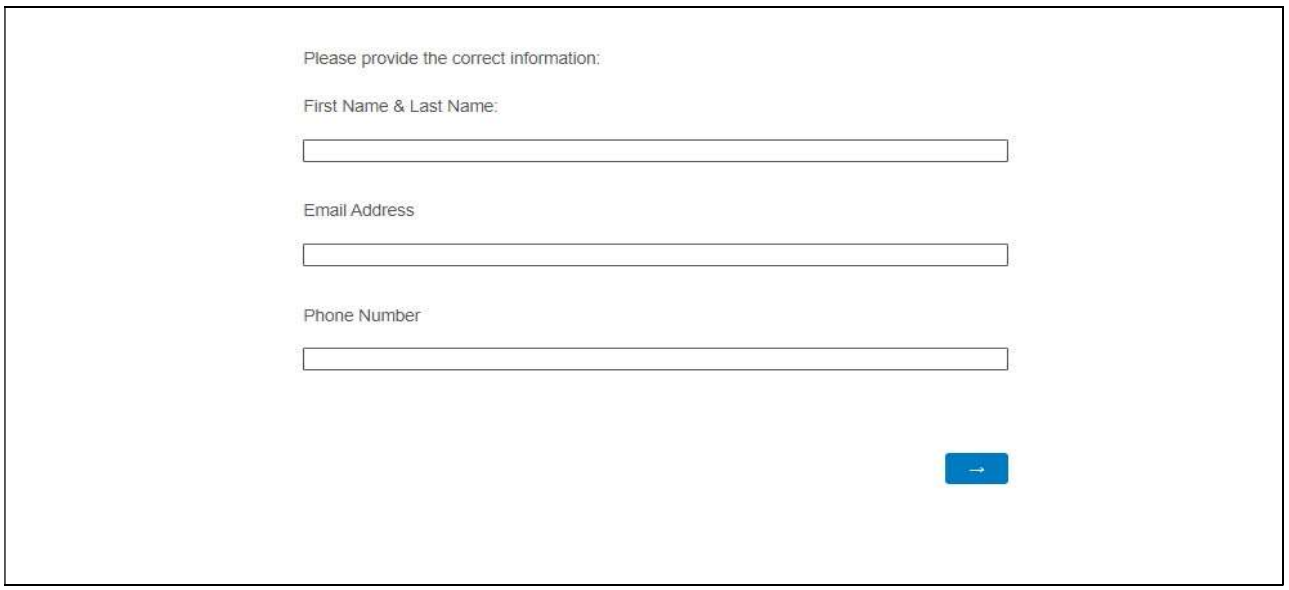


2. The first page of the survey will list the following:
    a. First Name & Last Name:
    b. Email Address
    c. Phone Number
3. These fields will be prefilled with the current information we have on file. Please click **YES** if the information is correct or **NO** if the information is not correct.
    a. If information is correct, it will take you to the next screen.
    b. If information is not correct, the fields will be editable for you to put in the correct information.



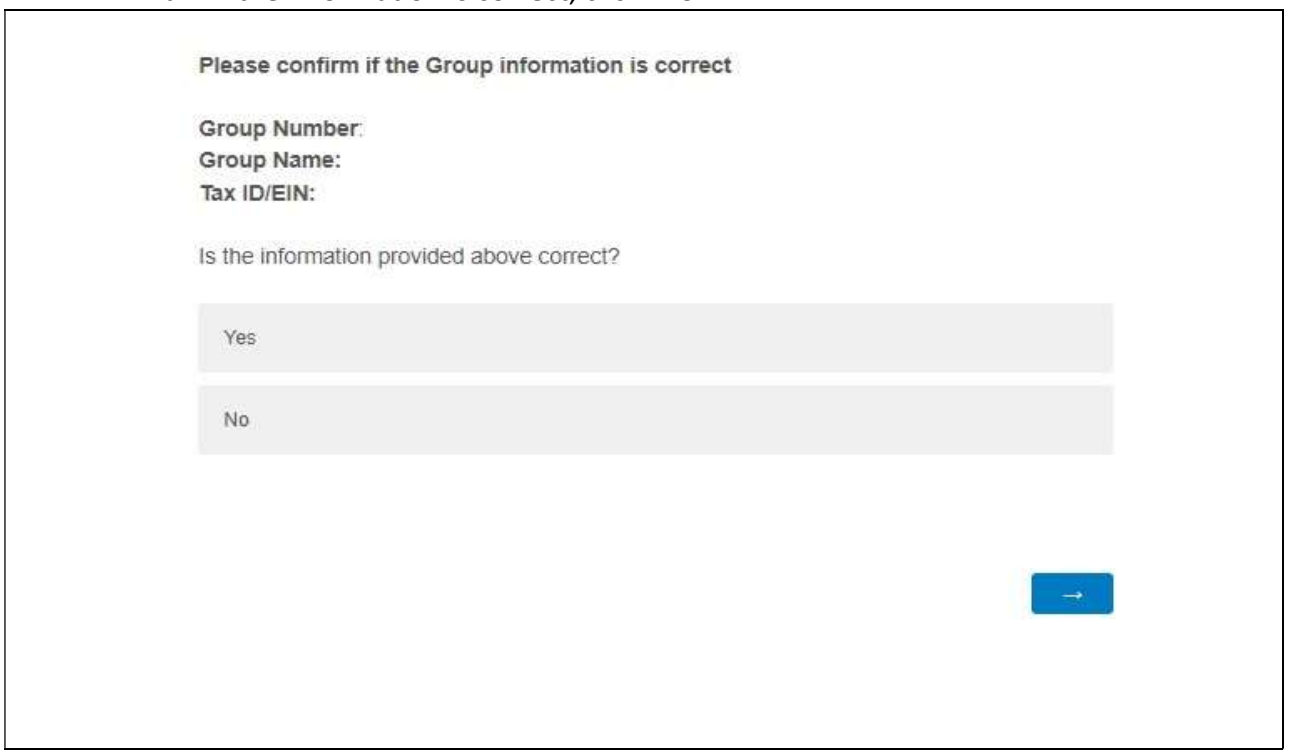
If the information is correct, click **YES** and click on the arrow button to go to the next screen.

If the information listed is not correct, click on **NO** and select the arrow to go to the next screen. Please complete the correct information in the text fields. The email must contain "@" and ".com" and the phone number must follow this format: XXX-XXX-XXXX.



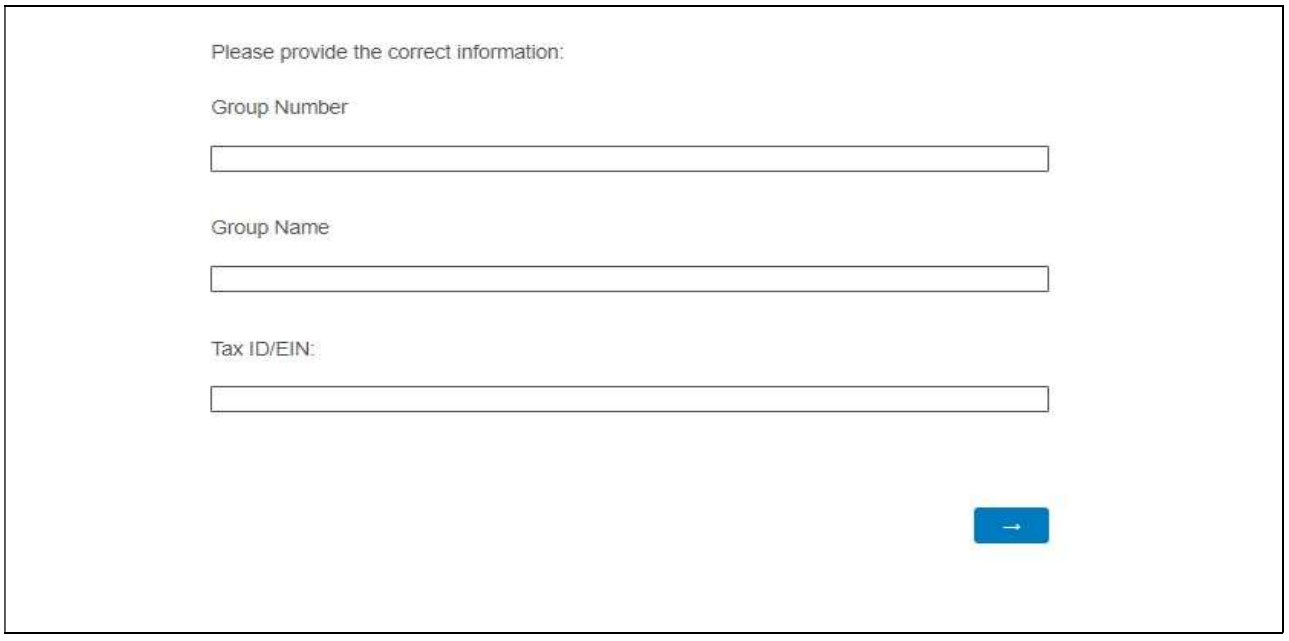
4. The next screen will show the prepopulated fields for Group Name, Group Number, and Tax ID/EIN.

