AssuredPartners

Gag Clause Attestation Guide

Updated Oct. 5, 2023

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Overview

The Consolidated Appropriations Act, 2021 (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 would constitute a "gag clause" (i.e., contract provisions that restrict specific data and information that a plan can make available to another party). A gag clause is contractual language that contains any of the following:

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

The gag clause prohibition requirements apply to virtually all employer-sponsored health plans, but not excepted benefits (e.g., stand-alone dental or vision, health FSA, EAP), retiree-only plans, or account-based plans (e.g., HRAs). The requirements went into effect on December 27, 2020.

Plans and issuers must annually submit an attestation of compliance with these requirements to the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, "the Departments"). The first attestation is due by December 31, 2023 (attesting to compliance for 2021 – 2023). Subsequent attestations are due by December 31 of each year thereafter. While the instructions from the agencies indicate that carriers or TPAs may attest for the group health plan on behalf of sponsoring employers, carriers and TPAs are taking a varied approach as to their willingness to attest on behalf of employers. If the carrier/TPA indicates a willingness to attest on behalf of the plan, that is generally good news for the employer (meaning the employer may have one less thing to do each year). If the carrier, TPA or any other service providers will not attest on the plan's behalf, the employer will need to reach out to all carriers and service providers and ask them to confirm that no gag clauses are present in the contracts they have entered into with providers on behalf of the plan. The reality is that employers cannot do much more than ask for this confirmation since employers generally do not play a role in the contracting and may not have access to all contracts entered into on behalf of the plan.

NOTE: This attestation requirement is a fairly straightforward process, requiring only some plan identifying information, employer contact information, and a checked box and signature to indicate compliance. This is all done via a website portal.

CMS created a webpage with information about how to comply with the gag clause prohibition as well as how to attest to compliance, which you can find here - https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance

The website for submitting the attestation can be found here - https://hios.cms.gov/HIOS-GCPCA-UI

Questions or difficulties with the attestation process can be submitted to - CMS_FEPS@cms.hhs.gov (put GCPCA in the subject line)

Which Plans Must Comply?

The gag clause prohibition and attestation requirements apply to all group health plans, but not excepted benefits (e.g., stand-alone dental or vision, health FSA, EAP), retiree-only plans, or account-based plans (e.g., HRAs). Both fully-insured and self-funded plans are subject to the requirements, as well as grandfathered plans, grandmothered plans, ERISA plans, and non-ERISA plans. Therefore, in addition to group medical plans, we assume that telehealth programs and direct primary care arrangements are subject to the requirements. However, employee assistance programs (EAPs), which typically qualify as excepted benefits, would not be subject to the requirements.

Beyond the carriers and TPAs involved with the group medical plan, there may be additional service providers that need to be considered as part of the attestation to the extent that they are involved in contracting with providers on behalf of the employer's group health plan. For example, provider contracts with and coordinated by PBMs, behavioral health vendors (e.g., network agreements for mental health providers), telehealth arrangements, direct primary care arrangements, and other medical providers (e.g., access to preferred pricing for certain procedures if using particular providers) are also prohibited from having gag clauses and should be considered by the employer when attesting to compliance.

See Q/A-8 from FAQ About Affordable Car Act and Consolidated Appropriations Act, 2021 Implementation Part 57 for more detail - https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-57.pdf

NOTE: For this first year of attestations, the coverage period is 2021 – 2023, during which time it is more likely that an employer may have switched carriers or other service providers. The attestation(s) due in 2023 should attest to compliance for all service providers connected to the plan during the 2021 – 2023 timeframe.

When is the Attestation Due?

The first attestation is due by December 31, 2023. The first attestation will apply to the time since the gag clause prohibition first went into effect on December 27, 2020. Therefore, plans must attest to compliance for 2021 – 2023 during by the end of 2023. The first attestation can be done any time between now and December 31, 2023.

Subsequent attestations will be due annually by December 31st and should cover the period of time since the plan's last attestation. For example, if the attestation is first completed December 15, 2023

and then again December 22, 2024, the plan must attest to compliance December 15, 2023 – December 22, 2024 during the second attestation.

Who Must Complete the Attestation?

Employers rely primarily on their carrier or TPA to contract with medical providers to provide services to participants in the health plans offered to employees. The Departments recognize this and provided guidance indicating employers can rely on their carrier or TPA to submit the attestation on behalf of their employer-sponsored plans. However, the carrier and/or TPA may not be willing to do so, especially if the employer separately contracts with other service providers on behalf of the group health plan (e.g., pharmacy carve-out with a PBM not managed by the carrier or TPA). When that is the case, the employer may have to attest on behalf of its group health plan, at least for some of its service providers.

