EPIC
Insurance Brokers & Consultants

EPIC 2023 Compliance Series

Gag Clause Prohibition Attestations and Other Updates

7/20/2023

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Presenters

Liz Mann, EPIC Director of Compliance
Liz Mann is EPIC's Internal Compliance Director. Liz and her team are responsible for disseminating information to clients about changing requirements and regulations and reviewing all plan designs and programs for compliance with Federal and State regulations. Liz is embedded into our account management team to provide timely support and guidance as ERISA-related regulations or concerns emerge in the marketplace. As a client, you have the option of directly accessing Liz or accessing her traditionally through your account team. Liz graduated Magna Cum Laude from Saint Mary's College in Notre Dame, IN with Bachelor of Arts degrees in History and French. She graduated with her law degree from University of Toledo, College of Law in Toledo Ohio in 2007. She has accumulated over 14 years of experience working in employee benefits and offers expertise in ERISA, IRS, COBRA, FMLA and ACA compliance.

Andreena Norfleet, EPIC Compliance Consultant
Andreena Norfleet is EPIC's Internal Compliance Consultant. Andreena assists clients by providing updates with the latest news from State and Federal regulators as well as reviewing plan designs for compliance. Andreena Norfleet is a double Panther - graduating magna cum laude from Georgia State University with a Bachelor of Arts degree and in 2022, she obtained her law degree from Georgia State University College of Law. Prior to law school, Andreena managed a private urgent care clinic with 3 locations across the metro-Atlanta area, overseeing the company's compliance and revenue-cycle management departments.

Agenda

Gag Clause Prohibition Attestations

Changes on the Horizon:

- End of COVID-19 HDHP Relief
- Proposed Rules for Short Term Limited Duration Insurance and Fixed Indemnity Programs
- FAQ 60 – Additional Guidance for NSA
- Updates on Reproductive Healthcare
- Proposed Bills for ACA Reporting
- Proposed Bills on PBM Transparency

Questions?

Gag Clause Prohibition Attestations

Background

Effective December 27, 2020, group health plans and health insurance carriers are prohibited from entering into agreements with health care providers, TPAs or other vendors that have access to healthcare providers or networks of providers containing gag clauses. Starting December 31, 2023, group health plans and insurance carriers must attest to compliance with this requirement.

Who does this apply to?

- Insurance carriers providing individual and group plans
- Group health plans covered by ERISA including grandfathered plans
- Non-federal government health plans
- Church plans

Who does this not apply to?

- Account based plans and short-term limited duration plans
- Excepted benefits and carriers that provide them
- Medicare and Medicaid

What is a Gag Clause?

A gag clause is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party.

Might exist in agreements between the plan and:

- A health care provider
- A network or association of providers
- A third-party administrator (TPA)
- Another service provider offering access to a network of providers (PBM)

What is Prohibited by the CAA?

- Restrictions on disclosures of provider-specific cost or quality of care information to referring providers, plan sponsors or participants
- Restrictions on electronic access to de-identified claims and encounter information for each participant consistent with HIPAA, GINA and the ADA
  - Provider financial information such as allowed amounts
  - Provider information, including name and clinical designation
  - Service codes
  - Other data included in claims
- Restrictions on sharing information or data described above with a business associate

Employers need review agreements with vendors such as insurance carriers, TPAs and PBMs to ensure that these agreements do not include provisions designed to restrict access to information described above.

What is Prohibited by the CAA?

Providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage.

Electronically accessing de-identified claims and encounter information or data for each participant, beneficiary, or enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the amendments made by the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Americans with Disabilities Act of 1990 (ADA), including, on a per claim basis—

- Financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract.
- Provider information, including name and clinical designation.
- Service codes; or
- Any other data element included in claim or encounter transactions; or

Sharing information or data described in items (1) or (2), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, the amendments made by GINA, and the ADA.

What is Prohibited by the CAA?

Examples

- A contract between a TPA and a group health plan states that the plan will pay providers at rates designated as "Point of Service Rates," but the TPA considers those rates to be proprietary and therefore includes language in the contract stating that the plan may not disclose the rates to participants or beneficiaries. The language prohibiting disclosure would be considered a prohibited gag clause.
- A contract between a TPA and a plan provides that the plan sponsor's access to provider-specific cost and quality of care information is only at the discretion of the TPA. That contractual provision would be considered a prohibited gag clause.

Note that health care provider, network or association of providers, or other service provider may place reasonable restrictions on the public disclosure of this information.

Attestation Requirement

Plans must attest to compliance with the gag clause prohibition requirement by December 31, 2023, and then annually.

