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Gag Clause Attestation Toolkit

October 2023

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Overview

On December 27, 2020, the Consolidated Appropriations Act, 2021 (2021 CAA) was enacted in part to amend the Employee Retirement Income Security Act (ERISA), the Public Health Services Act (PHSA), and the Internal Revenue Code. The 2021 CAA prohibits most group health plans and health insurance carriers from entering into agreements with health providers, third-party administrators (TPAs), or other service providers that include language that would constitute a “gag clause”. 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 (FINA), 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 2021 CAA gag clause prohibition enables the free flow of health care cost and quality information among insurers, health plans, health care consumers, providers, plan sponsors and their service providers. That free disclosure of information is necessary to optimize the various healthcare transparency provisions contained in the 2021 CAA and the Affordable Care Act (ACA). Once the gag clause prohibition became effective in late 2020, most insurers, TPAs, and other health plan vendors worked quickly to modify their contractual agreements to comply.

Significantly, the 2021 CAA also requires group health plans and health insurance carriers to annually submit an electronic attestation of compliance with the 2021 CAA’s gag clause prohibition to the Centers for Medicare and Medicaid Services (CMS). The first attestation to CMS is due December 31, 2023 (attesting to compliance for 2021 – 2023). Subsequent attestations will be due by December 31 of each year thereafter.

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

CMS has created this webpage offering FAQs, instructions, a user manual, and other information about how to comply with the gag clause prohibition as well as how to attest to compliance through the website portal – a process that they’ve labeled the Gag Clause Prohibition Compliance Attestation (GCPCA). Additionally, the website for submitting the attestation can be found at this link.

Which Plans Must Comply?

The gag clause prohibition and attestation requirements apply to virtually all employer-sponsored health plans, including plans that remain grandfathered according to Affordable Care Act standards. However, the focus of compliance will be on major medical plans and the contracts maintained between plan sponsors, insurers, TPAs, Pharmacy Benefit Managers (PBMs), health plan providers on behalf of such medical plans. Importantly, excepted benefits—including stand-alone dental or vision plans and health FSAs—are exempt, as are account-based health plans (e.g., HRAs) and short-term limited duration benefits.

Please refer to Q/A-8 from these FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 57 for more detail.

When is the Attestation Due?

The first attestation is due December 31, 2023. The first attestation will apply to the period beginning with the date the gag clause prohibition first went into effect, December 27, 2020. Therefore, plans must initially attest to compliance for the period from 2021 – 2023 by the end of 2023.

Subsequent attestations will be due annually by December 31st covering 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, 2023, the plan must attest to compliance December 15, 2023 – December 22, 2023 during the second attestation.

Who Must Complete the Attestation?

Ultimately, it's the responsibility of the health plan (and by extension, the sponsoring employer) to satisfy the requirement. Nonetheless, employers typically rely on their carrier, TPA, or network to contract with medical providers to provide services to participants in the health plans offered to employees. The Departments recognize that employers rarely directly enter into agreements with health care providers, so the guidance makes it clear that if specific requirements are met, employers can rely on their carrier or TPA to submit the attestation on behalf of their employer-sponsored plans.

However, a plan's carrier or TPA may not be willing to attest on the plan sponsor's behalf, 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 connected to the medical carrier or TPA). Aside from a few exceptions among carriers of fully-insured plans, the prevailing approach by most vendors has been to submit a general statement of confirmation of their own compliance with the gag clause rules and defer to the plan sponsor to take action to attest to CMS. When that is the case, the employer will have to submit the attestation of compliance to CMS on behalf of its group health plan.

Fully-Insured Group Health Plans

Carriers of group medical policies are required to submit an attestation regarding the group and individual health plans they offer, so the carrier could agree to attest on the plan sponsor's behalf as well. A limited number of carriers have offered to do so, in which case employers may rely on the carrier to submit the required attestation. However, it is recommended that the employer seek written 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 agreements or 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.

While it's possible that a self-funded plan's service provider(s) will agree to attest on behalf of the plan, it is more likely that the employer will need to attest on behalf of the plan.

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." Selection of either prompt 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 (p. 6) FAQs can be found in Appendix B (p. 14).

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.