    a. If the information is correct, click **YES**

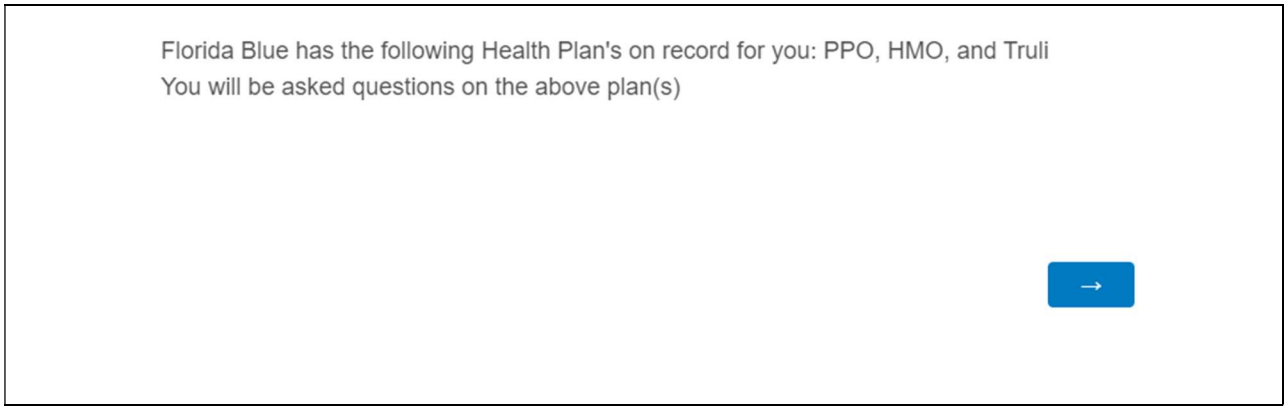


    b. If incorrect, click **NO**

    c. Please fill in the correct information in the available fields



5. On the next screen the health plans that Florida Blue has on record for your group will be displayed. For **Fully Insured**, the choices are PPO – Florida Blue, HMO – Health Options or HMO - Truli. For **MPP Groups**, the choices are PPO – Florida Blue and/or HMO – Health Options.



6. Once the plans have been provided, please complete the following fields for **each plan**:

    a. Please provide the total premium paid for XXX Plan by **EMPLOYEE** in the 2024 calendar year.

    b. Please provide the total premium paid for XXX Plan by **EMPLOYER** in the 2024 calendar year.

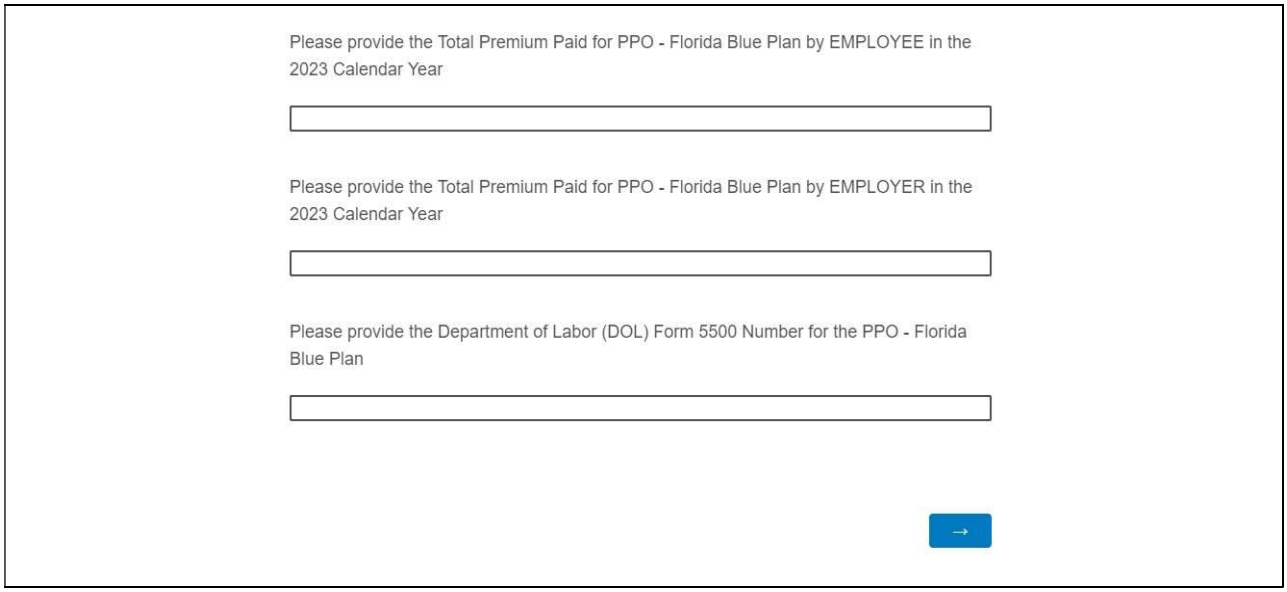
    c. Please provide the **Department of Labor (DOL) form 5500 number** for the XXX Plan.

Please Note: Premium amounts should be in the 000.00 format. Do not add any dollar signs.

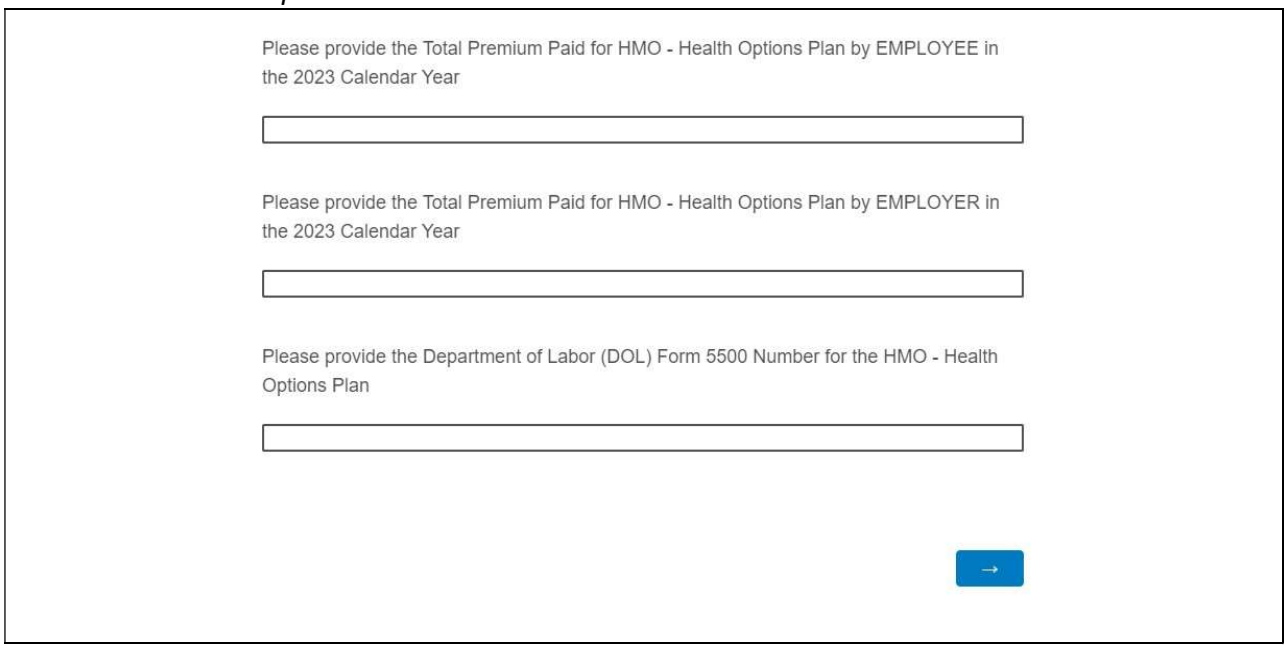
Depending on how many plans your group has, there will be a screen asking the same questions for each plan. It might seem like the screens are duplicated, but the plan type will be displayed in each question.