- The first attestation will be for plan language dating back to December 27, 2020
- We expect fully insured carriers to attest on behalf of fully insured plans
  - Because fully insured carriers are obligated to submit an attestation on their own behalf, the Departments will consider both the plan and the issuer to have satisfied the attestation submission requirement under the issuer's submission
  - Fully insured plan sponsors are encouraged to reach out to carriers for confirmation
- Self-funded plan sponsors will likely need to complete their own attestation
  - Level of involvement is vendor specific
  - Self-funded plan sponsors are encouraged to reach out to their vendors for more information
- Employer plan sponsors who handle their own agreements will need to provide their own attestation

Information Required to Attest

- Reporting Entity Information
  - Name, FEIN, type of plan, ERISA plan number, address and contact information for representative
- Attester contact Information
- Submitter contact Information
- Types of agreements
  - Medical, pharmacy, other
- Confirmation that the plan's agreements comply with the gag clause prohibition

Sample Attestation Language

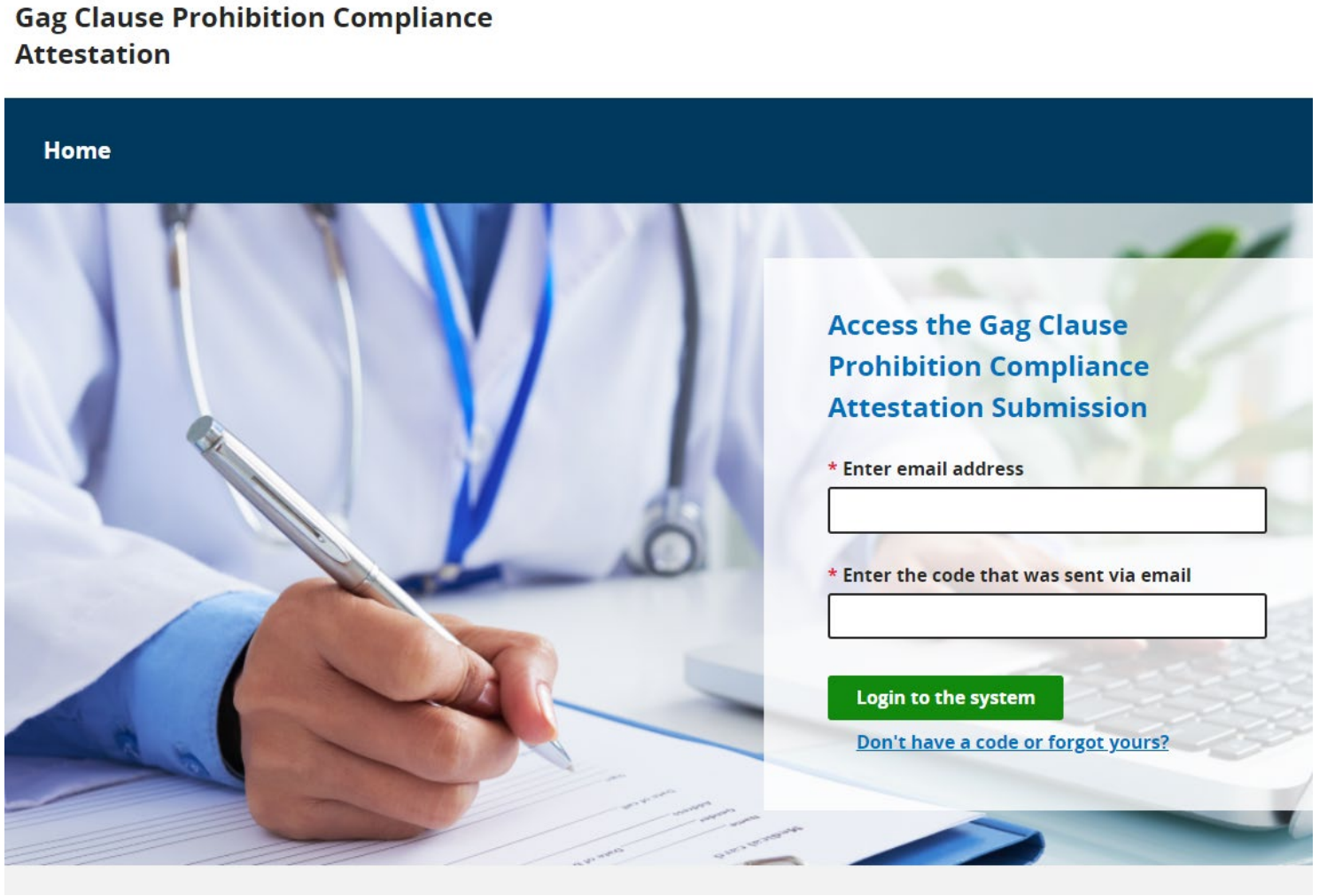
Group health plans, including non-federal governmental plans, and health insurance issuers offering group health insurance coverage

