Brown & Brown

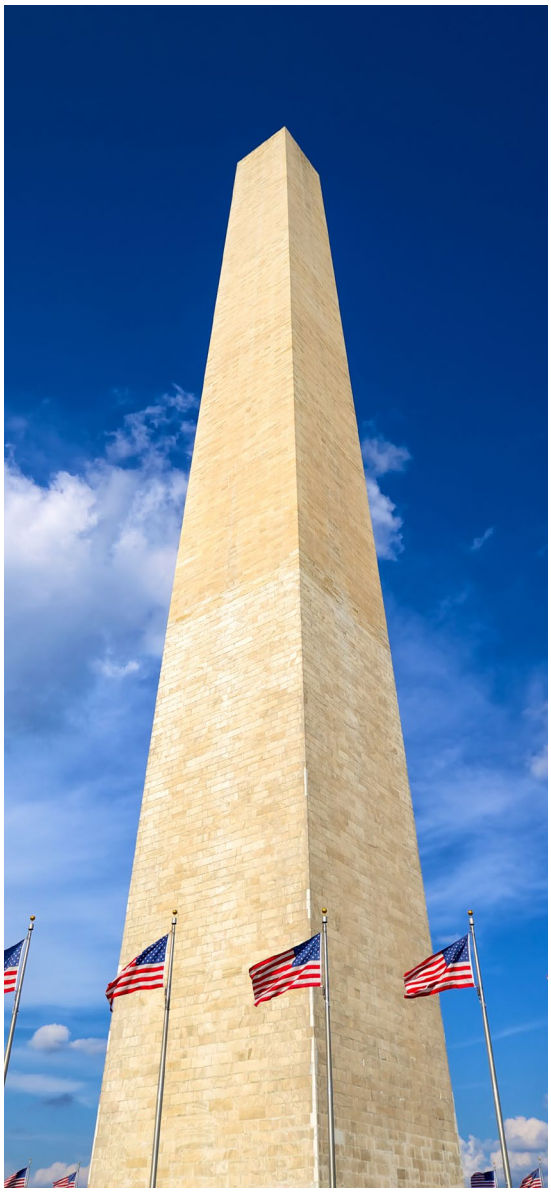
EMPLOYEE BENEFITS

Gag Clause Prohibition Compliance Attestation

Background

Under the No Surprises Act's rules prohibiting gag clauses (referred to herein as the "gag clause prohibition rules"), group health plans must report and attest that they do not have any direct or indirect agreements with providers that would restrict or prevent the disclosure of cost or quality of care information or negotiated fee schedules to certain groups. The gag clause prohibition rules became effective on December 27, 2020. The first attestation ("Gag Clause Prohibition Compliance Attestation" or "GCPCA") is due on or before **December 31, 2023**, and it covers the period of December 27, 2020, through the date on which the attestation is filed. For subsequent reporting years, GCPCAs must be made annually by December 31st of each year.

CMS has published instructions regarding the GCPCA requirements, which are available on the CMS website.



Reporting Entities

The GCPCA requirement applies to "Reporting Entities." Reporting Entities are defined as group health plans[1] (including ERISA and ERISA exempt health plans, grandfathered plans, non-federal governmental plans (e.g., state/county/city health plans), and church plans) and health insurance issuers that either directly or indirectly (e.g., through a third-party administrator, Pharmacy Benefit Manager, Behavioral Health Manager, etc.) enter into agreements with healthcare providers, networks or associations of providers, third-party administrators or other service providers offering access to a network of providers. The Reporting Entity must attest (through the GCPCA) that it and any vendor or third-party administrator (collectively referred to as a TPA) of the benefits or a subset of benefits provided under the group health plan comply with the gag clause prohibition rules.

1. *Except as identified below.*

While group health plans are Reporting Entities subject to the GCPCA requirements, regulatory guidance allows others to provide the GCPCA on behalf of the plan in certain situations.

- **Fully Insured Group Health Plans.** For fully insured plans, the government will consider the group health plan compliant with the GCPCA requirement so long as the fully insured carrier submits the GCPCA on behalf of the group health plan.

- **Self-Insured Group Health Plans.** For self-funded/self-insured plans, according to the GCPCA instructions, the plan "may satisfy the requirement to provide an attestation by entering into a written agreement under which the plan's service provider, such as a Third-Party Administrator (TPA) (including an issuer acting as a TPA), attests on its behalf." If a group health plan utilizes more than one TPA, with each TPA administering a subset of covered plan benefits (e.g., a medical claims administrator and a separate PBM), then each TPA may attest on the group health plan's behalf concerning the subset of covered plan benefits administered by that TPA.[2] Although a self-funded plan may have one or more TPAs submit the GCPCA on its behalf, ultimately, if the TPA fails to submit the attestation, the health plan will be considered as having failed its obligation to submit the GCPCA.

