**Hot Topics:**

**Attestations for Gag Clause Prohibition Compliance Due to CMS by December 31, 2024**

The Departments issued joint [FAQ guidance](https://www.cms.gov/files/document/aca-part-57.pdf) related to compliance with the prohibition of “gag clauses” as required under the Consolidated Appropriations Act of 2021 (CAA). Specifically, the rules require plans and issuers to submit a compliance attestation no later than December 31, 2024 and annually each year by December 31st.

 **Applies To:**

* Large employers with fully-insured and self-funded health plans
* Small employers with fully-insured and level-funded health plans

**Go Deeper:**

***What is a gag clause and what is prohibited?***

The CAA prohibits group health plans and insurance carriers from entering into agreements with providers, TPAs, or other service providers whose agreements include language that would constitute a “gag clause,” specifically:

1. restrictions on the disclosure of provider-specific cost or quality of care information or data to referring providers, the employer plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;
2. restrictions on electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee upon request and consistent with the privacy regulations promulgated pursuant to section 246(c) of HIPAA, GINA, and the ADA; and
3. restrictions on sharing information or data described in (1) and (2), or directing that such information or data be shared, with a business associate, as defined in 45 CFR 160.103, consistent with applicable privacy regulations.

For example, if a contract between a TPA and a group health plan states that the plan will pay providers at rates designated as “Point of Service Rates,” but the TPA considers those rates to be proprietary and therefore includes language in the contract stating that the plan may not disclose the rates to participants, that language prohibiting disclosure would be considered a prohibited gag clause (would not be allowed).

As another example, if a contract between a TPA and a plan says that the employer’s access to provider-specific cost and quality of care information is only at the discretion of the TPA, that contractual provision would be considered a prohibited gag clause.

Self-insured employer plan sponsors and fully-insured carriers must ensure that their agreements with health care providers, networks or associations of providers, or other service providers offering access to a network of providers do not contain these or other provisions that violate the prohibition on gag clauses. However, a health care provider, network or association of providers, or other service provider may place reasonable restrictions on the public disclosure of this information.

***What attestation is required?***

In addition to ensuring agreements do not contain such gag clauses, ALL plans and issuers are required to submit a Gag Clause Prohibition Compliance Attestation (GCPCA) directly to CMS online at <https://hios.cms.gov/HIOS-GCPCA-UI> no later than December 31, 2024 and each year thereafter.

***Will the carrier or TPA submit the GCPCA on the employer’s behalf?***

Employers and advisors will need to confirm with carriers, service providers and TPAs on what level of assistance will be provided.

* *Fully-insured group health plans*: the plan sponsor and the insurance carrier are **both** required to submit the GCPCA each year by December 31st. However, a fully-insured plan sponsor may shift liability to the carrier through a written agreement.
* *Self-funded and level-funded plans* may satisfy the requirement to provide a GCPCA by entering into a written agreement under which the plan’s service provider(s) (such as a TPA, including an issuer acting as a TPA) will attest on behalf of the employer plan sponsor. However, even if the plan enters into an agreement with the TPA, the legal requirement to remove any gag clauses and provide an attestation rests on the plan sponsor.

***Who is exempt?***

Generally, plans consisting of only excepted benefits, HRAs and ICHRAs are not required to attest as these plans do not typically need to enter into agreement with providers. Instead, these arrangements are usually integrated with other medical coverage that is required to submit an attestation (e.g., HRAs integrated with group health plan and ICHRAs with individual medical coverage).

However, all group health plans regardless of size, funding strategy or grandfathered status must submit the required attestation.

***What is the penalty?***

The FAQ mentions that plans and issuers who fail to submit their GCPCA by the December 31st deadline may be subject to enforcement action, but no specific penalties are provided.

***What are the changes to the*** [***2024 Attestation Instructions***](https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/gag-clause-prohibition-compliance-attestation-annual-submission-instructions-2024.pdf) ***(see Appendix 4.1)?***

1. Selection for the “attestation year.”
2. Field for the “attestation period.”
3. Employer plan types expanded to include ERISA plans, non-federal governmental plans, and church plans.
4. The term “Reporting entity” changed to “Responsible Entity.”
5. Selections for “Responsible Entity” (i.e., which entity is attesting)
6. Sections for types of provider agreements
7. Text box for submitter to enter “Other Limitations”
8. Modified language to remove forward-looking agreement actions.
9. Definitions added to the Appendix 4.2
10. Language added to accommodate date ranges and other information provided through the submission process.

