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GUIDANCE ISSUED ON CAA GAG CLAUSE ATTESTATION PROCEDURES

On February 23, 2023, the Departments of Labor, Health and Human Services, and Treasury (collectively, the Departments) issued guidance implementing the requirement that health plans and health insurers annually attest to compliance with the "no gag clause" provision in the Consolidated Appropriations Act, 2021 (CAA). The first attestation is due by December 31, 2023. Employers will need to confirm with their plan's service providers that contracts are compliant and whether their service providers will be attesting on their behalf.

What is the prohibition on gag clauses?

Group health plans and health insurers are prohibited from entering into agreements with health care providers, third-party administrators (TPAs), or other service providers offering access to a network of providers that would restrict a plan or insurer from providing, accessing, or sharing certain information.

Specifically, it prohibits the following items in a plan contract from being subject to a gag clause:

Provider-specific cost or qualify of care information or data through a consumer engagement tool or any other means;

Electronic de-identified claims and encounter information or data for individuals upon request and consistent with HIPAA, GINA, and the ADA;

The ability to share information or data in 1) and 2) above (or to direct such information be shared) with a HIPAA business associate, consistent with HIPAA, GINA, and the ADA.

What is the purpose?

The gag clause prohibition is one of many transparency reforms enacted by the CAA intended to improve health care purchasers' decision-making with respect to health care services. These "CAA reforms" – posting of machine-readable files, mental health parity comparative analysis disclosures, banning surprise medical bills, prescription drug reporting, cost-sharing estimates, etc. – have been taking effect in stages. The gag clause prohibition took effect upon enactment of the CAA in December 2020, so problematic provisions should have already been removed from agreements. Plans and insurers have since been operating under a good faith standard while waiting for the Departments to issue attestation procedures.

Which plans must comply?

The gag clause prohibition applies to group health plans (both fully insured and self-insured), including ERISA plans, non-federal governmental plans, and church plans (regardless of grandfathered status). Attestations are required for medical, pharmacy, and behavioral health plans but not for "excepted benefits", such as most dental, vision, health FSA, and EAP plans. The Departments have indicated they will not enforce the requirement against health reimbursement arrangements (including individual HRAs) or other account-based plans because such arrangements are integrated with other coverage that is required to complete the attestation.

How do plans attest?

Plans are required to annually attest to their compliance using the Gag Clause Prohibition Compliance Attestation (GCPCA) webform which is accessible through the CMS Health Insurance Oversight System (HIOS). FAQs, instructions, a user manual, and a reporting template are all available on the GCPCA webpage.

The first GCPCA is due by December 31, 2023, covering the period beginning December 27, 2020 (or the effective date of the applicable group health plan, if later) through the date of attestation. Subsequent GCPCAs are due by December 31 of each year and cover the period since the last GCPCA submission.

Fully Insured Plans

With respect to a fully insured group health plan, the group health plan (generally the employer) and the health insurer are each required to annually submit the attestation. Per Q/A-10 of the Departments' FAQs, however, when an insurer submits a GCPCA on behalf of the plan, the Departments will consider both the plan and the insurer to have satisfied the attestation submission requirement.

Self-Insured Plans

With respect to a self-insured group health plan (including a level-funded plan), Q/A-9 confirms that the employer may satisfy the attestation requirement by entering into a written agreement under which the service provider (TPA/PBM/behavioral health provider) will complete the GCPCA on the plan's behalf. The employer, however, retains ultimate responsibility for compliance. Q/A-10 recommends that service providers attesting on behalf of self-insured plans first coordinate with each plan to ensure that the plan does not intend to attest on its own behalf for some or all of its provider agreements.

In Closing

In preparation for the first attestation deadline, employers should familiarize themselves with the requirement and actions being taken by their service providers. Employers sponsoring fully insured medical plans should have no action item with respect to the GCPCA other than to confirm that their carriers are fulfilling the requirement. Insurers are directly responsible for completing the GCPCA, and there is no need for the employer to complete a separate one. Employers sponsoring self-insured medical plans need to consult with their service providers to determine which party will complete the GCPCA. Although the plan (employer) is directly responsible for attesting, it is likely that most TPAs/PBMs/behavioral health organizations will contractually agree to complete the GCPCA on the plan's behalf.