For example, if your group has more than one plan such as a PPO and an HMO, the following screens would appear:

For PPO – Florida Blue Plan



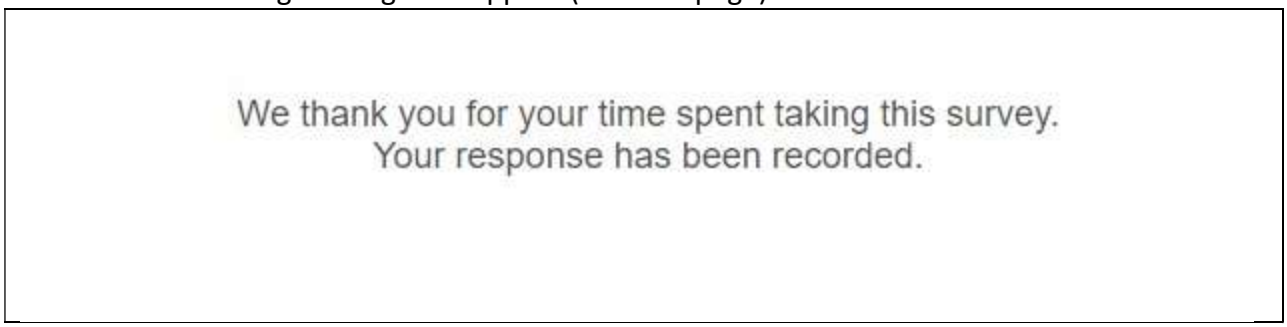
For HMO – Health Options Plan



Please Note: Premium amounts should be in the 000.00 format. Do not add any dollar signs.

If your group had a Truli plan, a screen would also appear. The screens will appear only for the plans that your group has.

7. Once completed, click on the arrow button at the bottom right to submit the survey. The following message will appear (see next page):



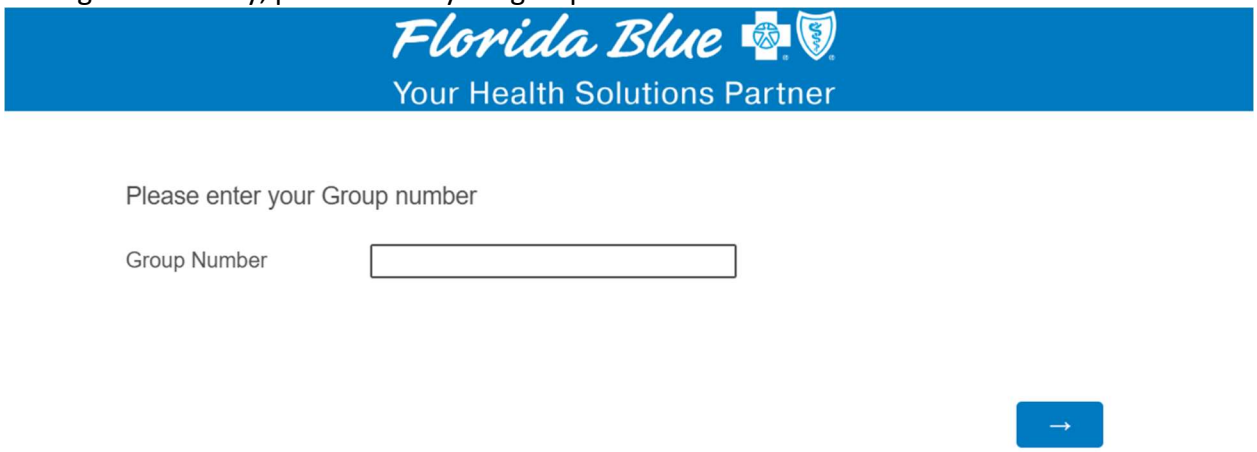
You will have the option to download your answers to a .pdf file for your records. An email confirmation will also be sent.

ASO/Self Insured Group

If you have a **ASO/Self Insured Group**, you will receive an email containing a unique link to your designated survey. Simply click on this link to access the first page of your survey, where you can begin the reporting process.

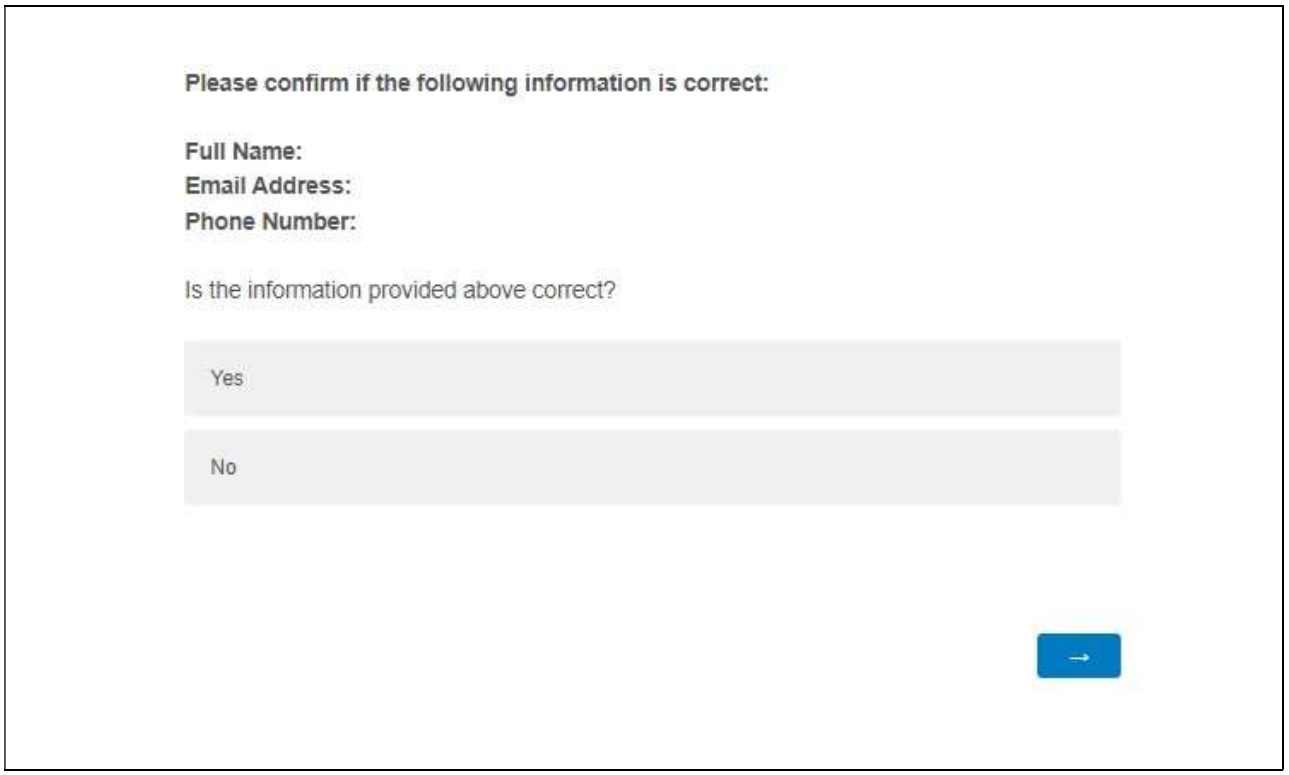
Completing the Survey:

1. To begin the survey, please enter your group number.

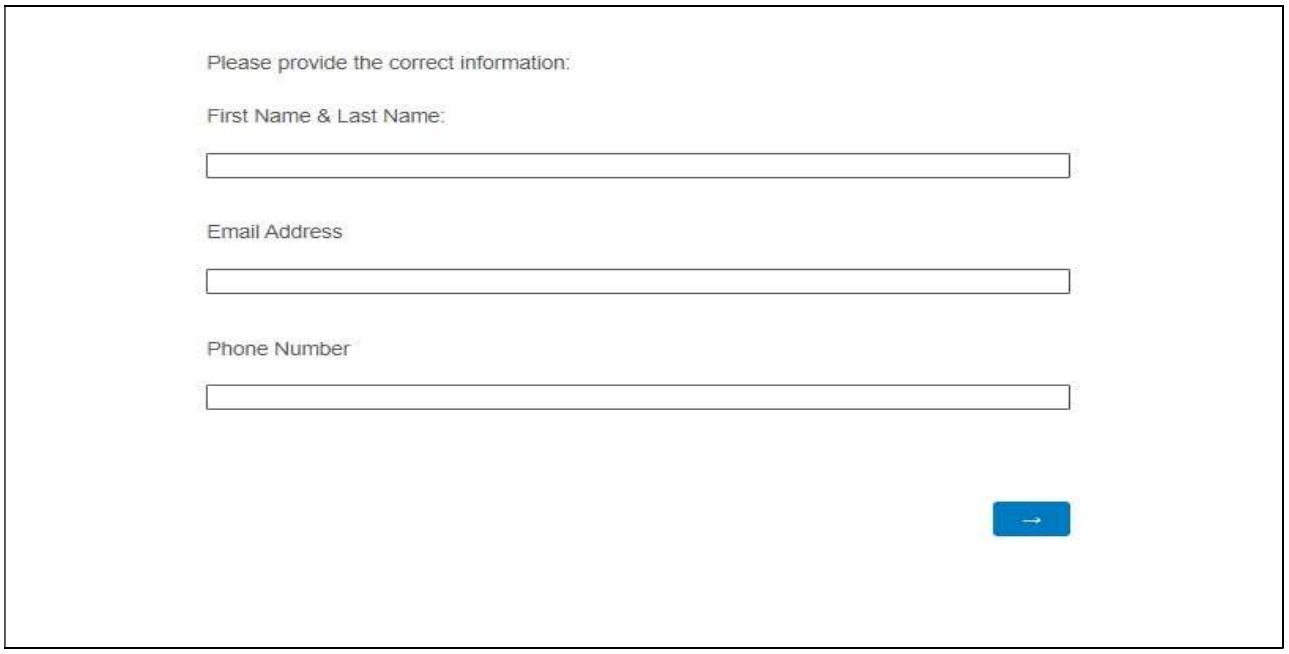


2. The first page of the survey will list the following:
    a. First Name & Last Name:
    b. Email Address
    c. Phone Number
3. These fields will be prefilled with the current information we have on file. Please click **YES** if the information is correct or **NO** if the information is not correct.
    a. If information is correct, it will take you to the next screen.
    b. If information is not correct, the fields will be available for you to put in the correct information.

4. If the information is correct, click **YES** and click on the arrow button to go to the next screen.

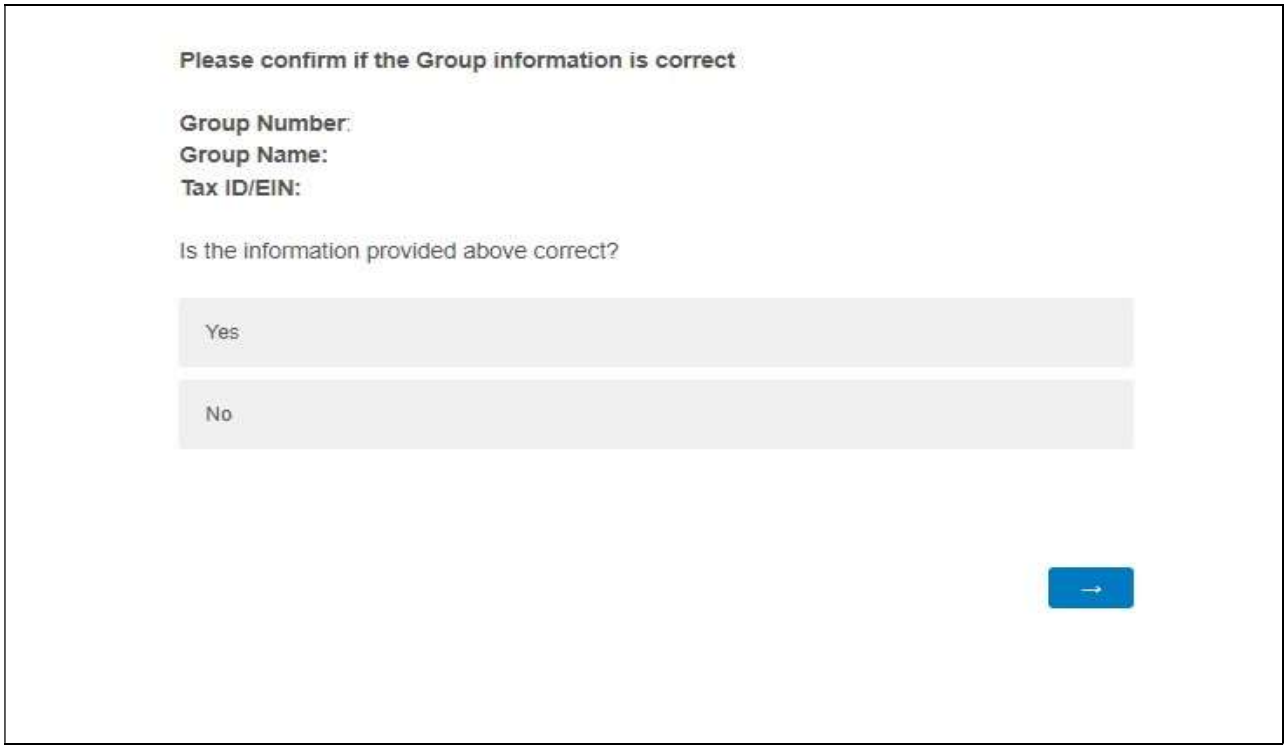


If the information listed is not correct, click on **NO** and select the arrow to go to the next screen. Please provide the correct information in the text fields. Example is on the next page.



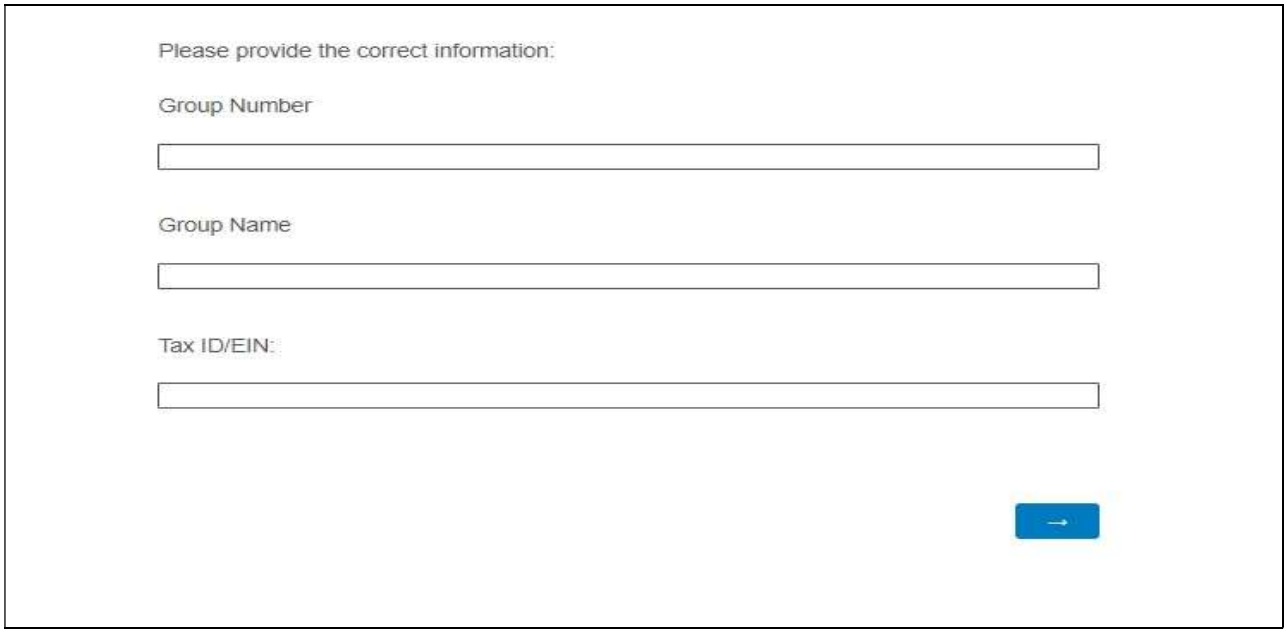
5. The next screen will show the prepopulated fields for Group Name, Group Number TaxID/EIN.

   c. If correct, click **YES**

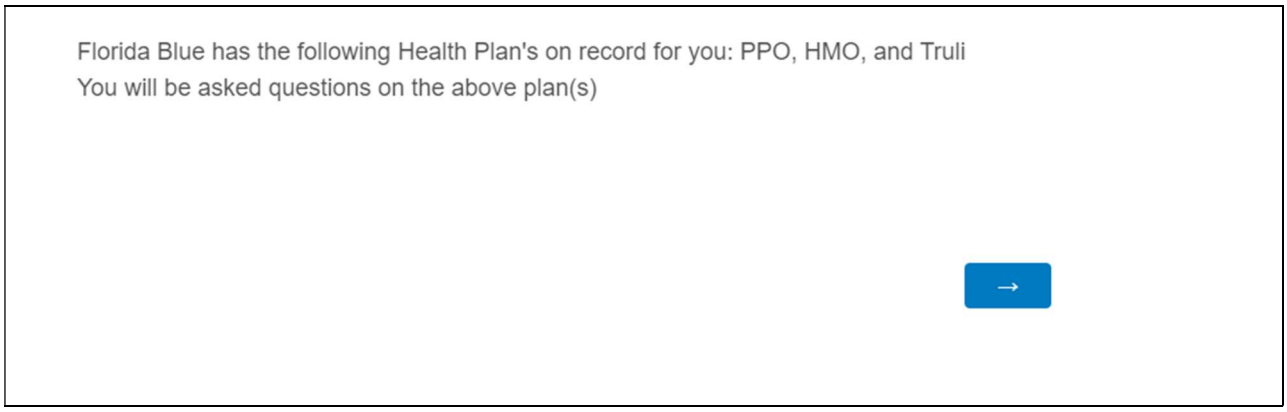


   d. If incorrect, click **NO**

   e. Please fill in the correct information in the available fields



On the next screen the health plans that Florida Blue has on record for your group will be displayed. For **ASO/Self-Insured** the choices are PPO – Florida Blue, HMO – Health Options or HMO – Truli



6. Once the plans have been provided, please complete the following fields for each plan:

    f. Please provide the total premium paid for XXX Plan by EMPLOYEE in the 2024 calendar year.

    g. Please provide the total premium paid for XXX Plan by EMPLOYER in the 2024 calendar year.

    h. Please provide the Department of Labor (DOL) form 5500 number for the XXX Plan.

