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New Guidance on "No Gag Clause" Rule for Group Health Plans and New Reporting Requirements

On February 23, 2023 the Departments of Labor, Health and Human Services, and Treasury ("Departments") issued guidance on the "no gag clause" rule that was added as part of the Consolidated Appropriations Act, 2021 ("CAA"). More information on the CAA may be found in our January 2021 Client Alert and November 2021 Client Alert.

This Client Alert summarizes the recent guidance on the "no gag clause" rule, including the new reporting requirements and how group health plans can comply with them.

1. What is a "gag clause"?

Generally, a "gag clause" is a contractual provision that restricts a health plan from providing certain information to another party. The "no gag clause" rule applies to contracts between a plan and a health care provider, a network or association of providers, a third-party administrator ("TPA"), or another service provider offering access to a network of providers.

2. What does the "no gag clause" rule prohibit?

Health plans cannot enter into agreements that directly or indirectly restrict the plan from (i) disclosing provider-specific cost or quality of care information to providers, the plan sponsor, and participants; (ii) electronically accessing de-identified claims and encounter information or data for each participant; and (iii) sharing this type of information with a business associate.

3. What are some examples of gag clauses?

- A contract between a group health plan and a TPA that states that the plan will pay providers at designated "Point of Service Rates," but the TPA contractually prohibits the plan from disclosing the rates to participants.
- A contract between a group health plan and TPA that states the plan sponsor's access to provider-specific cost and quality of care information is only available at the TPA's discretion.

4. Is a contractual term a prohibited gag clause if it does not explicitly restrict a plan from providing, accessing, or sharing the information described in Question 2?

Yes. A contract cannot directly or indirectly prevent a plan from providing, accessing, or sharing the identified information.

5. What is the Gag Clause Prohibition Compliance Attestation?

Group health plans must annually submit to the Departments an attestation that they comply with the "no gag clause" rule.

6. When is the Gag Clause Prohibition Compliance Attestation Due?

The first attestation is due December 31, 2023. The attestations will be due by December 31 each year thereafter. Failure to submit and late attestations may be subject to enforcement action by the Departments. For example, failure to comply with the no gag clause rule could result in a tax under the Internal Revenue Code.

7. How do plans submit an attestation?

Plans may visit https://hios.cms.gov/HIOS-GCPCA-UI to submit the attestation. Instructions and a user manual are available online, as well as a template for providing the required information.

8. What entities must submit a Gag Clause Prohibition Compliance Attestation?

Entities required to submit an attestation include:

- health insurance issuers offering group health insurance coverage; and
- fully insured and self-insured group health plans, including ERISA plans, non-federal governmental plans, and church plans subject to the Internal Revenue Code.

Among other types of plans, attestation is not required for plans offering only expected benefits, or short-term, limited duration insurance. Additionally, the Departments will not enforce the attestation requirement on plans that consist solely of health reimbursement arrangements ("HRAs") or other account-based group health plans because the design of such plans does not require entering into agreements with providers.

9. Who may attest to compliance on behalf of a plan or issue.

The plan, issuer, or authorized service provider (on behalf of a plan) may authorize an appropriate individual within the organization, such as the plan administrator, to provide the attestation.

10. Can another entity, such as a pharmacy benefit manager, TPA, or other service provider attest on behalf of a self-insured group health plan?

Yes. Self-insured and partially self-insured plans may provide an attestation by entering into a written agreement where the service provider attests on the plan's behalf, but the legal requirement to provide a timely attestation remains with the plan.

For fully insured group health plans, the plan and issuer must both submit an attestation, but if the issuer submits the attestation on behalf of the fully insured plan, the Departments will consider the plan and issuer to have satisfied the attestation requirement.

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11. What should an interested party do if there's a suspected violation of the gag clause prohibition or attestation requirements?

Concerns may be raised by contacting the No Surprises Help Desk at 1-800-985-3059, submitting a complaint at https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint or contacting the applicable state authority.

12. What steps should employers take to comply with the no gag clause rule and attestation requirements?

- Employers should review contracts between their group health plans and service providers to verify there are no prohibited gag clauses. Contracts with prohibited gag clauses should be amended.
- Employers with self-insured health plans should negotiate and enter into an agreement with their TPA to provide the attestation on the plan's behalf.
- Employers with fully insured plans should coordinate with the insurer and confirm in writing that the insurer will submit the attestation on the plan's behalf.

If you have any questions about the new guidance or need assistance reviewing service contracts, please reach out to a member of the Kutak Rock Employee Benefits Group.