It Benefits You
Your Employee Benefits Newsletter

November 2022

In This Issue:

"Small cheer and great welcome makes a merry feast."
–William Shakespeare

Whether juggling open enrollment, preparing for the year ahead, or simply planning for a season of feasting, it's also a time to reflect on the things we are grateful for. It's easy to get swept up before taking stock of the things that bring us cheer.

In that spirit of gratitude, McGriff thanks you for your partnership and for trusting us as your Benefits Consultants. Our Account Teams, National Specialty Practices and preferred vendors strive to continue to provide you with the best service and an exceptional experience.

Upcoming Compliance Deadlines

December 15 **Summary Annual Report (SAR) Extended Deadline for Calendar Year Plans**

A Summary Annual Report (SAR) summarizes a plan's Form 5500 annual report, provides a financial statement regarding the plan, and informs participants of their rights to receive additional information.

Generally, the plan administrator provides the SAR within nine months of the close of the plan year; however, if an extension to file Form 5500 is obtained, then the plan administrator must furnish the SAR within two months after the close of the extension period. For calendar year plans, that deadline is December 15.

December 27 **Reporting on Pharmacy Benefits & Drug Costs**

Health plans and issuers must report information about prescription drugs and health care spending to the Departments each year. Data for 2020 and 2021 reference (calendar) years is due December 27, 2022.This reporting is required for fully-insured and self-funded group health plans of all sizes. Click here for more information in our Compliance Q&A.

Recent IRS Announcements

The IRS Fixes the ACA's "Family Glitch"

The IRS has released a final rule that changes the eligibility criteria for the premium tax credit (PTC). While the final rule may result in more family members being eligible for the PTC, it does not increase (or eliminate) an employer's responsibility to provide affordable coverage to full-time employees under Pay or Play rules.

The IRS also expanded the Section 125 mid-year election change rules for elections effective on or after January 1, 2023, in connection with its new eligibility rules for the PTC. Click here to read more.

2023 Health FSA Limits Announced

On October 18, 2022, the IRS announced the inflation-adjusted maximum contribution and carryover limits for health flexible spending accounts (FSAs) in 2023. The employee contribution limit to health FSAs will be **$3,050** for plan years beginning in 2023. In addition, the maximum carryover limit for 2023 health FSAs will increase to **$610.**

These are relatively significant increases compared to prior years due to higher inflation across the broader economy. The timing of this announcement is a quick turnaround for calendar year plans in the midst of open enrollment. Plans hoping to allow the new maximums for 2023 should work with their TPA to ensure smooth, compliant administration. Timely notice to participants will also be essential to ensure they can take advantage of the updated limits and increase tax savings in 2023.

5 Tips for Effective 2023 Open Enrollment Communication

Now more than ever, employees are looking to their employers for guidance on navigating their available benefits. Employees are likely paying more attention this year as they navigate record-high inflation and work to maximize every hard-earned dollar.

During the 2023 open enrollment season, employers should be poised to provide their employees with resources and tools they can use to better understand and act with more confidence when making benefits decisions.

Consider these five tips to enhance communication about benefits:

1. **Start early.** Get the word out early about benefits offerings so employees have ample time to understand their benefits, consult with family members and determine their needs for the following year.
2. **Develop key messaging.** Key messaging may include a focus on new or updated benefits offerings and FAQs to address common concerns quickly.
3. **Keep it simple.** Employees don't need to know everything, so employers should highlight necessary information about the benefit to help them decide if they need it. Links or attachments could explore the benefits further and offer the fine print.
4. **Avoid jargon.** Avoiding HR or benefits-related jargon is best to help make benefits easier to understand. Many benefits are acronyms, so employers should help decode and explain what these mean.
5. **Personalize communication.** A personalized approach will depend on the workforce and their working environments. For example, open enrollment methods and communication could look different for remote, on-site and nonwired employees.

Summary

Educating and informing employees about their benefits options is an important part of open enrollment. Contact your McGriff Account Team today for more information on open enrollment.

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Yes! The Outbreak Period is Still in Effect

Faithful readers of *It Benefits You* are aware of the Outbreak Period related to the ongoing COVID-19 national emergency and its impact on group health plans. As a reminder, at the start of the pandemic regulators extended certain ERISA deadlines during an "Outbreak Period" beginning March 1, 2020 and scheduled to end 60 days after the announced end of the national emergency. Specifically, the rules extend participant deadlines related to: (1) claims and appeals procedures for ERISA plans, including medical, dental, vision, HRA and health FSA plans; (2) COBRA elections, premium payments and notices of qualifying events or disability; and (3) notices of HIPAA special enrollment events.