Fully-Insured Group Health Plans

Carriers are required to submit an attestation regarding the group and individual health plans they offer, so the carrier could agree to attest on the employer's behalf as well. We expect that many carriers will offer to do so, in which case employers may rely on the carrier to submit the required attestation, but it is recommended that the employer seek assurance from the carrier that the attestation is being submitted on their behalf.

In some cases, the carrier may choose only to attest on its own behalf and not on behalf of the employer as plan sponsor. The carrier may have concerns about attesting on the employer's behalf without knowing whether there are additional contracts with other service providers not coordinated by the carrier. If the carrier is not willing to attest on the employer's behalf, or if the employer does have separate contracts in place with other service providers (e.g., PBM or telehealth provider), then the employer will need to attest on behalf of the plan.

Self-Funded Group Health Plans

The TPA and other service providers for a group health plan are not directly subject to the gag clause prohibition or attestation requirements, but such service providers are often directly involved in contracting on behalf of the group health plan and administering the plan accordingly. For this reason, the rules specifically permit the service providers to attest to compliance on behalf of the plan if the employer enters into a written agreement under which the plan's service provider(s) [such as a TPA] will submit the required attestation. However, the Departments point out 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.

It is certainly possible that the plan's service providers will agree to attest on behalf of the plan, in which case the employers may rely on such attestation. However, for a self-funded plan, it is perhaps more likely that the employer will need to attest on behalf of the plan, at least for some of its service providers.

Attestation Process

Estimated time: 15-30 minutes if you have all information needed for the attestation.

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 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 https://hios.cms.gov/HIOS-GCPCA-UI

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 code will appear

Access Attestation Submission Form

- Go back to 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 would 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 5 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 either "Save and exit" at the end of the current section or by clicking "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' website and entering in 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 the Form 5500 or Form 1094-C).

Submitter Responsibilities

Sections 1 – 3 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 4 is a summary of the information provided in Sections 1 – 3 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 5, or if the Submitter is also the Attester, the Submitter should move on to the final section and complete the attestation in Section 5.

Attester Responsibilities

The Attester should review the information in Section 4 to confirm accuracy and then Section 5 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

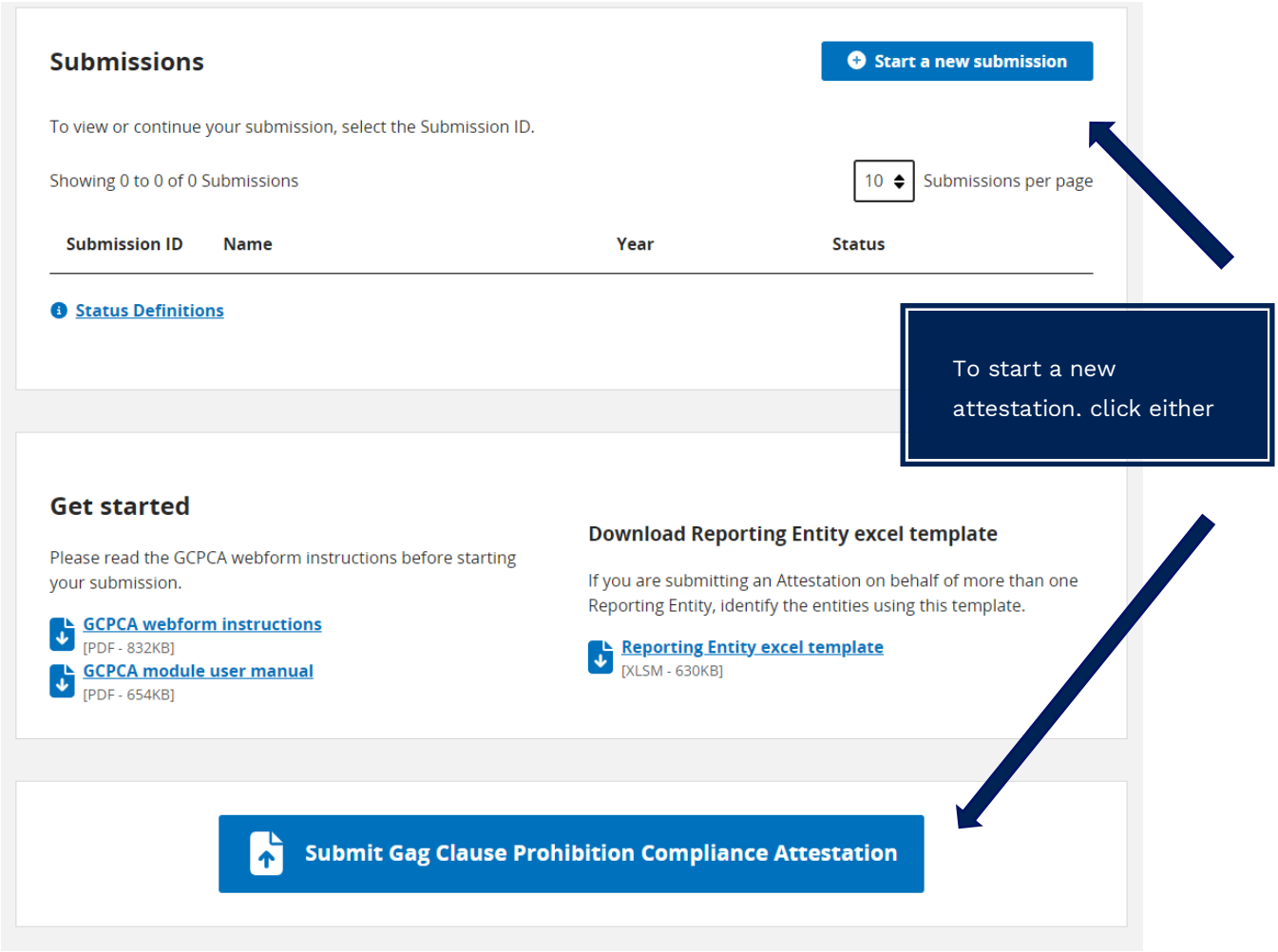
If the attestation is successfully submitted, the Attester should see a screen indicating the submission was successful along with the date and time. There is an option to download a receipt of the successful submission. It is recommended that the employer download the receipt and keep it in the employer's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