I attest that, in accordance with section 9824(a)(1) of the Internal Revenue Code, section 724(a)(1) of the Employee Retirement Income Security Act, and section 2799A-9(a)(1) of the Public Health Service Act, the group health plan(s) or health insurance issuer(s) offering group health insurance coverage on whose behalf I am signing will not enter into an agreement, and has not, subsequent to December 27, 2020, entered into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would be directly or indirectly restrict the group health plan(s) or health plan(s) or health insurance issuer(s) from—

1. Providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage.
2. Electronically accessing de-identified claims and encounter information or data for each participant, beneficiary, or enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the amendments made by the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Americans with Disabilities Act of 1990 (ADA), including, on a per claim basis—
    a. Financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract.
    b. Provider information, including name and clinical designation.
    c. Service codes; or
    d. Any other data element included in claim or encounter transactions; or
3. Sharing information or data described in items (1) or (2), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, the amendments made by GINA, and the ADA.

I am attesting on behalf of group health plans, including non-federal governmental plans, and health insurance issuers offering group health insurance coverage. (Check box)

Sample Attestation Submission



Sample Attestation Submission

*** Submitter first and last name**

Elizabeth Mann

*** Submitter position title**

HR Benefits Manager

*** Submitter e-mail address**

liz.mann@epicbrokers.com

*** Submitter telephone number**

Enter a phone number in the following format: "(xxx) xxx-xxxx".

(555) 555-5555

*** Submitter employer name**

Art Vandalay Industries

*** By what type of entity are you employed?**

You should select all options that apply. For example, if you work for a health insurance issuer that also functions as a Third-Party Administrator for self-insured ERISA plans, and you are submitting an attestation for the issuer and the self-insured ERISA plans, select both "Health Insurance Issuer" and "Third-Party Administrator." In this example, do not select " ERISA Plan (or sponsor of ERISA plan)." As another example, if you are work for a Pharmacy Benefits Manager and you are submitting an attestation on behalf of an issuer with respect to the issuer's pharmacy benefits, select "Pharmacy Benefit Manager." In this example, do not select "Health Insurance Issuer." If you work for a health insurance issuer that is attesting on behalf of a fully-insured group health plan, select "Health insurance issuer." Do not select the applicable type of group health plan. If you work for a plan or issuer that is attesting on its own behalf, select either "Health Insurance Issuer" or the applicable type of group health plan.

- [x] GHP
- [ ] Issuer
- [ ] Third-party administrator
- [ ] Pharmacy benefit manager
- [ ] Behavioral health manager
- [ ] Other third-party service provider

Sample Attestation Submission

2 Enter the Attester's Contact Information

Enter the Attester's name and contact information. This should be the person who will electronically sign the attestation and has the legal authority to attest for or on behalf of the Reporting Entity(ies). In some cases, the Attester and the Submitter are the same person. If they are, select the checkbox below.

☑ Submitter is the same as the Attester

*** Attester first and last name**

Elizabeth Mann

*** Attester position title**

HR Benefits Manager

*** Attester e-mail address**

liz.mann@epicbrokers.com

*** Attester phone number**

Enter a phone number in the following format: "(xxx) xxx-xxxx".

(555) 555-5555

*** Attesting entity (attester's employer)**

Art Vandalay Industries

Sample Attestation Submission

3 Enter Reporting Entity Details

If you are submitting on behalf of more than one plan or one issuer, select Yes.

- ○ Yes
- ◉ No

Entity/organization details

Please add the entity details for the entity you are submitting this attestation on behalf of.

Note: If you are submitting on behalf of yourself, the entity details you enter will need to represent your entity.

All fields are required unless marked as optional.

Entity/Organization Details

Please add the entity details for the entity you are submitting this attestation on behalf of.

Note: If you are submitting on behalf of yourself, the entity details you enter will need to represent your entity.

*** Name of the reporting entity**

Art Vandalay Industries

Reporting entity type

ERISA Plan (or sponsor of ERISA Plan)

*** Name of reporting entity point-of-contact**

George Costanza

*** Employer identification number**

123456789

*** Plan number**

This only applies if you are an ERISA plan.

501

*** Mailing address for the reporting entity**

123 Main street AnyTown ST 12345

*** E-mail address for the reporting entity point-of-contact**

georgecostanza@artvandalay.com

*** Phone number for the reporting entity point-of-contact**

Enter a phone number in the following format: "(xxx) xxx-xxxx".

