
RE: Gag Clause Memo

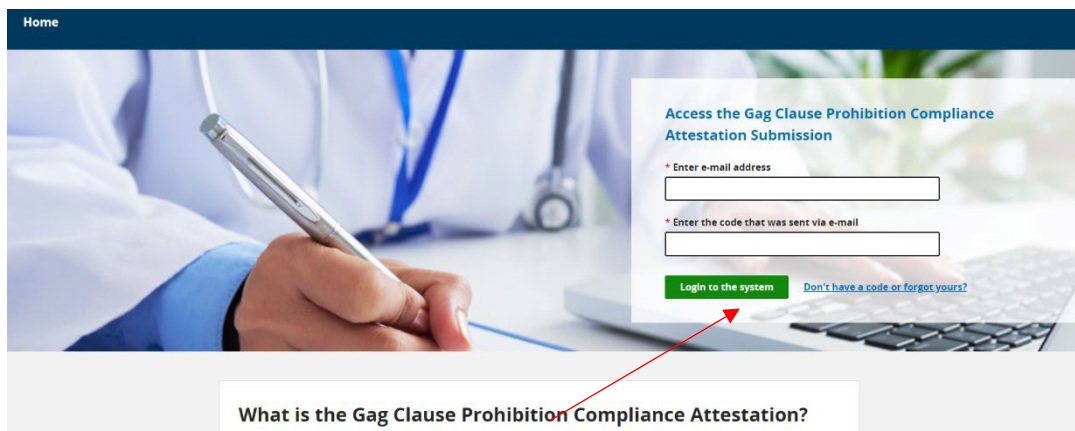
From: 90 Degree Benefits

Gag Clause Prohibition Compliance Attestation

Overview

Group Health Plans and health insurance issuers offering group or individual health insurance coverage must annually submit a Gag Clause Prohibition Attestation. The attestation clause is required to be compliant with the Internal Revenue Code Section 9824, Employee Retirement Security Act Section 724, and Public Health Service Act Section 2799A-9. The attestation gag clause is an attestation that plans or issuers ***do not have clauses in their agreements with providers that would prevent the disclosure of cost or quality of care information or data***, and certain other information to active or eligible participants, beneficiaries, and enrollees of the plan or coverage, plan sponsors, or referring providers, or restrict the plan or issuers from sharing such information.

1. In order to satisfy the requirement to submit the annual attestation of compliance, plans and issuers should submit their attestation using this link. [Gag Clause Attestation | Welcome! \(cms.gov\)](#). The link should lead you to the home page of the Gag Clause Prohibition Compliance Attestation.



2. To log in, click the “Don’t have a code or forgot yours?” Once you click the “Don’t have a code or forgot yours?” tab, you should see the next scene below.

Enter your e-mail address to access the Gag Clause Prohibition Compliance Attestation Submission

Once we receive your e-mail address, an access code will be generated and e-mailed to you. This e-mail will be from submissions@cms.hhs.gov. Follow the instructions in the e-mail.

* Enter e-mail address

Get my access code [Cancel](#)

3. The user should enter their email address into the “Enter email address” and then select “get my unique code.”
4. After completing a successful unique code request, the message “Request was successful” displays for the user.

✓ The code will be sent to your e-mail address within 10 minutes. If you do not receive a code within 10 minutes, you may either return to the homepage and request another code or contact the CMS Marketplace help desk support team at CMS.FEPS@cms.hhs.gov or 1-855-267-1515.

Access the Gag Clause Prohibition Compliance Attestation Submission

* Enter e-mail address

* Enter the code that was sent via e-mail

Login to the system [Don't have a code or forgot yours?](#)

5. The user receives an email with the unique code. This unique code will be valid for 14 days. Users should check their SPAM folders if they do not immediately see this email, but they should wait at least ten minutes before requesting another code. Users should receive the email below.

Dear User,

Please use the following access code to log into the GCPA portal (<https://hios.cms.gov/HIOS-GCPCA-UI>):

Note: On the GCPA portal, please enter only the access code (without double-quotes).

Please **DO NOT SHARE** your access code with anyone.

6. To login to the “Gag Clause Prohibition Compliance Attestation Submissions” system, the user enters the same email that was used to request their unique code,

and the associated unique code they received via email. **If you are submitting on behalf of only one health plan, you may skip the Excel spreadsheet instructions and click “Submit Gag Clause Prohibition Compliance Attestation.” The reporting entity Excel template is not needed.** If you are submitting on behalf of multiple reporting health plans, download the “Reporting Entity Excel template.”