Screenshots along with further instructions for each of the 5 sections of the form can be found in Appendix A. FAQs can be found in Appendix B.

In addition, you may find the CMS instructions and user manual helpful, both of which can be found on CMS' main information page and within the gag clause attestation portal.

Appendix A – Attestation Process Screenshots

GCPCA Dashboard



1 Enter the Submitter's Contact Information

Enter the name and contact information of the person completing the required fields (and the Excel Template if attesting for multiple Reporting Entities). This person is the "Submitter" and will be contacted in the event we have any questions.

*** Submitter first and last name**

*** Submitter position title**

*** Submitter e-mail address**

reganjean3@gmail.com

*** Submitter telephone number**

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

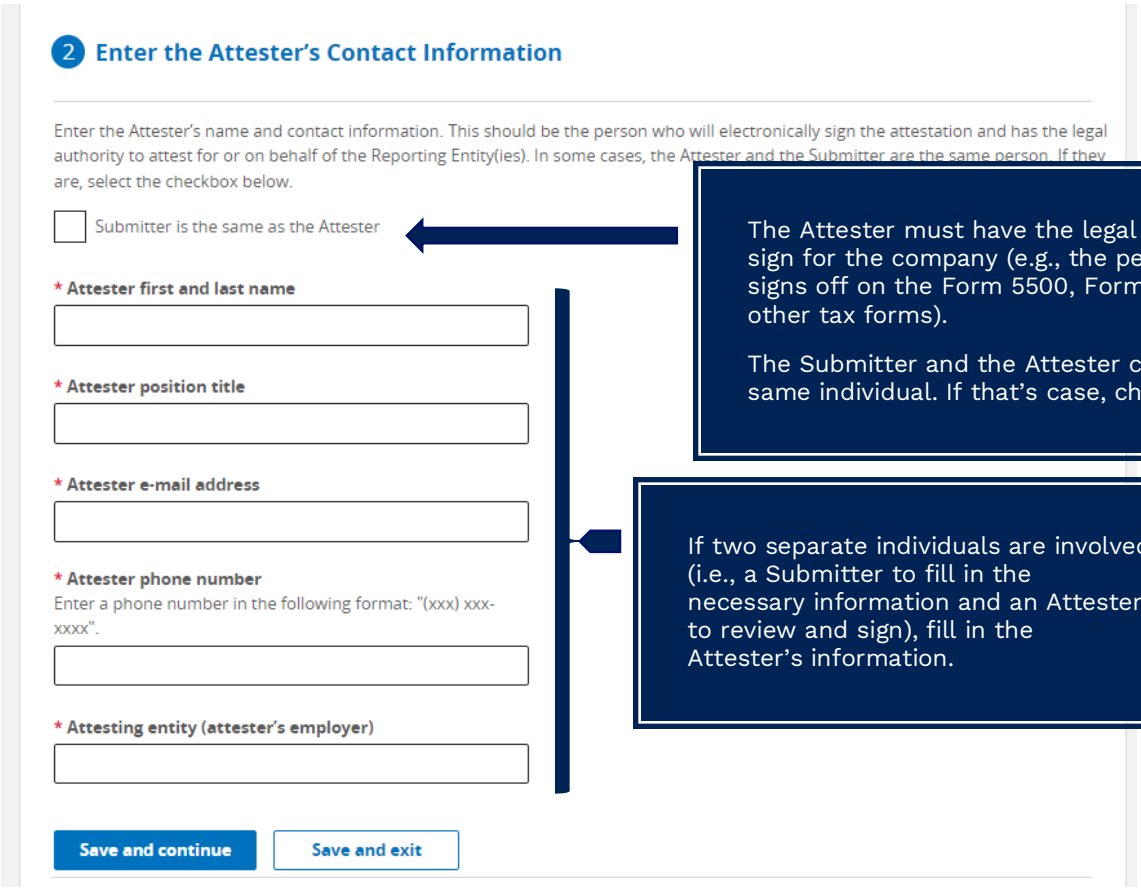
*** Submitter employer name**

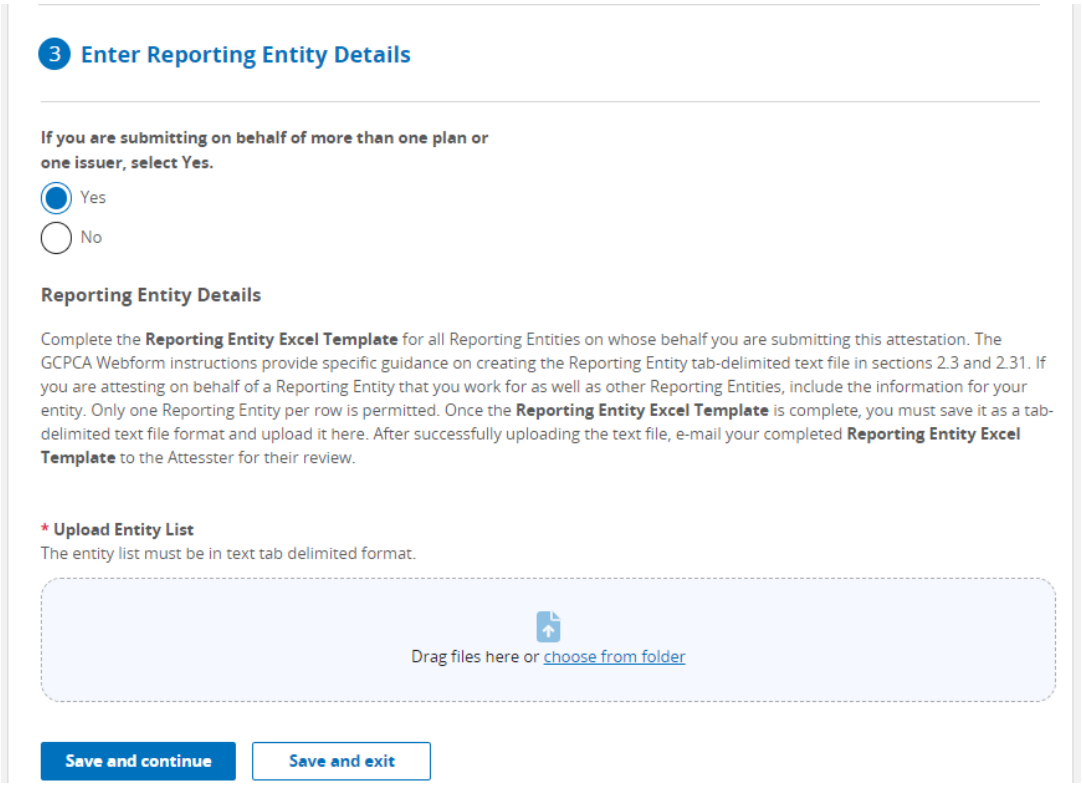
*** By what type of entity are you employed?**

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.

