

Consolidated Appropriations Act: Gag Clause Attestation

Under the Consolidated Appropriations Act (CAA) group health plans and health insurance issuers are prohibited from entering into agreements with providers that prevent enrollees, plan sponsors, or referring providers from seeing provider-specific cost and quality data. Plans and issuers must annually attest to CMS that they are in compliance with all requirements, known as the Gag Clause Prohibition Compliance Attestation (GCPCA).

1. What is the due date for the GCPCA?

Plans and issuers must attest no later than **December 31, 2025**, and are required to do so annually.

2. Who is affected by this new rule?

Most major medical commercial plans are impacted by this requirement ruling including all Sentara Health Plans fully insured, and self-funded plans.

3. What is a “gag clause”?

A “gag clause” is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party. Gag clauses in these rules might be found in agreements between a health plan/plan sponsor, or issuer and any of the following parties:

- Healthcare provider
- Network or association of providers
- Third-party administrator (TPA)
- Other service providers offering access to a network of providers
- Pharmacy Benefit Manager (PBM)
- Business Associate Agreement (BAA)

4. How will Sentara Health Plans support customers affected by these attestation requirements?

Sentara Health Plans will submit the attestation to CMS by December 31, 2025, deadline on behalf of the following:

- Fully insured groups
- Self-funded and Business**EDGE**® groups that have submitted a form to us by October 15, 2025, indicating that Sentara Health Plans will attest on their behalf and provide all required group-specific information.

5. Will groups receive a confirmation when the attestation is submitted?

CMS is not able to provide group-specific confirmation of attestation. To request confirmation that the attestation was submitted on your behalf by the December 31, 2025, deadline, please contact your Sentara Health Plans representative.

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6. What approach is Sentara Health Plans using to gather information to submit the attestation?

Fully insured groups do not need to submit any additional information, Sentara Health Plans will gather the required data points needed for the attestation. Self-funded and BusinessEDGE groups are required to submit a form no later than October 15, 2025, with the following information:

- Group Name
- Group Mailing Address
- Group EIN
- Group Number
- Group Funding Type (BusinessEDGE or Self-funded)
- Group Carve Out Information (Pharmacy, Mental Health/Substance Use Disorder, Other)
- 3-digit Form 5500 Plan Number for ERISA Plans
- Church, ERISA, or Non-Federal Governmental Plan designation if necessary

7. Will Sentara Health Plans be submitting reports for groups that carve out their pharmacy or behavioral health benefits?

We will only attest for contracted services covered under our issued or administered health plans. If an employer plan includes covered benefits not provided under our plan we cannot attest to compliance for those services. Employers that do not include pharmacy benefits, behavioral health benefits, or other carved-out services must self-attest to CMS that contracts for those services are in compliance.

8. Will Sentara Health Plans support groups to attest annually?

We will review any future guidance to determine what information we need to collect annually to continue to support required reporting.

9. Can Self-funded and BusinessEDGE groups file on their own behalf?

Self-funded and BusinessEDGE groups may attest on their own behalf with CMS. If you wish for Sentara Health Plans to attest on behalf of your self-funded plan, please select "yes" on the first question and fill out all required information on the form. If you do not select "yes" and provide all required information we will not attest on your group's behalf.

For more information visit
the CMS website.