***Next steps for employers***

Many TPA service agreements include provisions requiring compliance with applicable law, which presumably would override any contrary existing provisions. Nonetheless, plan sponsors and advisors will need to review applicable agreements for gag clauses and remove them.

In addition, employers sponsoring fully-insured, level-funded or self-insured plans should be in contact with their service providers to understand what level of assistance they will be providing in submitting the GCPCA by December 31, 2024.

Instructions, templates and other information is provided on the CMS GCPCA website: <https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance>

**New Notices Required for Employers offering Fixed Hospital Indemnity Insurance**

Employers offering ‘hospital and other fixed indemnity benefits’ are required to provide a notice for plan years beginning on or after January 1, 2025 telling participants that the coverage is not comprehensive health coverage.

**Applies To:**

* Large employers offering fixed hospital indemnity benefits
* Small employers offering fixed hospital indemnity benefits

**Go Deeper:**

Fixed indemnity benefits typically provide a flat cash amount following the occurrence of a health-related event, such as hospitalization or illness at a predetermined level regardless of claims incurred under the major medical plan.

Specifically, the new notice must be provided at the time or before participants have the chance to enroll or re-enroll in these benefits. The new notice applies to group hospital indemnity or other fixed indemnity insurance. So, while all types of fixed indemnity policies such as cancer, specified disease and accident plans are indeed subject to the final rules, they are not considered “hospital indemnity or other fixed indemnity insurance” strictly for purposes of the new notice.

Therefore, because fixed indemnity plans are subject to the final rules, but the notification requirement only applies to employers who provide hospital indemnity plans that pay a per day or per period, the notice is only required for employers providing fixed hospital indemnity policies.

Thus, employers offering hospital indemnity policies need to add the notice to open enrollment packets on the first page that discusses applicable benefits beginning for the 2025 plan year.

The final rules provide a model notice (see page 75) [https://www.govinfo.gov/content/pkg/FR-2024-04-03/pdf/2024-06551.pdf](https://url.avanan.click/v2/r01/___https%3A/www.govinfo.gov/content/pkg/FR-2024-04-03/pdf/2024-06551.pdf___.YXAzOmN0Zy1oYXVzbWFubjphOm86NWI0NGIwMTU3NDI2OGMwNzMxN2FjNjIyZDZiODA4MDk6NzphZDQ4OjIzMWIyMGFlMzk3MjhkMDRmODllZmE3MmJiN2ViODJhN2YyNTcwZGQwYTgzMzExNjkzYmRiZDIzYWMwMzlmMzI6aDpUOk4).

**Federal Updates:**

**Final 1095/1094-B & C Forms for 2024 Issued**

The IRS issued final forms and instructions related to ACA reporting requirements for 2024 (2024 Instructions for Forms [1095/1094-C](https://www.irs.gov/pub/irs-prior/i109495c--2024.pdf) and [1095/1094-B](https://www.irs.gov/pub/irs-prior/i109495b--2024.pdf)).

**Applies To:**

* Applicable large employers (ALEs) with fully-insured and self-funded health plans, including ICHRAs (1095/1094-C)
* Small employers with level-funded health plans, including ICHRAs (1095/1094-B)

**Go Deeper:**

According to the instructions, 1095/1094-C and B forms must be filed electronically for all employers who file in aggregate 10 or more of various types of information returns, including W-2s, 1099s, 1098s and 1095-B or C.

In addition, the penalty for failure to file electronically is increased to $330 per return (up from $310), not to exceed $3,987,000 (up from $3,783,000), for employers who have more than 10 total returns. However, there is no annual maximum if there is an intentional disregard of the requirements to file the returns and furnish recipient statements.

The 1095-C instructions mention that the affordability safe harbor and qualifying offer method are applied using the percentage for 2024, which is 8.39%.

Here are deadlines for filing ACA forms with the IRS in 2025:

* Paper filings are due to the IRS by February 28, 2025 (note: most employers can no longer file paper forms).
* Electronic filings are due to the IRS as of March 31, 2025.
* 1095-C and B statements to individuals must be furnished by March 3, 2025, reflecting a permanent automatic extension 30 days after January 31.