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

Save and continue **Save and exit**

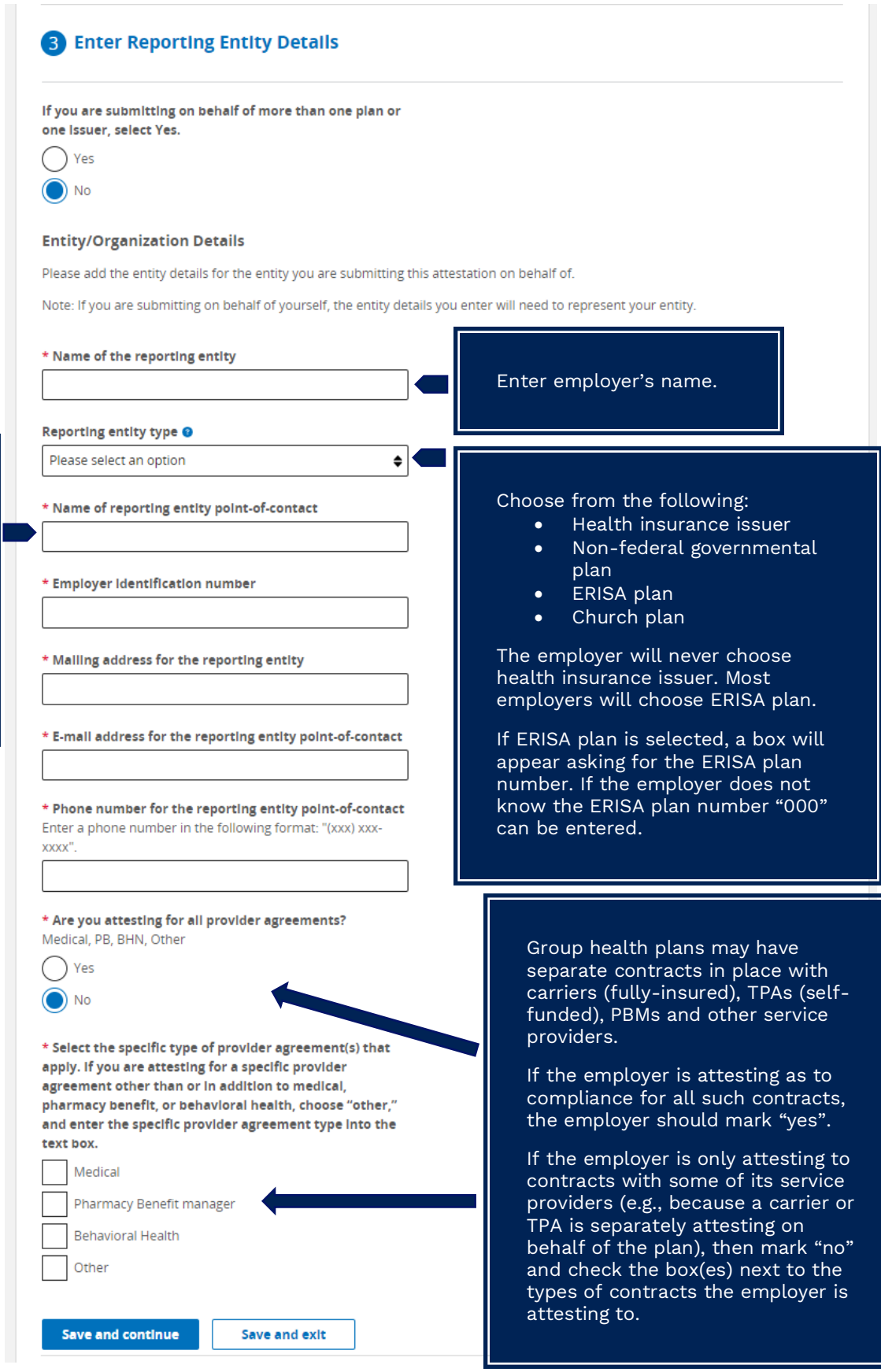

2 Enter the Attester's Contact Information
Enter the Attester's name and contact information. This should be the person who will electronically sign the attestation and has the legal authority to attest for or on behalf of the Reporting Entity(ies). In some cases, the Attester and the Submitter are the same person. If they are, select the checkbox below.
Submitter is the same as the Attester
* Attester first and last name
* Attester position title
* Attester e-mail address
* Attester phone number
Enter a phone number in the following format: "(xxx) xxx-xxxx".
* Attesting entity (attester's employer)
Save and continue
Save and exit
The Attester must have the legal authority to sign for the company (e.g., the person who signs off on the Form 5500, Form 1094-C or other tax forms).
The Submitter and the Attester can be the same individual. If that's case, check the box.
If two separate individuals are involved (i.e., a Submitter to fill in the necessary information and an Attester to review and sign), fill in the Attester's information.



The instructions assume that it will be primarily health insurance issuers (carriers) and TPAs that attest on behalf of multiple group health plans (e.g., their book of business), while employers will generally only attest on behalf of a single group health plan. This is true even if the employer offers multiple medical plan options. When the medical plan options are bundled into a single ERISA plan via a WRAP document and all fall under the same ERISA plan number, a single attestation can be done on behalf of all of the medical plan options. In addition, even when separate medical plan options are treated as separate plans (e.g., each with their own ERISA plan number), informal guidance from CMS indicates that it would still be okay to choose one of the plan numbers and attest only once on behalf of all of the employer's medical plan options. .

Most employers will therefore select "No" on this page, indicating they are filing on behalf of a single group health plan. NOTE: No spreadsheet is required for an employer attesting on behalf of a single group health plan.

In the less common scenario where the employer's various benefits subject to the attestation requirements are not bundled into a single ERISA plan, then the employer may need to attest on behalf of more than one plan and follow the steps for reporting on behalf of multiple plans (via a spreadsheet) similar to what is required of a carrier or TPA reporting on behalf of more than one plan. CMS' user guide provides detailed instructions on how to complete the spreadsheet and upload it into the blue box pictured above.



