**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
* Exempt:
  + Account-based plans such as FSA, HRA and ICHRA
  + Plans offering only excepted benefits, such as standalone dental/vision, on-site clinic, retiree-only, fixed indemnity, EAP, etc.

**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 pays providers at rates designated as “Point of Service Rates,” but the TPA considers those rates proprietary and therefore includes language in the contract stating that the plan may not disclose the rates to participants, that language prohibiting disclosure is considered a prohibited gag clause (i.e., not 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 is 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 need to confirm with carriers, service providers and TPAs on what level of assistance is 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?***

Plans consisting of only excepted benefits such as dental/vision or retiree-only plans are exempt. Also, account-based plans such as HRAs or ICHRAs are exempt as these plans do not typically need to enter into an agreement with providers. Instead, these arrangements are usually integrated with other medical coverage required to submit an attestation (e.g., HRAs integrated with group health plan and ICHRAs with individual medical coverage).

However, all group medical/Rx 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.

***Next steps for employers***

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

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 provide in submitting the GCPCA by December 31, 2024.

Visit the [CMS GSPCA website](https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance) for [2024 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), templates and other information

**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 when participants are presented materials about the plan and when they have the chance to enroll or re-enroll. The new notice applies to hospital indemnity or other fixed indemnity insurance that pays a flat amount per day or per period.

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, and must include the new notice in online enrollment systems to show on the screen where such indemnity plans are presented for enrollment.

The final rules provide a model notice (see page 75):  [Fixed Indemnity Final Rule](https://www.govinfo.gov/content/pkg/FR-2024-04-03/pdf/2024-06551.pdf)

**Federal Updates:**

**Disaster Relief Deadline Extensions due to Hurricanes Helene and Milton**

Federal agencies have issued [EBSA Disaster Relief Notice 2024-01](https://www.dol.gov/sites/dolgov/files/EBSA/employers-and-advisers/plan-administration-and-compliance/disaster-relief/disaster-relief-notice202401.pdf) to provide legally protected relief from certain group health and disability plan deadlines due to the recent hurricanes. The relief requirements were formally published in the [Federal Register](https://federalregister.gov/d/2024-26014) on November 8, 2024.

If you recall the pandemic Outbreak Period relief, this relief operates the same way.

**Applies To:**

* All employers sponsoring ERISA group health and/or disability plans with eligible individuals affected by the hurricane or tropical storm.
* Non-ERISA governmental and church plans might be exempt, but they are [encouraged](https://www.cms.gov/files/document/hurricane-helene-disaster-relief-bulletin.pdf) to participate.

**Go Deeper:**

***Impacted Individuals Eligible for Relief***

ERISA health and disability plans must comply with legally protected “Relief Periods” for individuals who resided, lived, or worked in one of the Covered Disaster areas eligible for FEMA Individual Assistance:

|  |  |
| --- | --- |
| **Covered Disaster Area** | **Relief Period** |
| Helene Individual Assistance areas in [FL](https://www.fema.gov/disaster/4828/designated-areas#individual-assistance) | 9/23/24 through 5/1/25 |
| Helene Individual Assistance areas in [GA](https://www.fema.gov/disaster/4830/designated-areas#individual-assistance) | 9/24/24 through 5/1/25 |
| Helene Individual Assistance areas in [SC](https://www.fema.gov/disaster/4829/designated-areas#individual-assistance), [NC](https://www.fema.gov/disaster/4827/designated-areas#individual-assistance), and [VA](https://www.fema.gov/disaster/4831/designated-areas#individual-assistance) | 9/25/24 through 5/1/25 |
| Helene Individual Assistance areas in [TN](https://www.fema.gov/disaster/4832/designated-areas#individual-assistance) | 9/26/24 through 5/1/25 |
| Milton Individual Assistance areas in [FL](https://www.fema.gov/disaster/4834/designated-areas#individual-assistance) not already included in the Helene FL disaster areas above | 10/5/24 through 5/1/25 |

Also, individuals covered under a plan directly impacted by a Covered Disaster are also eligible for the relief if:

* The principal place of business of the employer that maintains the plan,
* The principal place of business of employers that employ more than 50% of the active participants covered by the plan, or
* The office of the plan, plan administrator, or primary recordkeeper serving the plan was located in an Individual Assistance area above at the time of the hurricane or tropical storm.