Publications [5165](https://www.irs.gov/pub/irs-pdf/p5165.pdf) (guide for electronically filing ACA information returns for software developers and transmitters), [5258](https://www.irs.gov/pub/irs-pdf/p5258.pdf) (ACA AIR submission composition and reference guide), and [5308](https://www.irs.gov/pub/irs-pdf/p5308.pdf) (guide for automated enrollment for ACA providers) have also been revised. However, employers are encouraged to work with their payroll provider or other ACA filing platform for assistance with filing electronic returns.

Filers can apply for an extension with the IRS by submitting [Form 8809](https://www.irs.gov/forms-pubs/about-form-8809) prior to the filing due date.

**IRS Releases Guidance on Medical Care Expenses for FSAs, HRAs, HSAs and Preventive Care for High Deductible Health Plans**

The IRS has released two notices providing guidance on medical expense issues for health FSAs, HRAs, HSAs, and HDHPs. Specifically, the IRS will treat amounts paid for condoms as medical care expenses for reimbursement under health FSAs, HRAs and HSAs. In addition, several benefits are now considered preventive care for purposes of qualified high deductible health plan coverage.

**Applies To:**

* All employers offering high deductible health plans (HDHPs).
* All employers offering tax advantaged arrangements, including FSAs, HRAs and HSAs.

**Go Deeper:**

On October 17, 2024, the IRS released Notices [2024-71](https://www.irs.gov/pub/irs-drop/n-24-71.pdf) and [2024-75](https://www.irs.gov/pub/irs-drop/n-24-75.pdf). Here are the highlights to be reviewed by employers and TPAs:

*Medical care expenses for tax-advantaged arrangements* – Under a new safe harbor, the IRS will treat amounts paid for condoms as medical care under Code § 213(d). (According to the notice, amounts paid for condoms otherwise might or might not be considered medical expenses under Code § 213(d), depending on the specific facts and circumstances.) Therefore, these amounts can be paid or reimbursed under a health FSA, HRA, or HSA.

*Preventive care benefits for HDHPs* – The IRS gives an updated list of benefits that can be considered preventive care under a high deductible health plan and paid prior to meeting the minimum HDHP deductible:

* OTC oral contraceptives and OTC male condoms,
* Breast cancer screenings other than mammograms (e.g., MRIs and ultrasounds),
* Continuous glucose monitors under the same circumstances as other glucometers, if the monitor measures glucose levels using a similar detection mechanism. Other medical functions (e.g., insulin delivery) or nonmedical functions (other than minor functions—e.g., clock and date) that the continuous glucose monitor has must also be preventive care for the HDHP to cover benefits for the monitor before the HDHP minimum deductible is met.
* Insulin products, including any devices used to administer or deliver insulin products, whether it is for treatment of diabetes or prevent development of a secondary consider.

Changes in coverage may require amendments to the plan documents. TPAs and employers offering HDHPs, FSAs, HRAs and HSAs will need to review this guidance and update their plan benefits and plan documents accordingly.

**FAQ:**

**How do employers comply with the HIPAA Reproductive Health Care rules by December 23, 2024?**

The primary changes imposed by the new HIPAA rules are:

* Prohibits the use or disclosure of PHI in particular circumstances where reproductive health care is legally sought, obtained, provided, or facilitated.
* Requires a health plan (or its business associates) to obtain a signed attestation that certain requests for PHI potentially related to reproductive health care are not for prohibited purposes.
* Requires health plans to modify their notice of privacy practices to support reproductive health care privacy.

From a health plan prospective, most PHI related to reproductive health care will remain in the hands of third-party administrators and insurance carriers. However, the new rules will require action on the part of employers with self-funded group health plans (or insured plans with access to PHI) by Dec. 22, 2024. In particular, employers will need to:

* Conduct HIPAA training to incorporate the new requirements.
* Revise HIPAA policies and procedures and BAAs.
* Update & distribute the new Notice of Privacy Practices (by February 16, 2026)
* Develop an attestation [form](https://www.hhs.gov/sites/default/files/model-attestation.pdf).

Note: Many employers with fully insured health plans are not required to maintain or distribute their own privacy notice, as this responsibility is primarily imposed on the health insurance issuer. However, fully insured health plans with access to PHI (other than enrollment and summary health information) would also have to comply with the above obligations.

In addition, HHS provides model privacy notices for health care providers and health plans to use. It is expected that HHS will update its model notices to incorporate the new requirements for 2026. However, at this time, new model notices have not yet been issued.