Enter employer's name.

Enter a contact to answer questions related to the attestation. This could be the Submitter, Attester or another contact at the employer (e.g., HR personnel).

Choose from the following:

- Health insurance issuer
- Non-federal governmental plan
- ERISA plan
- Church plan

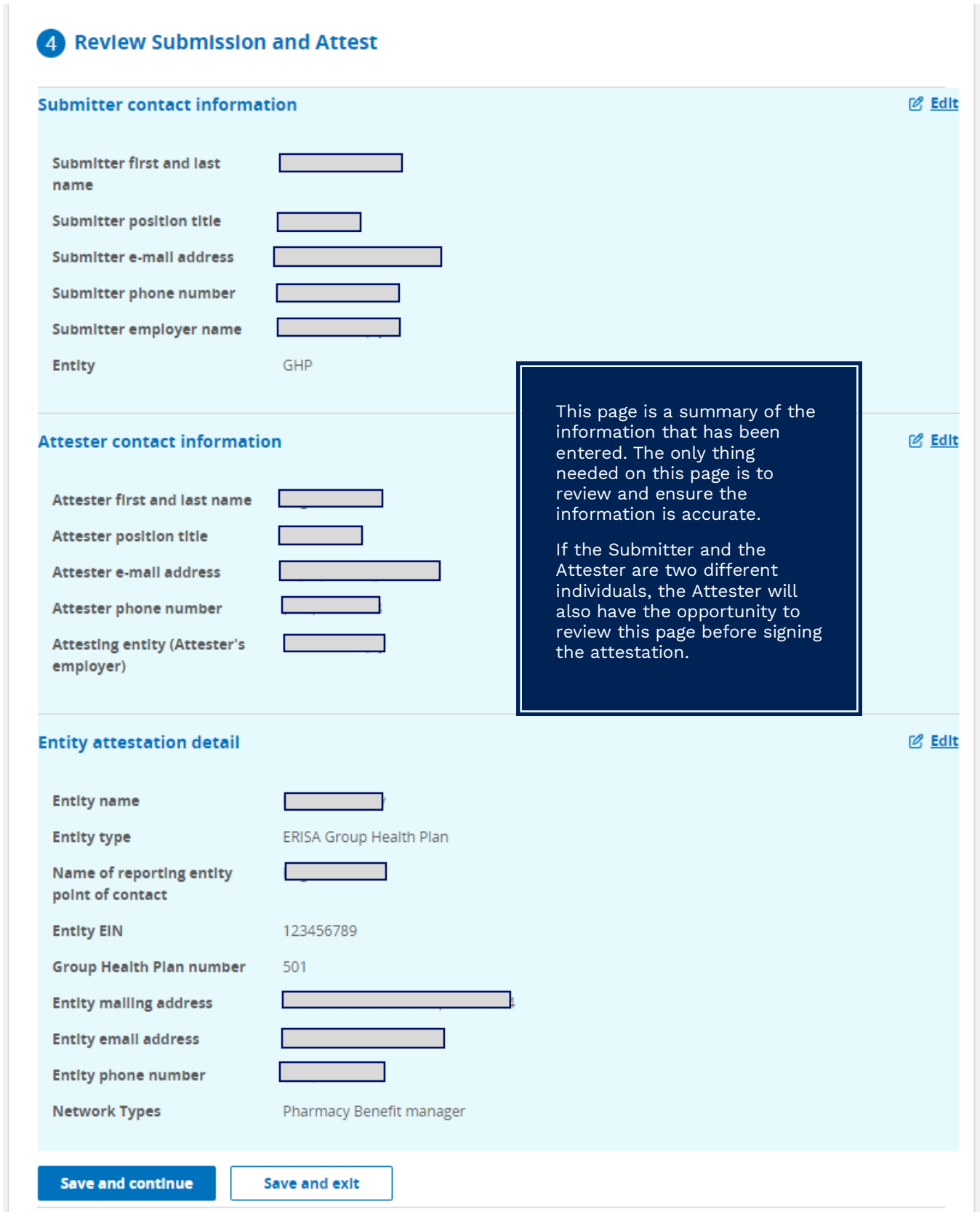
The employer will never choose health insurance issuer. Most employers will choose ERISA plan.