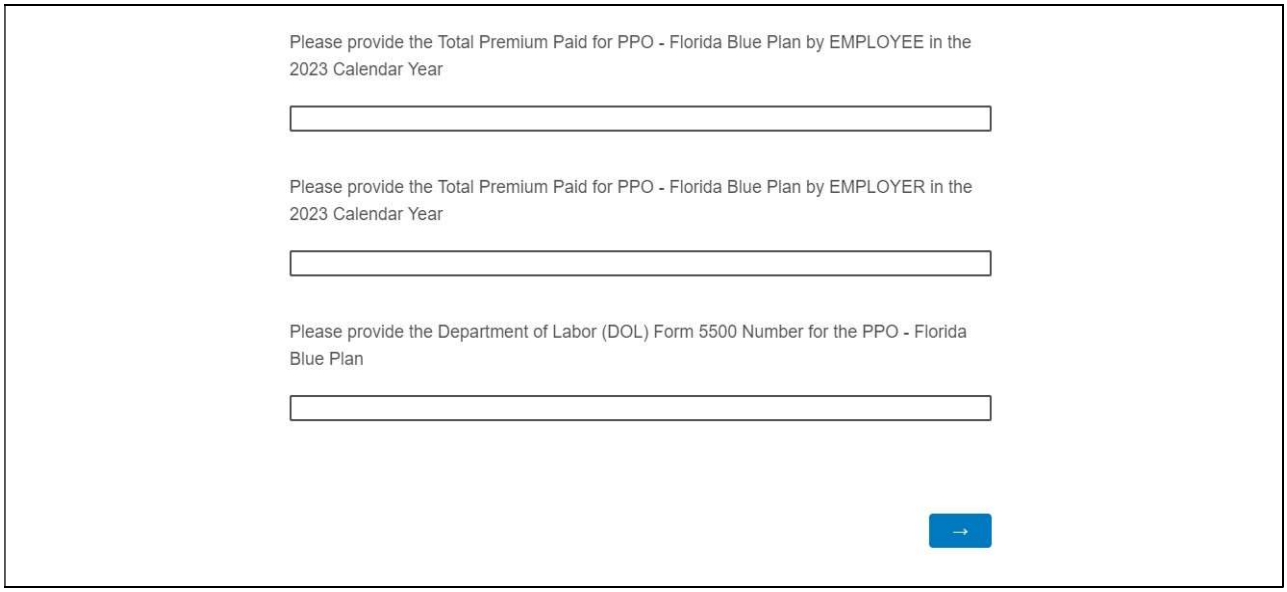
    Please Note: Premium amounts should be in the 000.00 format. Do not add any dollar signs.

Please Note: Premium amounts should be in the 000.00 format. Do not add any dollar signs.

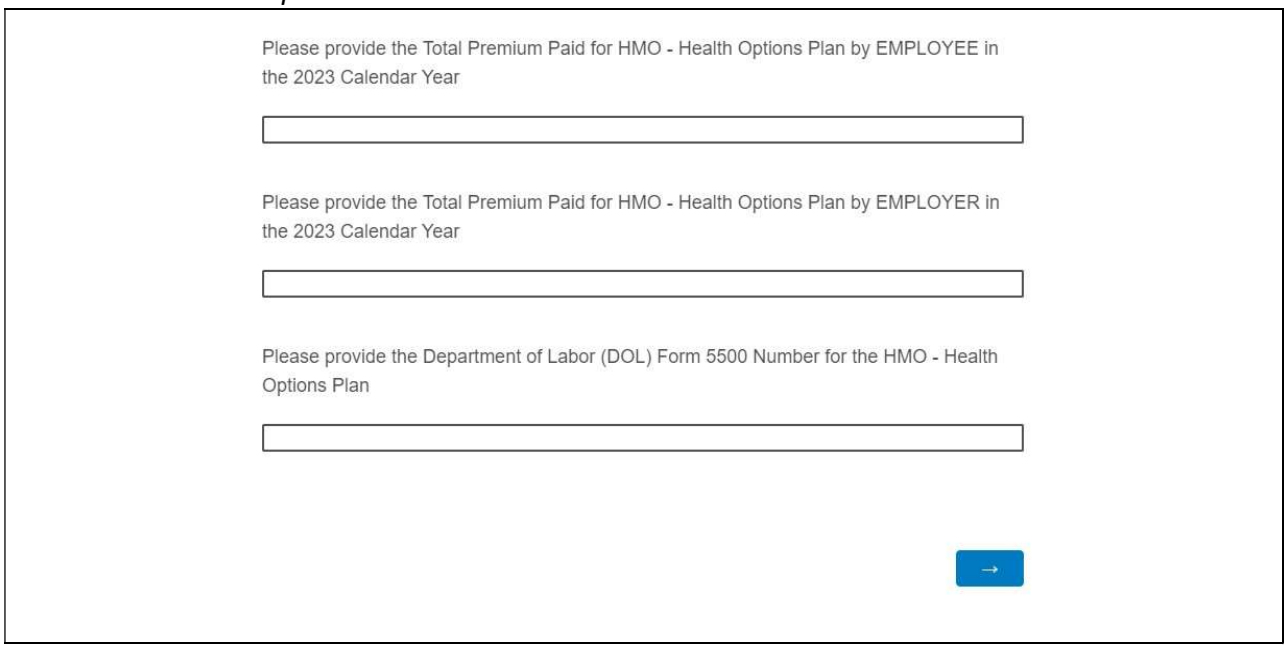
Depending on how many plans your group has, there will be a screen asking the same questions for each plan. It might seem like the screens are duplicated, but the plan type will be displayed in each question.

For example, if your group has more than one plan such as a PPO and an HMO, the following screens would appear:

For PPO – Florida Blue Plan



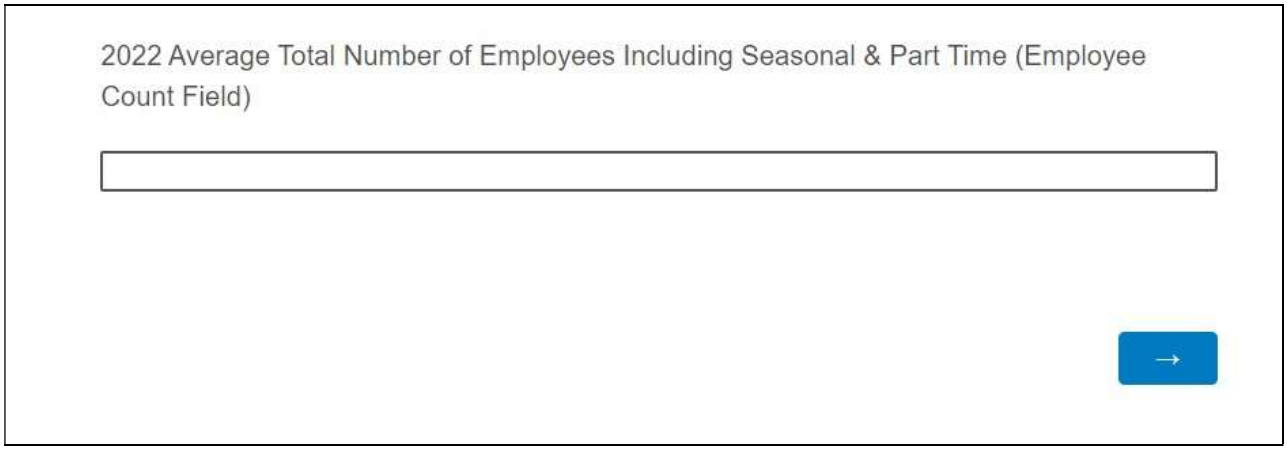
For HMO – Health Options Plan



Please Note: Premium amounts should be in the 000.00 format. Do not add any dollar signs.