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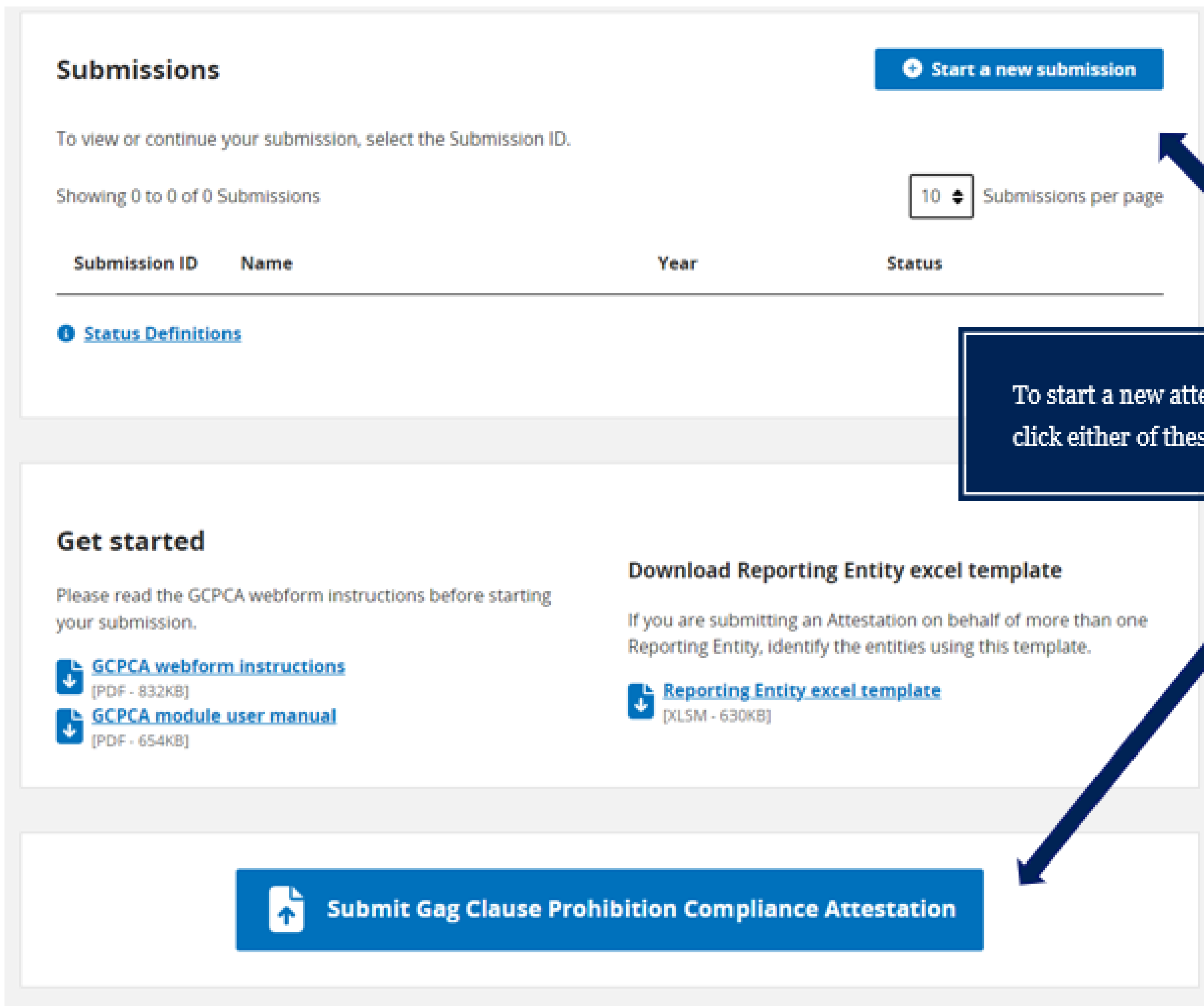
Appendix A – Attestation Process Screenshots

GCPCA Dashboard



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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**

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

* **Submitter employer name**

The Submitter is the individual tasked with filling out information about the group health plan. It could be the Attester, but it might be the broker, employer HR personnel, or someone else who is completing the form prior to the Attester's review and signature.