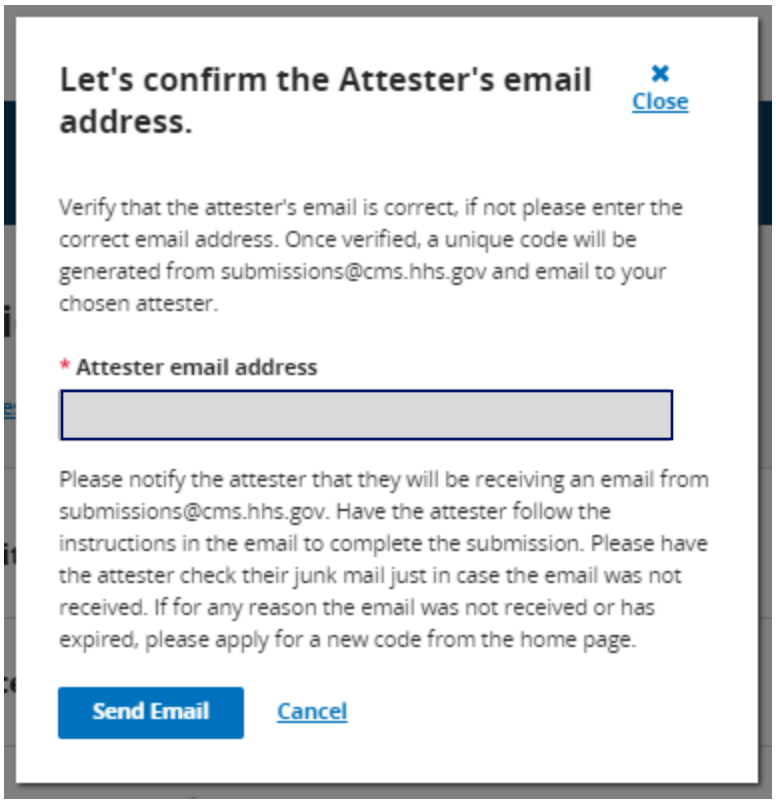
If ERISA plan is selected, a box will appear asking for the ERISA plan number. If the employer does not know the ERISA plan number "000" can be entered.

Group health plans may have separate contracts in place with carriers (fully-insured), TPAs (self-funded), PBMs and other service providers.

If the employer is attesting as to compliance for all such contracts, the employer should mark "yes".

If the employer is only attesting to contracts with some of its service providers (e.g., because a carrier or TPA is separately attesting on behalf of the plan), then mark "no" and check the box(es) next to the types of contracts the employer is attesting to.


4 Review Submission and Attest
Submitter contact information
Edit
Submitter first and last name
Submitter position title
Submitter e-mail address
Submitter phone number
Submitter employer name
Entity
GHP
Attester contact information
Edit
Attester first and last name
Attester position title
Attester e-mail address
Attester phone number
Attesting entity (Attester's employer)
Entity attestation detail
Edit
Entity name
Entity type
ERISA Group Health Plan
Name of reporting entity point of contact
Entity EIN
123456789
Group Health Plan number
501
Entity mailing address
Entity email address
Entity phone number
Network Types
Pharmacy Benefit manager
Save and continue
Save and exit
This page is a summary of the information that has been entered. The only thing needed on this page is to review and ensure the information is accurate.
If the Submitter and the Attester are two different individuals, the Attester will also have the opportunity to review this page before signing the attestation.



If the Attester is a different individual than the Submitter, this box will pop up during section 4.

If the information entered in section 4 is all correct, the Submitter may then click “send email” to alert the Attester that the submission is ready for final review and signature.

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 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 directly or indirectly restrict the group 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'm attesting on behalf of group health plans, including non-federal governmental plans, and health insurance issuers offering group health insurance coverage.

Health insurance issuers offering individual health insurance coverage

I attest that, in accordance with section 2799A-9(a)(2) of the Public Health Service Act, the health insurance issuer(s) offering individual 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, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance issuer(s) from —

1. Providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or
2. Sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in item (1) 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 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).

☐ I'm attesting on behalf of health insurance issuers offering individual health insurance coverage.

Attest your submission

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.**

Signed submission date
09/02/2023 11:34 AM

Submit Start over

The Attester should check these two boxes, provide a signature in the box, and then click “submit”.

A confirmation of submission will appear if the submission goes through.

Appendix B - FAQs

Does the timing of an attestation in one year affect the due date in subsequent years?

The timing of the attestation in one year does not affect the due date for the attestation the next year. The due date will always be on or before (by) December 31. However, the timing of the attestation will affect what period the plan is attesting for. For example, if the attestation is done December 5, 2023, it will be an attestation up through December 5, 2023. When the plan then attests next year (e.g., December 19, 2024), the attestation will cover the time frame December 6, 2023 through December 19, 2024.

See the following FAQ from CMS - https://www.cms.gov/files/document/aca-part-57.pdf

> **Q6: What is the due date for the Gag Clause Prohibition Compliance Attestation?**
>
> The first Gag Clause Prohibition Compliance Attestation is due no later than December 31, 2023, covering the period beginning December 27, 2020, or the effective date of the applicable group health plan or health insurance coverage (if later), through the date of attestation. Subsequent attestations, covering the period since the last preceding attestation, are due by December 31 of each year thereafter.