If your group had a Truli plan, a screen would also appear. The screens will appear only for the plans that your group has.

7. On the next screen, provide the Employee Count Field which includes the Average Total Number of Employees Including Seasonal, Part Time, and Retirees/COBRA during their months of Active service. Click on the blue arrow to proceed.

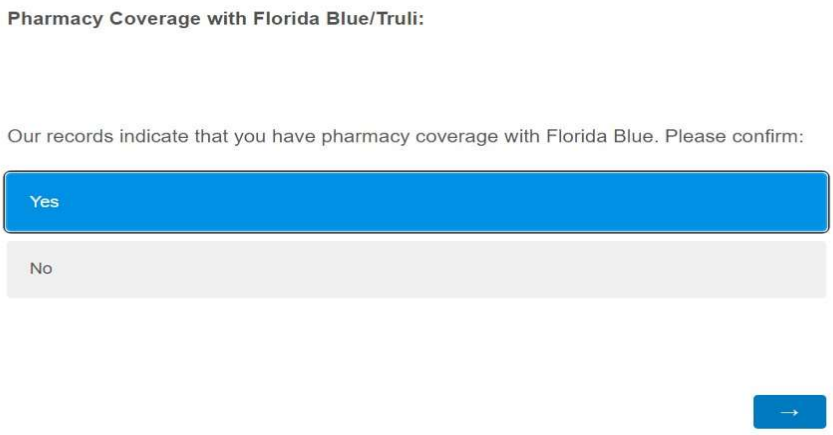


8. On the next screen, the pharmacy coverage information for your group will be prepopulated with the information on your group. You will receive **one** of the following messages:

- "Our records indicate that **you have** pharmacy coverage with Florida Blue".

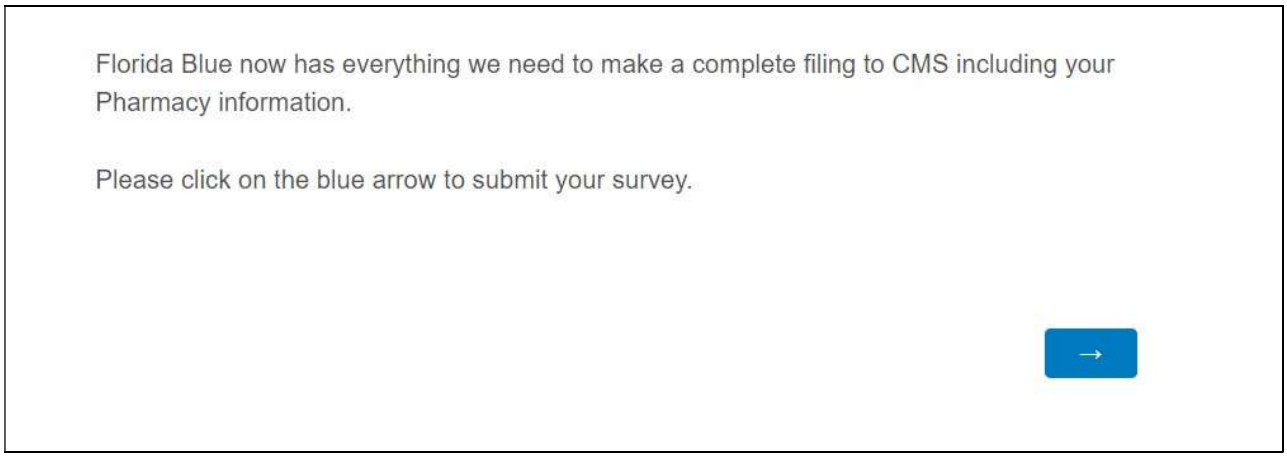
- "Our records indicate that **you do not have** pharmacy coverage with Florida Blue".

Please review your pharmacy coverage message and confirm if the information is correct. An example screen is below:

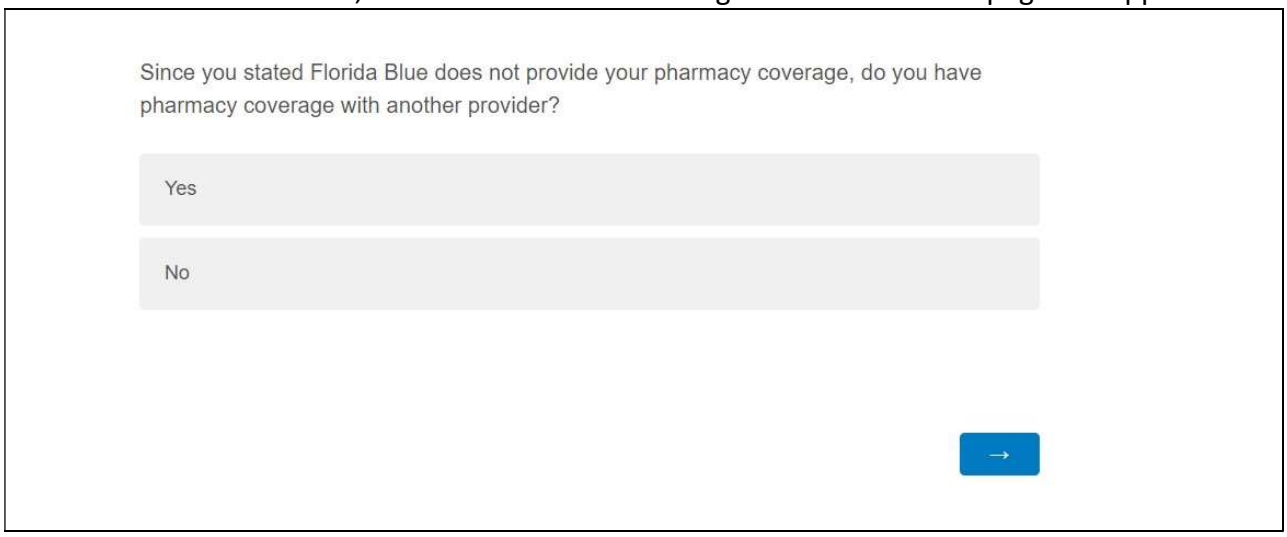


If The Message Stated Your Group Has Pharmacy Coverage:

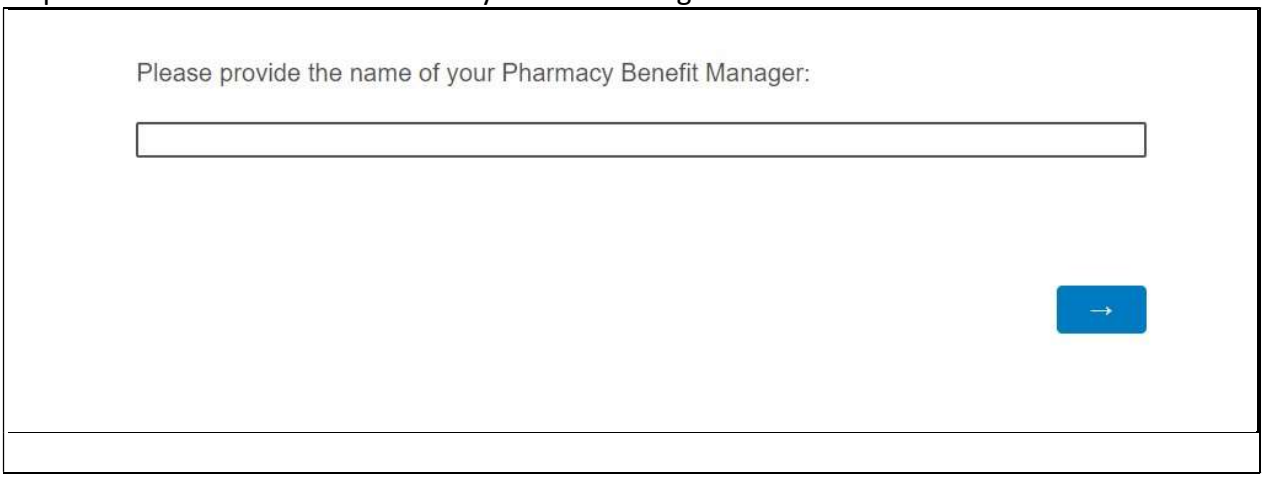
If you receive the message that you **do** have coverage and you have confirmed that the information is correct, then Florida Blue has everything they need to make a complete filing to CMS including the Pharmacy information. You will receive the following message:



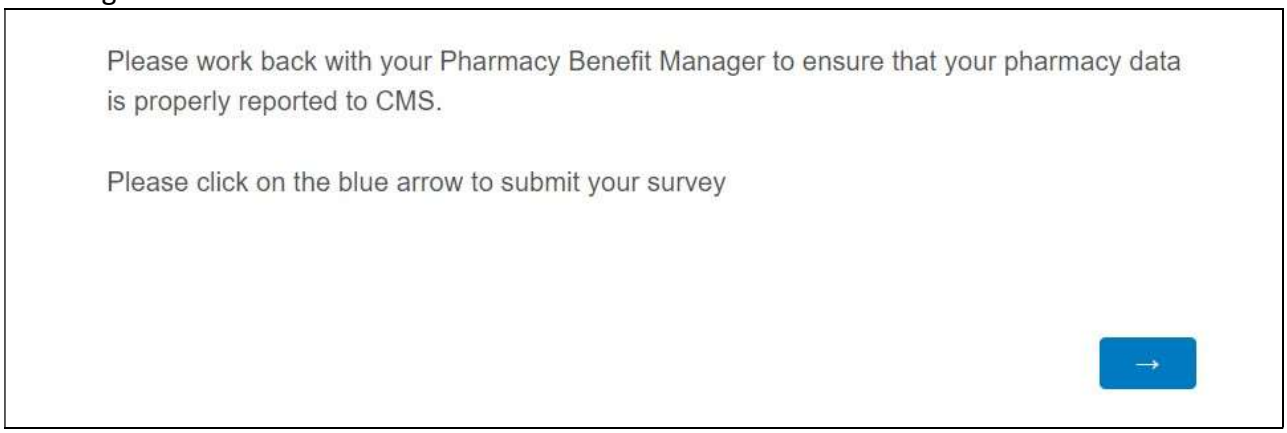
a. If you received the message that you do have coverage and you have confirmed that the information **is not** correct, select **NO** and the following screen on the next page will appear.



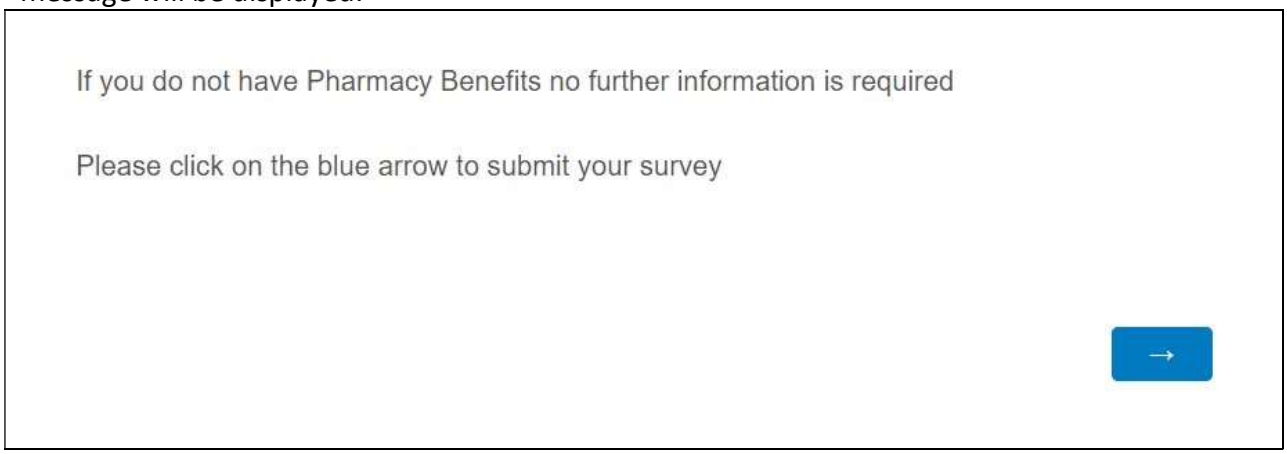
b. If **YES** is selected to having pharmacy coverage with another provider, then you will be asked to provide the name of the Pharmacy Benefit Manager.



c. Once the Pharmacy Benefit Manager is entered, the next screen will display the following message:



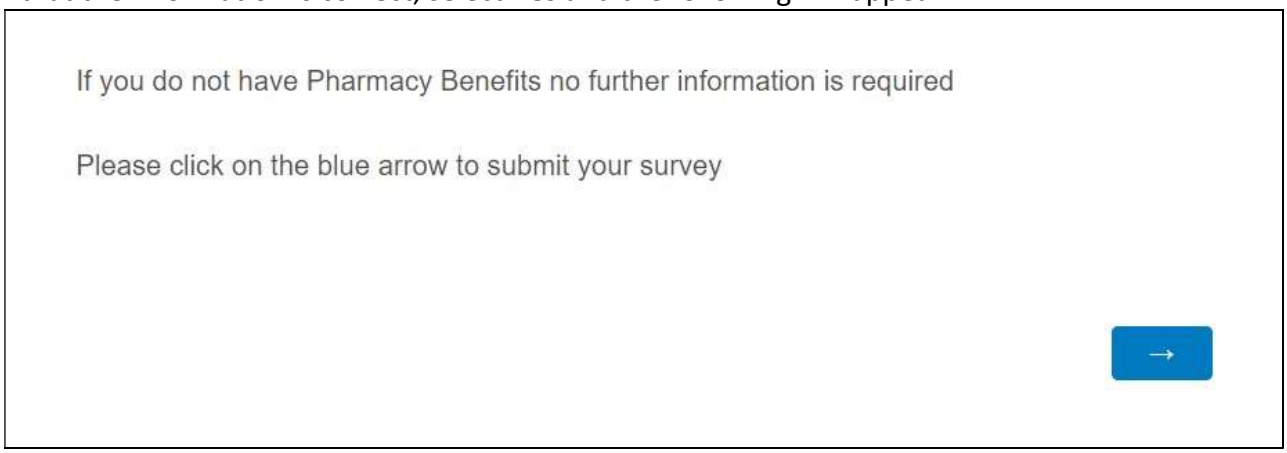
d. If **No** is selected to having pharmacy coverage with another provider, then the following message will be displayed:



9. The following message will confirm that the survey has been recorded and submitted.

You will have the option to download your answers to a .pdf file for your records. An email confirmation will also be sent.

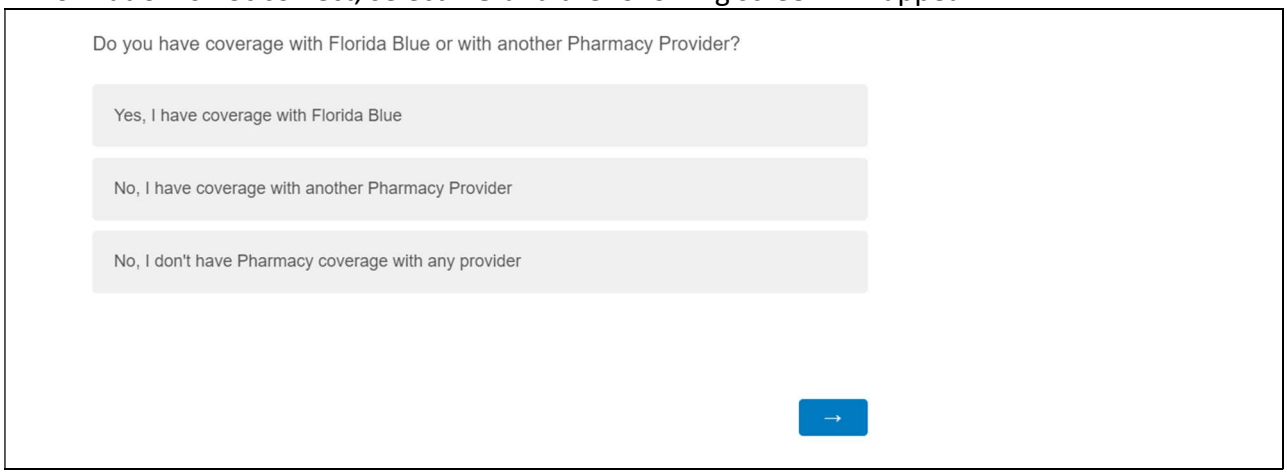
If The Message Stated Your Group Does Not Have Pharmacy Coverage:
If you received the message that you do **Not** have Pharmacy coverage and you have confirmed that the information is correct, select **Yes** and the following will appear.