(555) 555-5555

Sample Attestation Submission

*** Are you attesting for all provider agreements?**

Medical, PB, BHN, Other

- ○ Yes
- ◉ No

*** Select the specific type of provider agreement(s) that apply. If you are attesting for a specific provider agreement other than or in addition to medical, pharmacy benefit, or behavioral health, choose "other," and enter the specific provider agreement type into the text box.**

- ☑ Medical
- ☐ Pharmacy Benefit manager
- ☐ Behavioral Health
- ☐ Other

Save and continue | Save and exit

Sample Attestation Submission

5 **Verify the entity type(s) you are attesting on behalf of**

You must, at a minimum, select that you are either attesting on behalf of a group health plan or insurance issuer. If you are attesting on behalf of both a group health plan, whether fully insured or self-funded, and an issuer of individual health insurance coverage, check both boxes.

Group health plans, including non-federal governmental plans, and health insurance issuers offering group health insurance coverage

☐ I'm attesting on behalf of group health plans, including non-federal governmental plans, and health insurance issuers offering group health insurance coverage.

I attest that I have the authority to bind the plan(s) or issuer(s) entered/uploaded in the entity attestation details

☐ I attest that all information in this submission is accurate

Please enter your full name to sign this attestation

Elizabeth Mann

Signed submission date

05/23/2023 11:30 AM

Submit Start over

Action Items for Employers

- Reach out to EPIC account team to determine:
  - If the TPA/PBM/Vendor is completing the submission on their clients' behalf or
  - If they are providing confirmation of compliance for the clients' submission
  - NOTE: some vendors may require additional agreements and fees for the submission

- Clients completing their own submission:
  - Review the EPIC submission instructions with screen shots
  - Rewatch this recording and review the slides
  - Watch for additional alerts/resources/trainings from EPIC
  - Complete the submission by December 31, 2023, in the CMS webform

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What's New?

End of COVID-19 HDHP Relief

IRS Notice 2023-37

- June 2023, the IRS released guidance ending relief for COVID-19 testing and treatment for HDHPs and HSAs for plan years ending on or before December 31, 2024
- Intent is to provide a smooth transition period for plan sponsors and participants

Proposed Rules for STLDI, and Fixed Indemnity

Short Term Limited Duration Insurance

- Removes Trump-Era changes to term length
- Coverage is limited to three months with a one-month extension allowed
- Effective after the publication of the final rules (expected later this year)

Hospital and Fixed Indemnity

- Plans must pay on a "fixed period" basis
- Cannot make indemnity coverage contingent on participation in medical coverage
- Benefits that are provided on a pre-tax basis paid for without regard to whether an actual medical expense was incurred are taxable income to the employee
- New notice requirement
- Effective for new plans after the publication of the final rules and plan years starting January 1, 2027 for existing plans
- Clarification on taxation of benefits effective later of publication of final rules or January 1, 2024

Additional Guidance on Surprise Billing

FAQs Part 60

- Addresses the application of out-of-pocket maximum (OOPM) rules to claims subject to No Surprises Act prohibition against balance billing
  - Air ambulance
  - Emergency services
  - Out-of-network provider at an in-network facility
- 2023 ACA OOPM
  - $9,100 individual
  - $18,200 family (other than individual)
- Guidance states that participant cost sharing must be counted towards the OOPM when the claim is from a participating provider or for a non-participating provider, adjudicated through the NSA process

Reproductive Health Care

HIPAA

- Proposed changes to HIPAA to strengthen privacy for reproductive healthcare

Executive Orders

- Expand access to contraception
- Promote access to reproductive healthcare
- Address privacy concerns
- Promote compliance with non-discrimination and other federal laws

Preventive Care – FAQs Part 54

- Clarification on required contraception as preventive services under ACA

Proposed Bill on Telehealth

Telehealth Expansion Act

- Current relief under the CARES Act has been extended through 2024
- Allows permanently for health plans to cover telehealth visits for individuals with high-deductible health plans coupled with a health savings account (HDHP-HSA) before satisfying their deductible
- Bipartisan support in the House and Senate
- No vote yet

Proposed Bills for ACA Reporting

Employer Reporting Improvement Act

- Allows the use of name in lieu of TIN
- Allow electronic delivery of 1095 forms
- Allows 90 response for 226-J Letters
- Creates a 6-year statute of limitation for assessing ESR penalties

Proposed Bills for PBM Transparency

These bills were introduced in the beginning of 2023:

- Pharmacy Benefit Manager Transparency Act of 2023 (S)
- Prescription Pricing for the People Act (S)
- Pharmacy Benefit Manager Accountability Act (HR)
- Pharmacy Benefit Manager Sunshine and Accountability Act (HR)
- Pharmacy Benefit Manager Reform Act (S)
- Protecting Patients Against PBM Abuses Act (HR)

Questions?