Benefits Not Subject to Reporting

The following benefit offerings are **not** subject to the gag clause prohibition rule and therefore are not subject to the GCPCA requirement.

Benefit Plan Type	Example
Account-Based Plans	HRAs, FSAs and HSAs
HIPAA Excepted Benefits	• Certain hospital indemnity or fixed indemnity insurance • Disease-specific insurance • On-site medical clinics • Referral-Only EAP plans and certain EAPs with limited counseling sessions[3] • Stand-alone vision/dental/or long-term care insurance[4] • Accident-only, disability and workers' compensation insurance
Short-Term, Limited Duration Coverage	Gap insurance plans for uninsured individuals who may need coverage post-termination of employment until they can find another source of coverage
Medicare/ Medicaid Plans	Medi-Gap or Medicare Supplemental plans

2. *The CMS instructions specifically state that "If the plan utilizes more than one TPA, with each administering a subset of covered plan benefits, each TPA may attest on the plan's behalf with respect to the subset of benefits it administers."*
3. *HIPAA does not specifically define the number of counseling sessions an EAP may provide to remain an excepted benefit.*
4. *To constitute an excepted benefit, dental, vision and long-term care insurance benefits either (a) must be provided under a separate policy, certificate or contract of insurance from the employer's medical plan, or (b) may not be an integral part of the health plan.*

Benefits Subject to Reporting

Below is a sample list of group health plans and health plan benefits that **are** subject to the attestation requirements under the GCPCA rules if they involve direct or indirect agreements with healthcare providers. **This is not meant to be an exhaustive list of covered health plan benefits. Employers should consult their legal counsel for advice regarding which benefits they sponsor are covered by the GCPCA requirements.**

- Fully Insured Group Medical Plan (including the plan's Prescription Drug/Pharmacy Benefits)
- Self-Insured Group Medical Plan (including the plan's Prescription Drug/Pharmacy Benefits)
- Behavioral Health Benefits offered outside of the medical plan (i.e., stand-alone benefits)
- Wellness Program (if it provides medical care to employees, such as biometric testing or flu shots)
- Concierge Service (if it provides medical care to employees)
- Telehealth Services offered outside of the medical plan (i.e., stand-alone benefits)
- Other covered plan benefits offered outside of the medical plan (e.g., direct primary care arrangements, transplant programs or specialty Rx solutions, etc.)

Attestation Submission

Reporting Entities must submit their GCPCA to CMS on their website. A user manual for submitting the GCPCAs is also available on the CMS website.

The procedure for reporting is different depending on whether the person or entity submitting the GCPCA (the "Attesting Entity") is doing so on behalf of a single Reporting Entity or multiple Reporting Entities (e.g., a single group health plan or multiple group health plans). See Option A and Option B, Section 2.2 of the instructions. Option B (which is applicable when the Attesting Entity is submitting the GCPCA for multiple Reporting Entities) requires the submission of an Excel worksheet as part of the GCPCA. CMS has made a template Excel worksheet (the "GCPCA Reporting Entity Excel Template") available at the bottom of this webpage.

Next Steps

Plan sponsors should consider taking, **with the assistance of legal counsel**, the following steps concerning the GCPCA requirements:

1. Determine which group health plans it sponsors are subject to the GCPCA requirements. Specific questions regarding whether a particular benefit is subject to the GCPCA requirements should be addressed with legal counsel.

2. Determine which vendors/insurance carriers/TPAs are involved in providing covered benefits under the group health plan(s) identified in item #1.

3. Determine whether the vendors/insurance carriers/TPAs identified in item #2 will submit the GCPCA on behalf of its group health plan(s), keeping in mind that a third party's submission of the GCPCA on behalf of a self-insured group health plan should be addressed in a written agreement.

4. In the event any of the vendors/insurance carriers/TPAs identified in item #2 ***will not*** submit the GCPCA on behalf of its group health plan(s), determine whether the vendors/insurance carriers/TPAs have provided sufficient information about the absence of prohibited gag clauses in the provider agreements maintained by that vendor/insurance carrier/TPA that apply to the plan sponsor's covered group health plan(s). This determination should be made with the assistance of legal counsel.

5. In the event any of the vendors/insurance carriers/TPAs identified in item #2 ***will not*** submit the GCPCA on behalf of its group health plan(s), follow the CMS instructions for submitting a GCPCA to CMS on behalf of its group health plan(s) by December 31, 2023. The scope of the submission may be contingent upon the determination made in item #4.

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

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Find Your Solution at BBrown.com

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