Get started

Please read the GPCPA Annual Submission Instructions before starting your submission.

- [Instructions for submitting the GPCPA](#) [PDF - 408 KB]
- [User Manual for submitting the GPCPA](#) [PDF - 2.90 MB]
- [Frequently Asked Questions \(FAQs\) about GPCPA](#) [PDF - 110 KB]

Download Responsible Entity Excel Template

If you are submitting an Attestation on behalf of more than one Responsible Entity, identify the entities using this template.

- [GPCPA Responsible Entity Template](#) [XLSX - 108 KB]

- If you are reporting on behalf of multiple entities and have completed the Excel spreadsheet, click the button below titled “Submit Gag Clause Prohibition Compliance Attestation.” **Once again, if you are not reporting on behalf of multiple health plans, do not worry about the Excel sheet and proceed to the next page.**

Get started

Please read the GPCPA Annual Submission Instructions before starting your submission.

- [Instructions for submitting the GPCPA](#) [PDF - 832KB]
- [User Manual for submitting the GPCPA](#) [PDF - 654KB]

Download Responsible Entity Excel Template

If you are submitting an Attestation on behalf of more than one Responsible Entity, identify the entities using this template.

- [Responsible Entity Excel Template](#) [XLSX - 630KB]

 **Start a new Gag Clause Prohibition Compliance Attestation**

- You will enter the Submitter’s Information on the next page below. This person may be contacted in the event of an audit and should be available to answer any questions. The following information is input for submission. For “Attestation Year,” please select 2024. Under the question “By what type of entity are you employed?” Select **“ERISA Group Health Plan (GHP) or sponsor of ERISA plan, including a plan sponsored or established by a union.”** If you are classified as a “Church Plan” under ERISA, please select “Church Plan.”

Submissions

[Start a new submission](#)

To view or continue your submission, select the Submission ID.

Start a new submission



All fields marked with an asterisk (*) are required.

* Attestation year

2025

Select your attestation year

2021-2023

2024

2025

is submission's information. Not all the previous submission information will
tion on Step 5. You can review and modify the prefilled information before

☐ Yes, include information from a previous submission

[Start a new submission](#) [Cancel](#)

9. This year, you can prepopulate information from a previous year's submission. To do so, check the box in front of **"Yes, include information from a previous submission"**.

Start a new submission



All fields marked with an asterisk (*) are required.

* Attestation year

2025

Use information from a previous submission?

Choose a previously completed submission to fill in most of this submission's information. Not all the previous submission information will be included, such as network type and the attestation information on Step 5. You can review and modify the prefilled information before completing the submission.

☐ Yes, include information from a previous submission

[Start a new submission](#) [Cancel](#)

Doing this brings up a listing of all your prior year submissions. Select the radio button in front of the one you want to start with, and then click Start a new submission at the bottom of the screen.

Start a new submission



All fields marked with an asterisk (*) are required.

* Attestation year

2025

Use information from a previous submission?

Choose a previously completed submission to fill in most of this submission's information. Not all the previous submission information will be included, such as network type and the attestation information on Step 5. You can review and modify the prefilled information before completing the submission.

☒ Yes, include information from a previous submission

Showing 1 to 2 of 2 Submissions

	Submission ID	Attestation Year	Submitted date
☐	6480	2021-2023	02/11/2025
☐	6421	2024	02/11/2025

Start a new submission

[Cancel](#)

Start a new submission



All fields marked with an asterisk (*) are required.

* Attestation year

2025

Use information from a previous submission?

Choose a previously completed submission to fill in most of this submission's information. Not all the previous submission information will be included, such as network type and the attestation information on Step 5. You can review and modify the prefilled information before completing the submission.

☒ Yes, include information from a previous submission

Showing 1 to 2 of 2 Submissions

	Submission ID	Attestation Year	Submitted date
☒	6480	2021-2023	02/11/2025
☐	6421	2024	02/11/2025

Start a new submission

[Cancel](#)

10. Fill in the information for “Step 2” or click “Submitter is the same as the Attester.”

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 Responsible 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

* Attester's first and last name

* Attester's position title

* Attester's e-mail address

* Attester's phone number

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

* Attesting Entity (Attester's Employer)