Subsequent guidance tolls these affected deadlines until the earlier of: (1) one year; or (2) the end of the Outbreak Period. Because the national emergency declaration is still in effect, so too is the Outbreak Period. The current national emergency declaration is set to expire on February 28, 2023, although the Biden administration can announce an earlier end or extend beyond that date. As long as the national emergency and Outbreak Period remain in effect, plan sponsors must comply with these mandatory extensions.

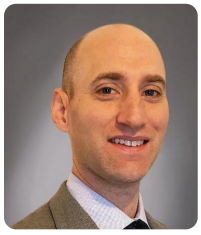
Here is a fictitious, but practical, example related to HIPAA notifications of special enrollment events during the Outbreak Period:

Q: On October 1, 2022, Suzy, an employee of Acme, Inc., informed HR that her spouse lost group health coverage under the spouse's plan on March 1, 2022, as a result of termination of employment. The employee wants to add coverage for the spouse under the Acme group health plan. Should Acme enroll Suzy's spouse in coverage?

A: Yes. As a result of the spouse's loss of coverage, Suzy is entitled to a HIPAA Special Enrollment Period to add her spouse to the Acme group health plan. While Suzy's deadline to notify the plan of the loss of coverage is subject to plan design, most plans require notice of HIPAA special enrollment events from the employee within 30 days (60 days for loss of Medicaid). Under that standard timeframe, Suzy's notice would not be timely, and the plan would generally not permit enrollment.

Because of the deadline extensions, now Suzy's deadline to notify the plan is the earlier of (1) 30 days after the end of the Outbreak Period; or (2) one year + 30 days after the HIPAA special enrollment event date. Because the Outbreak Period continues and one year + 30 days has not passed since the spouse's loss of coverage, Suzy's notice is timely, and Acme should enroll her spouse in the plan.

We will continue to remind you about the Outbreak Period and its impact on your plans while it remains in effect. We will also notify you as soon as it ends and provide some practical steps you should take at that time. The key takeaway for plan sponsors now is to be aware the deadline extensions are still in effect. Please do not hesitate to reach out to your McGriff Account Team if you have any questions.



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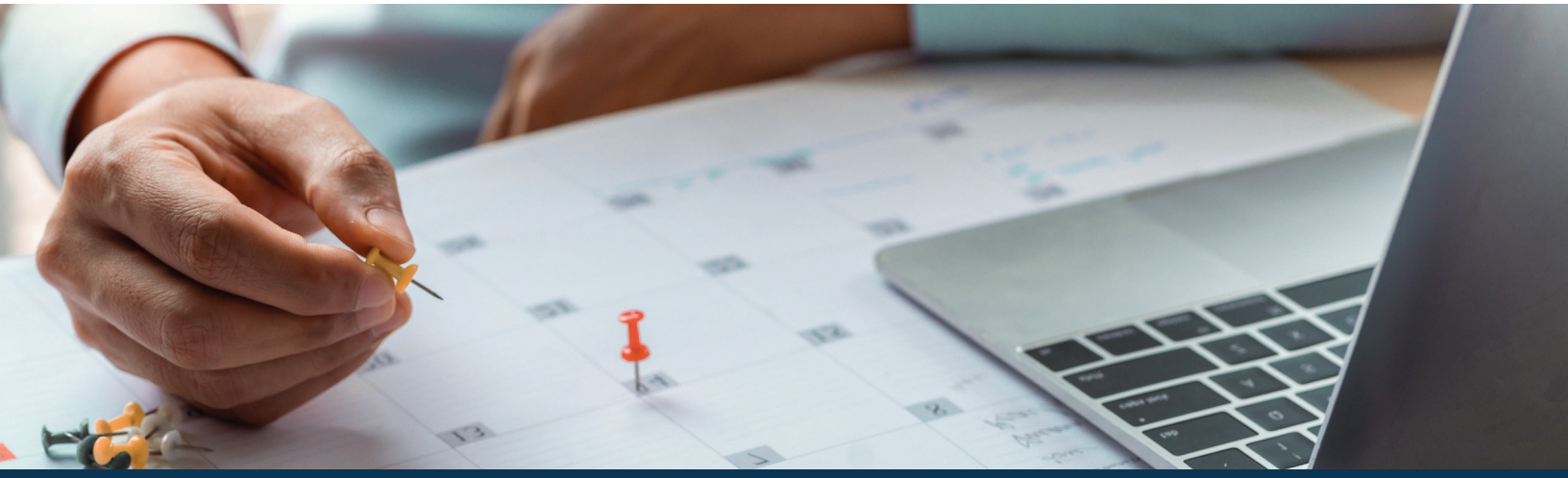

