COMPLIANCE ALERT

Gag Clause Prohibition Attestation Due Later This Year

August 1, 2023

Quick Facts

- The Consolidated Appropriations Act of 2021 (CAA) prohibits group health plans and health insurance carriers from entering into agreements with providers, third-party administrators (TPAs), or other service providers that include language that constitutes a "gag clause."
- The gag clause prohibition became effective on December 27, 2020, but the gag clause prohibition compliance attestation (attestation) requirement was delayed pending the release of further guidance.
- The first attestation is due December 31, 2023, and then annually.
- The Departments have provided instructions for completing the attestation on the CMS webform.
- Plan sponsors should be ready to comply with the first attestation.

Background

The next installment of compliance obligations required by the CAA is the Gag Clause Prohibition Attestation (GCPA). In February 2023, the Internal Revenue Service (IRS), Department of Labor (DOL), and Department of Human Services (HHS), collectively, "the Departments," **released FAQ guidance** on the GCPA, and soon afterward released instructions for submitting the attestation. The first attestation must be submitted by December 31, 2023. While many employers will be able to rely on their carrier or TPA to submit the required attestation, other plan sponsors will need to complete all or part of the attestation themselves. Below is a brief overview of the new requirement and instructions for submission.

The gag clause prohibitions became effective on December 27, 2020 (the date of enactment of the CAA); however, the attestation requirement was delayed pending the release of further guidance. With the release of the February 2023 guidance, the first gag clause compliance attestation is now due December 31, 2023, with subsequent attestations due annually by December 31.

What Is a Gag Clause?

The CAA amended the Employee Retirement Income Security Act (ERISA), the Public Health Services Act (PHSA), and the Internal Revenue Code to prohibit group health plans and health insurance carriers (referred to as "issuers" in the rules) from entering into agreements with providers, TPAs, or other service providers that include language that constitutes a "gag clause." A gag clause is contractual language that contains any of the following:

(1) restrictions on the disclosure of provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees;
(2) restrictions on electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee (consistent with the privacy regulations included in the

Health Insurance Portability and Accountability Act (HIPAA), the Genetic Information Nondiscrimination Act (GINA), and the Americans with Disabilities Act (ADA); and

(3) restrictions on sharing information or data described in (1) and (2), with a business associate (as defined by HIPAA privacy regulations).

In recent **FAQ guidance**, the Departments provided these examples of gag clauses:

"If the 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, that language prohibiting disclosure would be considered a prohibited gag clause."

"If 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. Plans and issuers must ensure that their agreements with healthcare providers, networks or associations of providers, or other service providers offering access to a network of providers do not contain these or other provisions that violate the prohibition on gag clauses under Code section 9824, ERISA section 724, and PHS Act section 2799A-9."

Note that the Departments specifically state that a healthcare provider, network or association of providers, or other service providers may place reasonable restrictions on the public disclosure of this information.

The Attestation Requirement

The gag clause prohibition attestation requirements apply to virtually all employer-sponsored health plans, including fully insured and self-funded group health plans subject to ERISA, non-Federal governmental plans, church plans, and grandfathered plans. Health Reimbursement Arrangements (HRAs), Health Flexible Spending Accounts (HFSAs), and other account-based plans are exempt from the attestation requirement. Also exempt from attesting are group health plans that only provide excepted benefits such as stand-alone dental and vision plans, fixed indemnity plans, disability plans, employee assistance programs not offered as part of a group health plan, and short-term limited duration insurance.

The **instructions** define the entity with the compliance obligation as the "Reporting Entity." Reporting entities, such as group health plans, may have directly or indirectly (through a TPA or other service provider) entered into an agreement with healthcare providers, network or association of providers, third-party administrators, or other service providers offering access to a network of providers. The Reporting Entity is the entity responsible for compliance with the GCPA, ensuring that it annually attests, or that another party (such as its TPA or vendor) attests on its behalf.

Completing the Attestation

Employers typically rely on their carrier, TPA, or network to contract with medical providers to provide services to participants on the health plan offered to employees. The Departments recognize that employers rarely enter directly into agreements with healthcare providers, so the guidance makes it clear that if specific requirements are met, employers can rely on their carrier or TPA to submit the attestation on behalf of their employer-sponsored plans.

Fully Insured Employer Plans

Since carriers are required to submit an attestation regarding the plans they offer, employers may generally rely on their carrier to submit the required attestation. While liability for the submission rests with the carrier, employers should still seek assurance from their carrier that the attestation is being submitted.