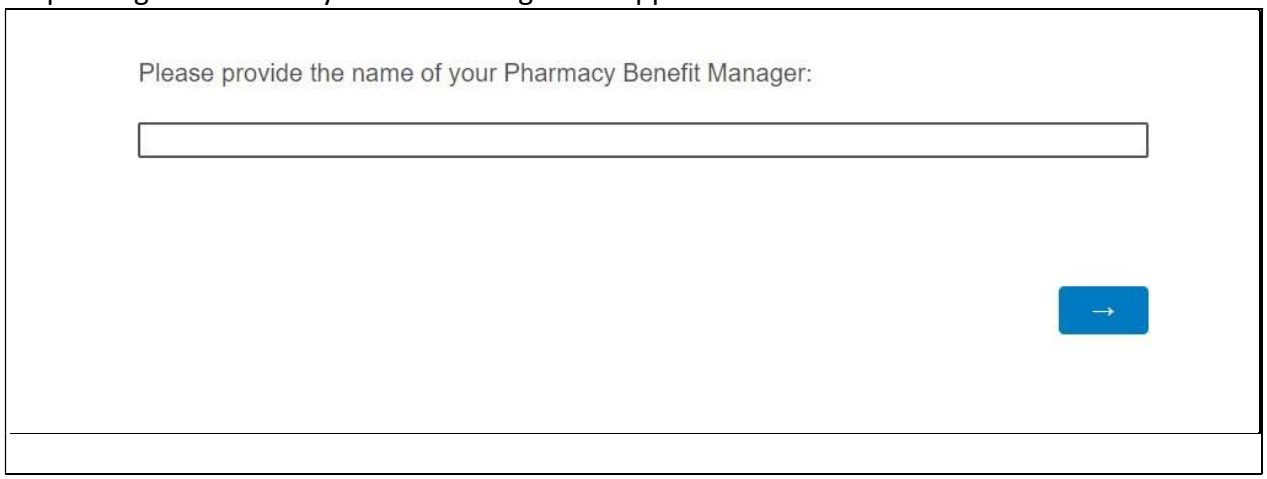
The following message will confirm that the survey has been recorded and submitted.

<u>You will have the option to download your answers to a .pdf file for your records. An email confirmation will also be sent.</u>

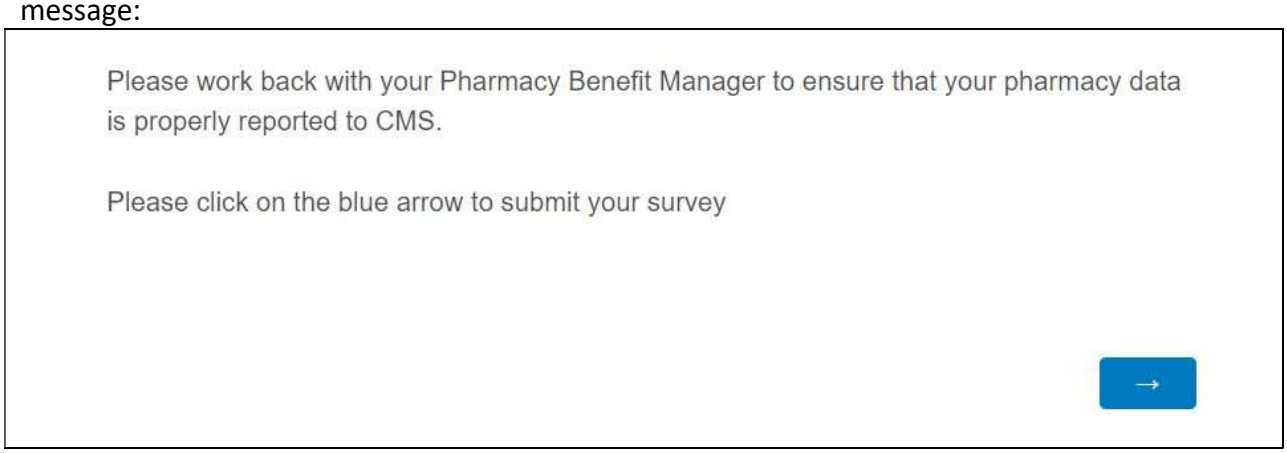
If you received the message that you do **Not** have coverage and you have confirmed that the information is **not** correct, select **NO** and the following screen will appear.



If **Yes** is selected to having pharmacy coverage with another provider, then the following screen requesting the Pharmacy Benefit Manager will appear:



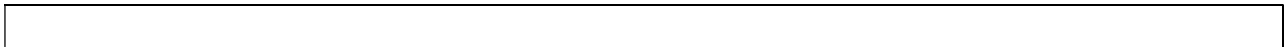
Once the Pharmacy Benefit Manager is entered, the next screen will display the following message:

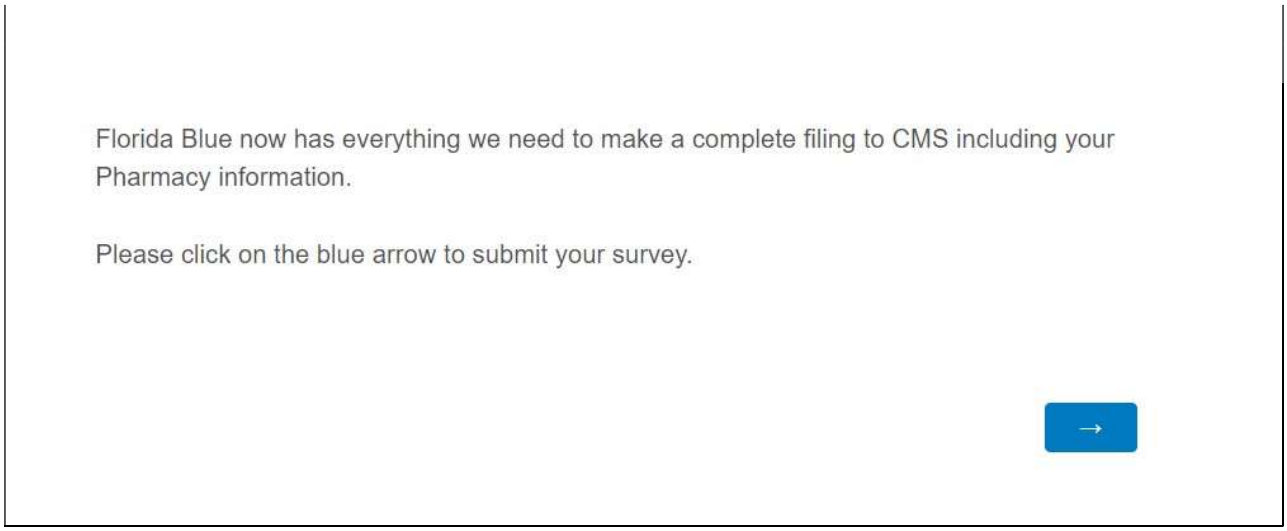


The following message will confirm that the survey has been recorded and submitted.

If you select:

- **Yes**, I have Coverage with Florida Blue, the following screen will appear.

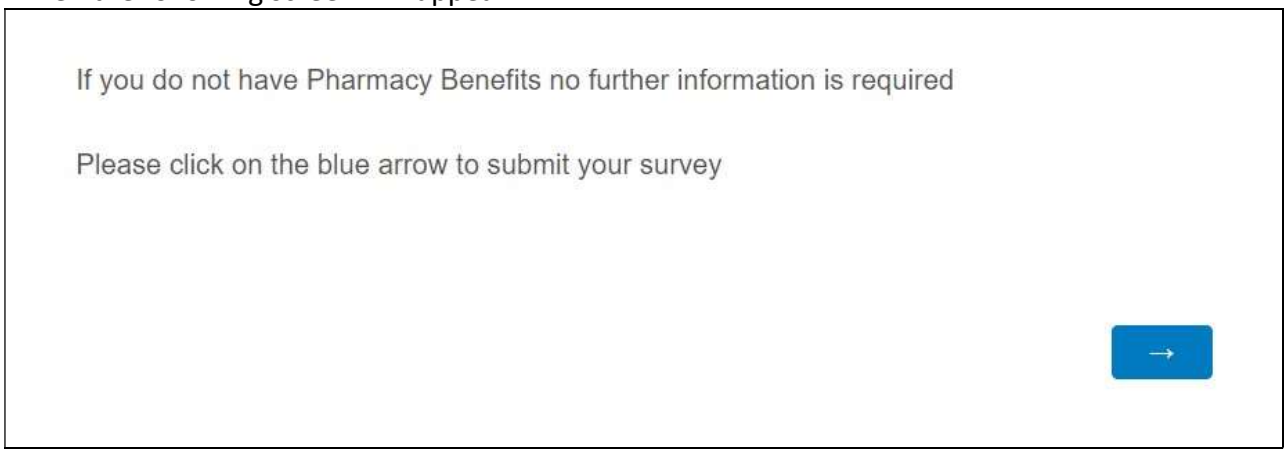




If you select:

- **No**, I don't have coverage with any provider

Then the following screen will appear:



The following message will confirm that the survey has been recorded and submitted.