***Deadlines Subject to the Relief***

Impacted individuals cannot have dates within the Relief Period count toward the following deadlines:

* 30-day HIPAA special enrollment rights for birth, adoption, marriage, or loss of other coverage (60 days for Medicaid/CHIP events)
  + *Tip: Only birth/adoption results in retroactive coverage. If someone takes extra time to notify the plan of a marriage, loss of other coverage, or Medicaid/CHIP event, coverage will not begin retroactively.*
* 60-day COBRA election period
* The date a COBRA premium is due, including the initial 45-day payment deadline and monthly payment deadlines with grace periods
  + *Tip: When a qualified beneficiary takes extra time to elect or pay for coverage, the plan “may initially deny claims and then, after premiums are paid, must make retroactive payment” for those claims.*
* The date for individuals to notify the plan of a COBRA qualifying event or determination of disability
* Timely filing of a claim, appeal, external review request or perfecting a request for external review

For a brief example, if an employee in a Covered Disaster area married 10/15/24, they would typically have 30 days (until 11/14/24) to add their new spouse to health coverage. However, all dates from the marriage through 5/1/25 cannot count toward their 30-day deadline. Instead, the 30 days does not start until 5/2/25, giving the employee until 5/31/25 to add their new spouse to health coverage.

In addition, ERISA disability plans cannot have dates within the Relief Period count for impacted individuals with respect to timely filing of a claim or appeal.

***Employers Receive Similar Deadline Relief***

The notice also provides impacted employers with similar relief with respect to issuing COBRA notices, as long as they act in good faith to provide the notice as soon as practicable. This may include using electronic means that are reasonably assured the individual will receive or making other reasonable accommodations. The relief applies if the principal place of business, or the principal place of business of employers that employ more than 50% of the active participants covered by the plan, or the office of the plan, plan administrator, or primary recordkeeper, is in the Covered Disaster areas listed above.

Likewise, impacted employers have relief for 5500 deadlines falling within the Relief Period, and impacted multiple employer welfare arrangements (MEWAs) have relief for the federal Form M-1 typically due by 3/1/25. All such deadlines are extended to 5/1/2025, in alignment with the [IRS’s announcements](https://www.irs.gov/newsroom/tax-relief-in-disaster-situations) from October which extended various employer deadlines to 5/1/2025.

**Next Steps for Employers**

Employers will want to work with their COBRA vendors immediately to ensure COBRA deadlines can be pended for impacted individuals during the legally protected Relief Period. Allowable exceptions must occur for impacted individuals who elect late or pay late to have COBRA (or have it reinstated).

Likewise, insurance companies and third-party administrators (TPAs) should “deny and pend” incoming COBRA claims for affected individuals and automatically reprocess them at the time a COBRA payment is provided for a date of service the payment covers. This process will be much harder for pharmacy benefit managers (PBMs) to accommodate, so they might just identify a process to reach out to someone who had attempted to fill a prescription while COBRA was “pended” to see if they would like the PBM to request a copy of what the member paid from the pharmacy to reimburse them what the plan would have paid.

Employers will also want to communicate with impacted individuals that they have extra time for the deadlines described above. We have a sample employee communication available, and the DOL has provided [FAQs](https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/helene-and-milton-faqs-for-participants-and-beneficiaries.pdf) employers may like to provide to impacted employees.

**FAQ:**

**What is the status of telemedicine benefits in 2025?**

There is bipartisan support to keep extending flexibility for telemedicine and to even make flexibility permanent.

While Congress explores possible flexibility, here is the status of telemedicine with respect to employee benefits:

* HSA Qualified High Deductible Health Plan (QHDHP) plan years starting in 2025 must ensure that non-preventive telehealth services charge the member a fair market value for those services until the federal minimum deductible is met.
  + QHDHP plan years that started in 2024 were the last allowed to have low- or no-cost telehealth services.
* Employer-sponsored telemedicine benefits are considered group health plans, making them subject to many compliance obligations, including but not limited to:
  + Must be “integrated” with the employer’s major medical plan (i.e., the only individuals who should be allowed access to the telemedicine program are employees and family members enrolled in the employer’s major medical plan)
  + Must be included on the Summary of Benefits and Coverage (SBC) or have its own SBC.
  + Must have a plan document/SPD.
  + Must be included in COBRA offers.
  + Must comply with MHPAEA, including the required parity analysis and NQTL analysis.
  + Must comply with HIPAA.
  + Must not have prohibited gag clauses in service agreements.
  + Must provide data to support RxDC reporting requirements and other CAA-21 transparency requirements.

While telemedicine is a popular benefit for many employers, it is important to understand that these benefits are viewed as group health plans themselves, and carry with them many compliance obligations.

In addition, employers offering an HSA QHDHPs with a telemedicine component should ensure the fair market value for telemedicine services is charged for plan years beginning in 2025. Otherwise, low or no-cost telehealth services paid prior to the minimum deductible is considered disqualifying coverage for purposes of HSA eligibility.