Self-Funded Employer Plans

Self-funded plan sponsors will likely have additional compliance obligations. Self-funded plans may satisfy the requirement to provide an attestation by entering into a written agreement under which the plan's service provider(s), such as a TPA or PBM, will submit the required attestation. The guidance does not define what constitutes an acceptable written agreement; however, the Departments state that if a self-funded plan chooses to enter into such an agreement with the plan's service provider(s), the legal requirement to provide a timely attestation remains with the employer's plan (the Reporting Entity).

Many self-funded plans will need to submit at least part of their attestation. Vendor involvement with the requirement varies, and at this time there is no uniform standard for what level of assistance vendors are providing. Because the attestation is broken down into segments based on the various agreements a Reporting Entity may have, it is possible that a plan sponsor may need to complete the attestation for one agreement, while another plan sponsor needs to complete the attestation for multiple agreements or does not need to complete anything. Plan sponsors should reach out to their EPIC account team and/or vendors to determine the level of involvement their vendors are taking with this new requirement.

Employer Direct Provider Contract Arrangements

Some employers enter into direct contracts with providers. In these cases, the employer will likely need to take responsibility for submitting the attestation on behalf of their plan.

CMS Webform Attestation Submission

Reporting entities must submit the attestation in the CMS webform by December 31, 2023. Attestations can be made directly in the webform or through uploading an Excel file in tab-delimited format. The Excel file option is best for a third-party attesting on behalf of multiple reporting entities. The instructions below are intended for a Reporting Entity submitting on their own behalf. EPIC may provide additional instructions for third-party attesters in the future.

Key Definitions

- **Reporting Entity** is a group health plan or issuer that has directly or indirectly entered into an agreement(s) with healthcare providers, a network or association of providers, third-party administrators, or other service providers offering access to a network of providers. The Reporting Entity is responsible for ensuring it annually attests, or that another party (such as its TPA or vendor) attests on its behalf, that the Reporting Entity complies with the prohibition against gag clauses.
- **Attester** is an individual with legal authority to act on behalf of the Reporting Entity.
- **Submitter** is an individual who completes the tasks in the webform on behalf of the Attester. If the Submitter is authorized to sign the attestation on behalf of the Attester, then they are both the Attester and the Submitter.

Instructions for Reporting Entities

1. Enter the Submitter's contact information.
2. Identify the type of entity for which the Submitter is submitting. Most self-funded group health plans will choose "ERISA plan" (or sponsor of ERISA plan).

3. Enter the Attester's contact information. Note that the Submitter and the Attester may be the same individual.
4. Enter information for the Reporting Entity and select "No" in response to the question of whether you are submitting for more than one plan or issuer. The following information is required for the Reporting Entity:

- Name
- FEIN
- Type of plan attesting
- ERISA plan number (if applicable)
- Mailing address
- Contact information for the individual with the Reporting Entity responsible for gag clause prohibition compliance.

5. To complete the attestation, answer the following questions:

- For the question, "Are you attesting for all provider agreements?"
    - Select "Yes" if attesting to all types of agreement(s) in place (medical, pharmacy, behavioral, and any other agreements).
    - Select "No" if attesting to only certain agreements.

6. Review the submission and confirm that all information is entered correctly.

7. Select "Notify Attester" if the Attester and Submitter are different individuals and the Attester will be completing the attestation from this point. The Submitter will need to notify the Attester that they must complete the remainder of the attestation process.

8. Complete the Attestation

- Indicate whether the Attester is attesting on behalf of a group health plan or insurance issuer.
- Read the attestation text and select the box indicating that the Reporting Entity is in compliance with the prohibition on gag clauses.
- Affirm that the Attester has the authority to attest for the Reporting Entity.
- Indicate that the information submitted is accurate to the best of your knowledge.

9. Attester should enter their first and last name to electronically sign the Attestation.

10. Click the "Submit" button to submit the attestation to CMS.

Next Steps for Plan Sponsors

Action Items

- Confirm with your EPIC account team and vendors that you are in compliance with the gag clause prohibition.
- Determine whether your vendors will complete the attestation on your behalf.
- Select an Attester and Submitter for the Reporting Entity.
- Submit the attestation.

Resources

The Departments have launched a webform for submitting the attestation and have issued **instructions**, **frequently asked questions**, a system **user manual**, and an **Excel reporting template** for plans and issuers to submit the required attestation. Plans and issuers should use this **website** to satisfy the requirement to submit the annual Attestation. EPIC has created informational resources for client use. Please reach out to your EPIC account team for more information and watch this **webinar recording**.

Summary

Most employers will need to rely on their vendors (health insurance carrier or TPA) to comply with the rules. Most fully insured employers should be able to rely on their carriers to submit the attestation on behalf of their plan, but this may be more complicated for self-funded employers. Plan sponsors should review the instructions and action items and be prepared to complete the attestation before the end of the year.

EPIC Employee Benefits Compliance Services

For further information on this or any other topic, please contact your EPIC benefits consulting team.