* **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

An employer completing the attestation will typically mark GHP for "group health plan".

Save and continue | Save and exit

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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

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.

* 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)

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.

Save and continue | Save and exit

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3 Enter Reporting Entity Details

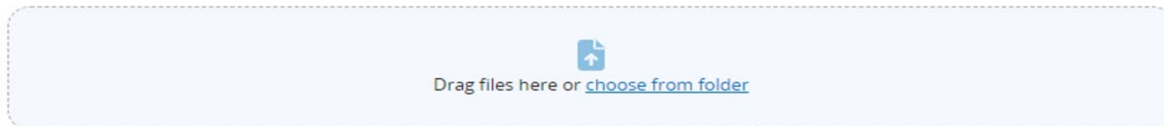
If you are submitting on behalf of more than one plan or one issuer, select Yes.

- (●) Yes
- ( ) No

Reporting Entity Details

Complete the **Reporting Entity Excel Template** for all Reporting Entities on whose behalf you are submitting this attestation. The GCPCA Webform instructions provide specific guidance on creating the Reporting Entity tab-delimited text file in sections 2.3 and 2.31. If you are attesting on behalf of a Reporting Entity that you work for as well as other Reporting Entities, include the information for your entity. Only one Reporting Entity per row is permitted. Once the **Reporting Entity Excel Template** is complete, you must save it as a tab-delimited text file format and upload it here. After successfully uploading the text file, e-mail your completed **Reporting Entity Excel Template** to the Attesster for their review.

* **Upload Entity List**
The entity list must be in text tab delimited format.



Save and continue | Save and exit

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 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.

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3 Enter Reporting Entity Details

If you are submitting on behalf of more than one plan or one issuer, select Yes.

- ( ) Yes
- (•) No

Entity/Organization Details

Please add the entity details for the entity you are submitting this attestation on behalf of.

Note: If you are submitting on behalf of yourself, the entity details you enter will need to represent your entity.

* Name of the reporting entity

> Enter employer's name.

Reporting entity type

Please select an option

> 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.

* Name of reporting entity point-of-contact

> 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).

* Employer identification number

* Mailing address for the reporting entity

* E-mail address for the reporting entity point-of-contact

* Phone number for the reporting entity point-of-contact
Enter a phone number in the following format: "(xxx) xxx-xxxx".

* Are you attesting for all provider agreements?
Medical, PB, BHN, Other

- ( ) Yes
- (•) No

* Select the specific type of provider agreement(s) that apply. If you are attesting for a specific provider agreement other than or in addition to medical, pharmacy benefit, or behavioral health, choose "other," and enter the specific provider agreement type into the text box.

- [ ] Medical
- [ ] Pharmacy Benefit manager
- [ ] Behavioral Health
- [ ] Other

> 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.

Save and continue | Save and exit

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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)	

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.

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

Let's confirm the Attester's email address.

Close

Verify that the attester's email is correct, if not please enter the correct email address. Once verified, a unique code will be generated from submissions@cms.hhs.gov and email to your chosen attester.

* Attester email address

Please notify the attester that they will be receiving an email from submissions@cms.hhs.gov. Have the attester follow the instructions in the email to complete the submission. Please have the attester check their junk mail just in case the email was not received. If for any reason the email was not received or has expired, please apply for a new code from the home page.

Send Email Cancel

If the Attester is a different individual than the Submitter, this box will pop up during section 3.

If the information entered in section 3 is all correct, the Submitter may then click "send email" to alert the Attester that the submission is ready for final review and signature.

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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.

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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 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:

> **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. However, 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 may 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 contracts involved with the group health plan.

There is a question in the submission 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 separately attest to such contract's 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 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.

How is reporting different when an employer has a single group health plan versus multiple group health plans?

When submitting information about the plan, the employer must choose whether reporting is being done on behalf of one group health plan or multiple group health plans. If the reporting is done for a single group health plan, then the required information is entered right within the attestation portal. If the reporting is done for multiple group health plans, then the required information is not entered directly into the attestation portal, but instead is entered into an Excel spreadsheet (one line for each group health plan), and then the Excel spreadsheet is uploaded into the attestation portal.

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. Therefore, we assume employers will need to 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 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 contract (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.