Some have asked whether an attestation must be made within 12 months of the previous attestation. The instructions require subsequent attestations to be filed no later than December 31 of each calendar year and to attest to compliance for the time period since the last attestation. There does not appear to be any requirement that a subsequent attestation be made within one year of the prior one.

How many attestations are required on behalf of a single group health plan?

The answer will vary depending upon the group health plan's setup. For example, for a fully-insured plan coordinating solely through a carrier, only a single attestation is generally required (and will likely be handled by the carrier). Similarly, for a self-funded group health plan, the TPA or employer could attest on behalf of all service providers in connection with the plan in a single attestation. However, it is also possible for the employer and/or different service providers to separately attest to compliance on behalf of the plan, resulting in multiple attestations tied to a single group health plan to ensure that there is a complete attestation as to all provider contracts in place for the group health plan.

There is a question in the submission form asking if the attestation is being submitted on behalf of all service providers involved with the plan. If "yes," then only one submission would be required on

behalf of the group health plan. If "no," then any service provider that is not part of the attestation would also need to attest, or the employer would need to attest to such contracts being in compliance.

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

Reporting is handled 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).

Controlled Group

When entities that are part of the same controlled group share benefit plans, the employers are treated as a single employer. Therefore, a single attestation by whichever company is designated the plan sponsor should be adequate if the attestation covers all service provider contracts tied to the group health plan.

MEWA

When a MEWA is formed, the MEWA may be treated as a single plan at the MEWA level if certain commonality and control requirements are met. However, more often, each participating employer is deemed to have a separate ERISA plan. If there is a single ERISA plan at the MEWA level, a single attestation by the MEWA plan sponsor would be adequate. On the other hand, if each participating employer sponsors a separate ERISA plan, then each participating employer is responsible for ensuring an attestation is submitted on behalf of their plan.

What if an employer changes carriers, TPAs or service providers during the attestation period?

If there was more than one carrier or TPA involved with the group health plan during the attestation period, the employer must ensure that the attestation covers all such contracts. The employer is responsible to confirm that no prohibited gag clauses existed in any applicable contracts with service providers during the attestation period and will need to ensure that all such carriers or TPAs (or other service providers) are attesting on behalf of the plan; alternatively, the employer would need to attest on behalf of any contracts that any of the service providers do not agree to attest to on the employer's behalf.

When must a spreadsheet be included in the attestation?

The spreadsheet is required only when the same reporting entity is attesting to multiple different group health plans. This will often be the case for carriers or TPAs, but will rarely be used by for employers. If all the employer's benefits subject to the attestation have been bundled into a single ERISA plan, the employer may report on behalf of just the one plan and attest to all benefit arrangements at once. In this case, no spreadsheet is required. A spreadsheet is not part of the attestation process for a reporting entity that is attesting on behalf of only a single group health plan. In addition, even if the various benefits/arrangements are not bundled into a single ERISA plan via a WRAP document, informal guidance from CMS indicates the employer may still report on a single group health plan by picking one of its plan numbers and attesting to all benefit arrangements at once. Alternatively, the employer would need to report for each plan (i.e., "submitting on behalf of more than one plan") using the Excel spreadsheet and uploading it as part of the attestation process.

What does "Are you attesting on behalf of all different types of service providers" mean?

This question is not asking about how many different benefits or plans an employer maintains, but instead is asking about the different 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.

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

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). But 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 arere 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 for its contracts, the employer still has a record of its good-faith attempt to reach out to all service providers.

Should documentation of verification/attestation from a service provider be included in the attestation submission?

There is not an option to upload anything into the attestation portal other than the Excel spreadsheet used when reporting is done for multiple group health plans. CMS guidance indicates employers should keep in their records any communication with carriers, TPAs, PBMs, and other service providers confirming compliance with the gag clause prohibition.

Are the Submitter and the Attester the same person?

Sometimes, yes. When the employer is handling the attestation on behalf of their group health plan(s), one individual may play both roles as the Submitter and the Attester. It is also possible that an individual that does not have the authority to sign the attestation goes through and fills out all of the required information (playing the role of the Submitter), and then a separate individual with signing authority provides a final review and signature (playing the role of the Attester), in which case there would be two different individuals as the Submitter and Attester.

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

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.

What is the penalty for noncompliance?

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.

Will this make it more likely that carriers and TPAs will share claims data?

Maybe…it may take some additional regulatory guidance and court decisions to force this behavior. It's not perfectly clear what is and is not permitted under the current framework. It is certainly worth pushing back on any refusal to share such information and asking for clarification as to what permits the service provider to avoid providing the information in light of the new gag clause prohibition.