COMPLIANCE ALERT

Gag Clause Prohibition Attestation Due Soon

November 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 by December 31, 2023, and then annually.
- The Departments have provided instructions for completing the attestation on the Centers for Medicare and Medicaid (CMS) web form.
- Plan sponsors of fully insured and self-funded group health plans 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 prohibition became effective on December 27, 2020 (the enactment date 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 on 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: 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 gag clause prohibition and the attestation apply to group health plans that provide access to health care providers or networks of providers. Many plan sponsors think of these plans only to include major medical or prescription drug coverage, but they also include plans such as stand-alone telemedicine, carved-out behavioral health, and direct primary care, to name a few. Plan sponsors should reach out to these service providers to confirm that their service agreements do not contain prohibited gag clauses.

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.

The first attestation covers the time period between December 27, 2020 (the effective date of the CAA) through 2023. During this time employers may likely have switched carriers or service

providers. The attestation(s) due in 2023 should attest to compliance for all service providers connected to the plan during this time period. This means some employers may have to attest to multiple carriers, TPAs or service providers.

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 in this situation, 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 any additional attestation. 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 first attestation in the CMS webform by December 31, 2023. Attestations can be made directly in the web form or by 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. The attestation itself is fairly straightforward and should take no more than 20 minutes to complete if the Reporting Entity has all the information necessary for the submission.

Step 1: Confirm Compliance

Review any group health plan contracts to confirm there are no prohibited gag clauses. Alternatively, reach out to all carriers, TPAs and any other service providers and ask for written confirmation that

the contracts they handle on behalf of the group health plan do not contain any prohibited gag clauses. Such documents should be kept in the employer's files.

Step 2: Website Access

Go to **the CMS webform**

Obtain Unique Authentication Code

- Click on "Don't have a code or forgot yours?"
- Enter an email address and click "Get my unique code"
- Wait approximately 10 minutes and the code will appear

Access Attestation Submission Form

- Go back to the home submission page to enter email address and code sent via email and login

NOTE: The authentication code will only provide access for 15 days, after which time it will be necessary to obtain a new code (however, previously entered information tied to the email address will be saved).

Step 3: Complete the Attestation Form

From the Gag Clause Prohibition Compliance Attestation (GCPCA) Dashboard, click on "Start a new submission" or "Submit Gag Clause Prohibition Compliance Attestation." Both boxes/links will take you to the same place, allowing you to begin the attestation process.

The attestation form is made up of five sections, and the form must be completed sequentially. It is necessary to complete a section and then click "Save and continue" before you can advance to the next section. It is possible to stop mid-process and then return and complete the other sections later by clicking "Save and exit" at the end of the current section or "Return to Gag Clause Attestation dashboard" at the top of the screen. The process can be picked up again at any time by logging in and clicking on the "Submission ID" number on the GCPCA Dashboard.

There are two roles in the attestation process, the "Submitter" and the "Attester," but both roles could be played by the same individual. The Submitter is responsible for initiating the attestation process via CMS's website and entering the required information about the Submitter, the Attester and the group health plan. The Attester is responsible for reviewing the information entered and signing off on the group health plan's attestation of compliance with the gag clause prohibition rules. The Attester must have the legal authority to sign for the company (e.g., the person who signs off on Form 5500 or Form 1094-C).

Submitter Responsibilities

Sections one through three of the form will be completed by the Submitter. This portion of the form asks for information about the Submitter, the Attester and about the reporting entity (e.g., employer EIN, group health plan number).

Section four is a summary of the information provided in Sections one through three for the Submitter to review.

After confirming that the information entered is correct, the Submitter will either notify the Attester to review and complete the attestation in Section Five or if the Submitter is also the Attester, the Submitter should move on to the final section and complete the attestation in Section five.

Attester Responsibilities
The Attester should review the information in Section four to confirm accuracy and then Section four must be completed by the Attester (which may be the same individual as the Submitter). This section requires a formal attestation that the information entered is correct along with a signature.

Step 4: Confirm Submission

If the attestation is successfully submitted, the Attester should see a screen indicating the submission was successful along with the date and time. There is an option to download a receipt of the successful submission. It is recommended that the employer download the receipt and keep it in the employer's files.

CMS has provided **instructions** and a **user manual**, both of which can be found on CMS's main information page and within the gag clause attestation portal. EPIC's resources can also be found on our Insights Pages and by contacting your EPIC representative.

Frequently Asked Questions

Q: If multiple employers participate in a single group health plan, does each participating employer attest separately?

A: Reporting is managed on a per-plan basis, and therefore reporting is not necessarily required for each participating employer. This determination may be different depending on whether the participating entities form a controlled group due to common ownership (under IRS §414 rules) or whether the plan is a multiple employer welfare arrangement (MEWA).

Q: What does "are you attesting on behalf of all different types of service providers" mean?

A: This question is not asking about how many different benefits or plans an employer maintains, but instead is asking about the distinct types of provider agreements related to the employer's group health plan(s). Whether an employer will attest on behalf of all service providers will vary. For example, a single group health plan may have separate contracts in place for its TPA and PBM, in which case there are two different service providers involved with the employer's group health plan. In this example, if the employer is attesting to the agreements in place with the TPA and the PBM, the employer would answer "yes." But if the employer is only attesting to the agreements in place with the PBM (perhaps the TPA is separately attesting to the TPA's agreements with the plan but is unwilling to attest to PBM contracts for which it is not directly involved), then the employer should answer "no" and then indicate that it is attesting solely on behalf of the PBM agreements.

Q: What should an employer do if some of its service providers are unwilling to cooperate?

A: Most carriers and TPAs (and perhaps PBMs) will probably attest on behalf of the group health plan or will at least provide written confirmation of compliance with the gag clause prohibition for any of their contracts. However other service vendors such as telemedicine providers may not be as helpful. Service vendors beyond the carriers, TPAs and PBMs may think of themselves as providers and not as group health plans (and technically they are not group health plans). However, the employer offering their arrangements to employees creates a group health plan. Such service providers are less likely to agree to do the attestation because they are not directly required to do so. However, the employer has the ability to review contracts in place with those service providers and should also reach out and ask them to certify that they do not have any gag clauses in their contractors with providers. If the service provider is willing to provide that certification, then the employer has what is needed to attest to compliance, and the certification is kept in the employer's files. If the service

provider(s) will not provide a confirmation of compliance with its contracts, the employer still has a record of its good-faith attempt to reach out to all service providers.

Q: Is it okay to rely on a carrier's or TPA's attestation?

A: It should be reasonable to rely on the carrier's or service provider's representation that there are no gag clauses in their contracts. The reality is that the employer's role in negotiating the contracts, and even access to the contracts themselves, may be limited, in which case many employers will have to rely on the service providers' representations.

Q: What is the penalty for noncompliance?

A: For failure to attest on behalf of a group health plan, the penalties are not clear. The FAQs from the tri-agencies state *"Plans and issuers that do not submit their attestation, as required under Code section 9824, ERISA section 724, and PHS Act section 2799A-9, by the deadlines above, may be subject to enforcement action."* Presumably, they could assess the standard $100 per violation per day excise tax that applies when a plan violates a requirement of the tax code.

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 web form 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.