Save and continue

Save and exit

11. Fill in the information below for "Step 3." For the question "If you are submitting on behalf of more than one plan or one issuer?" If you are only reporting for one health plan, select "No." After selecting "No," the screen at the bottom shall appear. If you are submitting for multiple health plans, select "Yes." If you are reporting multiple health plans, please skip to Step 11 of the instructions because a different screen will appear. For the Type of Responsible Entity, click "ERISA Group Health Plan" or "Church Plan" if that applies to your ERISA selection. For the question "ERISA Plan Number," that number is listed on the last page of your Summary Plan Document. It is either 501 or 505. Please check your Summary Plan Document. For the question "Are you attesting to all provider agreements?" Select "YES." Then enter the attestation period.
12. The screen below shall appear if you select "Yes" when reporting for multiple health plans. You must complete and upload the Excel sheet under "Upload Entity List." **Once again, upload the Excel sheet here only if you are reporting on behalf of multiple health plans.** THE GPCPA Webform instructions provide specific guidance on creating the Reporting Entity tab-delimited text file. Only one Health Plan per row is permitted.

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

☒ Yes
☐ No

Responsible Entity Details

Complete and upload the **Responsible Entity Excel Template** for entities on whose behalf you are submitting the attestation. For detailed instructions, please select the "View detailed instructions" link and also refer to the GPCCA User Manual.
[View detailed instructions](#)

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


Drag files here or [choose from folder](#)

Additional Information
Provide any other information that is relevant to this attestation.
1000 characters remaining

13. After selecting "Save and Continue," "Step 4" The Submitter will see the "Let's confirm the Attester's email address" pop-up asking them to confirm the Attester's email address to send them a unique code, a link to the GPCCA system, and instructions. Further, on the following pages, review the submission and verify your information."

*** Are you attesting for all provider agreements?**

☒ Yes
☐ No

Attestation Period

Enter the start and end dates that your attestation covers. If you attested last year and would like to use the end date of your previous submission as your start date for the current submission, select "previous attestation end date" below.

If, after entering all the information, you find there are corrections to make, click the edit button at the top right-hand side of the screen.

4 Review your submission and attest

If the information below is correct, add your attestation below and then select the "Submit" button to complete your submission. If you need to change any previously entered information, use the edit buttons to return to the appropriate step and make your changes.

Submitter's contact information

[Edit](#)

Attestation year
2024

Submitter's first and last name
Jane Doe

Submitter's position title
CEO

Submitter's e-mail address
Jane@Doe.com

Submitter's phone number
(123) 456-7890

Submitter's employer name
Jane Doe LLC

Entity

ERISA group health plan (GHP) or sponsor
of ERISA plan, including a plan sponsored
or established by a union

Attester's contact information

[Edit](#)

Attester's first and last name
John Doe

Attester's position title
CFO

Attester's e-mail address
John@Doe.com

Attester's phone number
(123) 456-7890

Attesting entity (Attester's employer)
Jane Doe LLC

Review your submissions and click "Save and Continue."

Responsible Entity's attestation detail

[Edit](#)

Responsible Entity's name
John Doe LLC Group Health Plan

Responsible Entity's type
ERISA group health plan (GHP)

Responsible Entity's point of contact
John Doe

Responsible Entity's EIN
222222222

ERISA Plan Number
501

Responsible Entity's mailing address
123 ABC St Somewhere, DC 12345

Responsible Entity's e-mail address
John@doe.com

Responsible Entity's phone number
(123) 456-7890

Provider agreement type(s)
Imaging Benefits

Attestation Period
01-15-2024 to 01-14-2025

Additional Information
This is a test.

Save and continue

Save and exit

14. On Step 5, you will check the 1st box that states "I'm attesting on behalf of group health plans, including non-federal governmental plans, and/or health insurance issuers offering group health insurance coverage"

5 Verify the entity type(s) on whose behalf you are attesting

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 and except as provided herein, the group health plan(s) or health insurance issuer(s) offering group health insurance coverage on whose behalf I am signing has not, for the dates specified and as provided in the foregoing information, 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/or 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 and except as provided herein, the health insurance issuer(s) offering individual health insurance coverage on whose behalf I am signing has not, for the dates specified and as provided in the foregoing information, 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.

In the same step, you will confirm that the submitted information is accurate :

Attest to the Responsible Entity's compliance with the Gag Clause Prohibition Compliance requirement

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.

* To sign this attestation, enter your full name below.

Signed submission date

04/04/2024 01:52 PM

Submit

[Start over](#)

Lastly, check the box and enter your full name, clicking your final submit at the bottom of the screen.

If you have any questions, issues, or concerns regarding the Attestation Clause, please contact your 90 Degree Benefits office.