Gag Clause Attestation Requirements
Post-Webinar FAQs Guide

Deadline for Gag Clause Attestations is December 31st

Background

The Gag Clause Prohibition Compliance Attestation (GCPCA) is the latest requirement that employers must adhere to as part of the Consolidated Appropriations Act (CAA) of 2021. The GCPCA specifically requires employers to attest that their plans contain no prohibited gag clauses beginning December 27, 2020. The first report is **due December 31, 2023**, and covers the time period from December 27, 2020 – December 31, 2023. Thereafter, reports are due annually by December 31, 2023 and will cover a calendar year timeframe.

What is a Gag Clause?

Gag clauses are contractual provisions that restrict plans or issuers from sharing provider-specific cost information or quality-of-care information with patients, other providers, or plan sponsors. They can also prevent plans or issuers from electronically sharing de-identified claims data and other encounter information with patients and providers. These types of gag clauses inhibit transparency and therefore are prohibited under the CAA.

Why is This Happening?

The reporting requirements under the CAA are all building toward greater healthcare transparency. The Consolidated Appropriations Act of 2021 in Section 201 entitled "INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION," prohibits Health Plan Sponsors from entering into agreements with healthcare providers, third-party administrators, and other service providers, which would directly or indirectly restrict the plan sponsor from accessing, owning, and benchmarking certain cost and quality health plan data.

More plainly stated, Health Plan Fiduciaries cannot be party to a contract that restricts their ability to perform their fiduciary duties of monitoring and assessing plan vendor performance and assessing unit cost for reasonableness.

When gag clauses are removed, plan sponsors gain access to all unit cost information with fully transparent agreements and access to data. An active fiduciary process that leverages this data will expose unnecessary cost, so employers can remove it, then pay less for healthcare. Access to information will also provide transparency to healthcare consumers who in turn can make informed decisions about their care.

Questions & Answers:

1. Does this apply to MEC Plans? What about Reference-Based Pricing?

A: Yes, this applies to both MEC plans and Reference-Based Pricing plans.

2. Please provide a list of what each carrier is doing in response to the reporting requirements.

A: https://www.savoyassociates.com/news/caa-2021-gag-clause-attestation-carrier-reference

3. Are you saying that we need to submit four different reports for each year from 2020 through 2023, or just submit the one report based on the most current active plans?

A: The attester will submit one report by 12/31/2023, which covers the timeframe from 12/27/2020-12/31/2023. Thereafter, each year by December 31st an attestation will be submitted covering the time period from January 1 - December 31 of that year.

4. If the employer contracts with a TPA to do the attestation for them, does the employer retain the liability?

A: Yes, self-insured and level-funded employers retain the liability for the attestation in all cases. It cannot be contracted away. Fully-insured employers can rely on their carrier communications.

5. When does an employer need to complete the multiple employer attestation spreadsheet?

A: Employers complete the multiple employer attestation spreadsheet if they are submitting the attestation on behalf of multiple entities. Examples include associations, TPAs who complete the attestation, or carriers submitting on behalf of their book.

6. Can brokers submit on behalf of the employer?

A: It is not recommended that brokers submit this attestation on behalf of the employer. The employer must sign off on the attestation, or have their carrier/TPA do it on their behalf.

7. Will the group receive communication from the carrier surrounding their requirements under the GCPCA?

A: We do not anticipate employers receiving communications from the carrier regarding these requirements. The employer is responsible for being aware of and completing the attestation.

8. Will the group receive communication from the carrier regarding the presence or absence of gag clauses in the contract?

A: Carriers may advise employers of the presence or absence of gag clauses in their contracts, but they are not required to do so. Employers who are not sure and must complete the reporting on their own behalf should contact the carrier for details on the presence or absence of any gag clauses in their contracts.

Questions & Answers:

9. Will the group receive communication from the carrier confirming a submission of the gag clause attestation on behalf of the employer?

A: We do not anticipate fully-insured carriers confirming their submission if they file on behalf of the employer. If the employer contracts with a vendor or a TPA to report on their behalf, they should request a confirmation of submission. If the employer is reporting on their own behalf, they will receive confirmation of their submission upon completion and should keep this for their records.

10. Does this apply to employers in all states?

A: Yes, this new requirement applies to employers of all sizes in all states. There is no exemption for employer size, fully-insured vs self-insured, etc.

11. Which plans must report? Do EAP plans report?

A: This requirement applies to fully-insured and self-insured group health plans, including ERISA plans, non-federal governmental plans and church plans subject to the Internal Revenue Code. This means that major medical plans, prescription drug plans and behavioral health plans (even if they are carved out) are all required to submit the annual attestation; however, the following plans are not required to do so:

- Retiree-only plans
- Account-based plans (e.g., health reimbursement arrangements and individual coverage health reimbursement arrangements, health flexible spending accounts and health savings accounts)
- Plans that qualify as excepted benefits (including limited scope benefits and supplemental benefits)
- Short-term, limited-duration insurance
- Medicare, Medicaid, State Children's Health Insurance Program plans, the TRICARE program, the Indian Health Service program and Basic Health Program plans

EAPs must meet four requirements to qualify as excepted benefits. The EAP cannot:

- Provide significant benefits in the nature of medical care
- Be coordinated with benefits under another group health plan and cannot act as a gatekeeper
- Require employee contributions
- Have any cost sharing for its services

The first requirement above is the hardest to interpret given that the government has not issued guidance on what constitutes "significant benefits in the nature of medical care" (e.g., visit limits, costs). If the EAP does not meet the requirements of an excepted benefit, an attestation will be required.

12. Does this apply to an employer that pays for their employees' Medicare Supplement coverage?

A: Excepted benefits (including Medicare Supplemental coverage) are excused from the gag clause requirements. But, if the employer offers any other group health plan(s), they will need to ensure their service agreements are in compliance and attest on behalf of those plans.

Questions & Answers:

13. How does an employer report if they have a plan change during the year? Do they have to re-attest? What if there is a carrier change or a change from self-insured to fully-insured (or vice versa)?

A: The first attestation is for the period covering 12/27/2020—12/31/2023 and is required to be filed by 12/31/2023. The attester is attesting for the entire attestation period. A new attestation, during the same attestation period, is only needed if there is a change to who is carrying out the attestation. For example, if an employer on a fully-insured plan moves from one carrier to another in the same attestation period and both carriers are submitting on behalf of their clients, there is no need for the employer to also attest. However, if the employer is moving from a fully-insured plan where the carrier is submitting the attestation on the client's behalf and then moves to a self-funded or level-funded plan where the carrier is NOT providing the attestation, the employer will need to comply during the same attesting period.

14. What happens if an employer states there are gag clauses in the contract?

A: There isn't a way to submit an attestation that there are gag clauses in a contract. We recommend that employers try to work out any gag clauses with their services providers in advance of the attestation deadline so that they can ideally attest that there aren't any. Alternatively, groups can submit partial attestations if some of their service providers are in compliance while others aren't.

Interested parties with concerns about a plan's or issuer's compliance with the gag clause prohibition may contact the No Surprises Help Desk at 1-800-985-3059, submit a complaint at https://nsa-idr.cms.gov/providercomplaints/s/, or contact the applicable state authority. For ERISA plans, individuals may contact DOL for help at www.askebsa.dol.gov or 1-866-444-3272.

15. Can two attestations be submitted for one employer? For example if both the carrier and employer submit an attestation.

A: Yes. This will occur when a partial attestation is submitted. An example would be if the employer submits an attestation for the self-funded medical plan and they are working with a third party for pharmacy, the third party would submit for the pharmacy plan, which means there would be two attestations for the same employer albeit for different benefit types.

16. If there is a gag clause, where would the employer find it or how would they know? Are there any carriers who are known to have gag clauses in their contracts?

A: Employers that want to perform this analysis internally will need to read through their service provider contracts to see if they include any gag clauses. A "gag clause" is a contractual term that directly or indirectly restricts specific data and/or information that a plan can access or make available to another party. We recommend that groups not comfortable doing this type of analysis reach out to a compliance consultant for assistance with reviewing their contracts. We do not have knowledge of specific carriers that have gag clauses in their contracts.

Questions & Answers:

17. What do you suggest to plan sponsors who were on a plan where the carrier has since gone out of business and there is no way to confirm whether or not a gag clause existed? Also, since the first attestation period is 12/27/2020–12/31/2023, if the group was with the carrier who no longer is in business for only a part of the reporting period, how does the group reflect this? Meaning they can't attest to the timeframe with the carrier no longer in business, however, they can attest based on the time with the new carrier.

A: At the current time, the CMS's attestation systems is not sophisticated enough to account for these complexities. Given this, we recommend that groups keep thorough internal records for which of their service providers have agreed to attest, which the group is attesting for, what time period that attestation covers, note any carriers(s) that information was not available and why, etc. Good recordkeeping will be important should this information ever be requested in the future.

18. Are there penalties if our group health plan does not complete the attestation?

A: There are no specific penalties outlined in the CAA; however, in the FAQs, the Agencies indicate that failing to submit the attestation by the deadline may subject the plan or carrier to enforcement action. In such cases, it's possible for the Agencies to assess a penalty of up to $100 per day per affected individual.

19. Please provide vendors who can assist with the attestation

A: We recommend MZQ Compliance consulting.

They will help to collect all applicable contracts that were/are in force during the reporting period of 12/27/2020—12/31/2023.

They will review those contracts and any GCA-specific communications. They will also send a letter (as applicable) to those entities reminding the prohibition on gag clauses and putting them on notice that the client considers those provisions to be illegal and as such is null and void. This will bolster a "best efforts" position for the client.

If, during their review, they discover items of concern, they will notify the client, outline those concerns, and offer recommendations.

Acting as the submitter, they will prepare the form for the client's attestation and filing through the CMS HIOS Gag Clause Prohibition Attestation System. The client will need to identify an "Attester" who is authorized to sign on behalf of the plan. This individual will receive an email from the CMS HIOS system once they have set up the filing. They can follow that link to e-sign the actual attestation.

✔ **PRICING:**

$1,000 for 3 hours of consulting. MZQ expects most (if not all) of these to be completed within 3 hours. They will notify the client if they find that the work will take more than 3 hours and, with the client's approval, bill those additional hours at $350 per hour.

To engage, please email gagclause@mzqconsulting.com. Since time is short, MZQ will only accept new Gag Clause Attestation engagements through December 1st.