Primary Care in Healthcare

Does primary care impact healthcare outcomes? There is widespread evidence that high-quality primary care improves healthcare outcomes and cost effectiveness (emphasis on "high-quality" and "cost effective"). There is also proof that integrating behavioral health services into primary care can enhance mental healthcare access and coordination and will lead to improved outcomes and lower costs. Improved primary care means healthier, happier patients and lower overall healthcare costs. U.S. adults who regularly see a primary care physician (PCP) have 33% lower health care costs and 19% lower odds of dying prematurely than those who see only a specialist.[1]

What is the scope of care for the primary care physician? Primary care is the cornerstone of a healthcare system focused on high-quality, cost-effective healthcare and improved health outcomes. In theory, a PCP may be defined by their set of skills and scope of practice, which generally includes basic diagnosis and treatment of common illnesses and medical conditions as well as physical exams.

Many PCPs are trained in basic medical testing, such as interpreting results of blood or other patient samples, electrocardiograms, or x-rays. After collecting data, the PCP arrives at a differential diagnosis and formulates a plan including, if appropriate, more testing, specialist referral, medication, therapy, diet or lifestyle changes, patient education, and treatment follow-up. Along with screenings and immunizations, primary care physicians also counsel and educate patients on safe health behaviors, self-care skills and treatment options.

Roadblocks. Unfortunately for both consumers and PCPs, in the U.S. and around the world there is no shortage of challenges when it comes to receiving and providing this level of care. As we've seen for decades, not all primary care is created equal. Several barriers, some more complex than others, limit improved outcomes and affordability. Critical discussions, studies and recommendations on how to improve healthcare outcomes through primary care are taking place around the world by industry leaders such as the National Institutes of Health's National Library of Medicine and National Center for Biotechnology; the Patient-Centered Outcomes Research Institute (PCORI); the World Health Organization (WHO); and countless other experts, professionals and organizations.

A reformed primary care system requires innovations. As mentioned above, integrating behavioral health uniformly into primary care is vital and the urgency has only increased during the COVID-19 pandemic. Mental health care is hard to access and of variable quality, but mental health care is primary care and needs to remain part of primary care.

Convincing individuals to seek the care they need from their PCP can also be a challenge. One of the positive effects of the pandemic in this regard has been an upsurge in the use of telehealth, also referred to as telemedicine. With telehealth a patient does not have to travel to the office or wait for care, leading to a happier patient who may be more apt to continue with their care.

There are widespread Physician shortages, including PCPs, as fewer medical students are opting for this career path. PCPs earn less than specialists yet incur the same or similar student debt, work longer hours, and experience the highest levels of emotional and physical fatigue. Now add the unforeseen immense toll from the pandemic. PCPs were ill-equipped to meet the demands of such a catastrophic national emergency.

Adding insult to injury is the image issue for the PCP, i.e., they're often perceived as inferior to specialists. The challenges PCPs face in our nation and throughout the world are quite complex, which is why there are ongoing studies to help determine how PCPs can have a greater universal impact. With healthcare resources strained, many people are seeing a nurse practitioner or physician's assistant instead.

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Underserved Populations. To improve healthcare outcomes in underserved populations – including consumers who encounter barriers to primary care due to economic, cultural, and language challenges – we need to revamp the healthcare system. Consumers who live in rural regions, the elderly, low literacy, blue-collar and poor populations are also underserved. There will be comprehensive discussions relative to underserved populations which will be held during the PCORI 2022 Annual Meeting Oct. 26-27 according to Executive Director Nakela L. Cook, who said, "… You won't want to miss two plenary sessions, which will focus on our work to make health equity achievable for everyone."

Does effective, comprehensive, high-quality primary care improve healthcare outcomes? Yes, it does. Is all primary care effective, accessible, all-encompassing, cost-effective and high-quality? No, it is not. To learn more about successful primary care models, see the 132-page "Operational Framework for Primary Health Care" from WHO at https://www.who.int/publications/i/item/9789240017832.

Reference

[1]PBGH October 4, 2021 Using Primary Care's Potential to Improve Health Outcomes

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Three Key Failure Points in Wellness Programs and How to Overcome Them

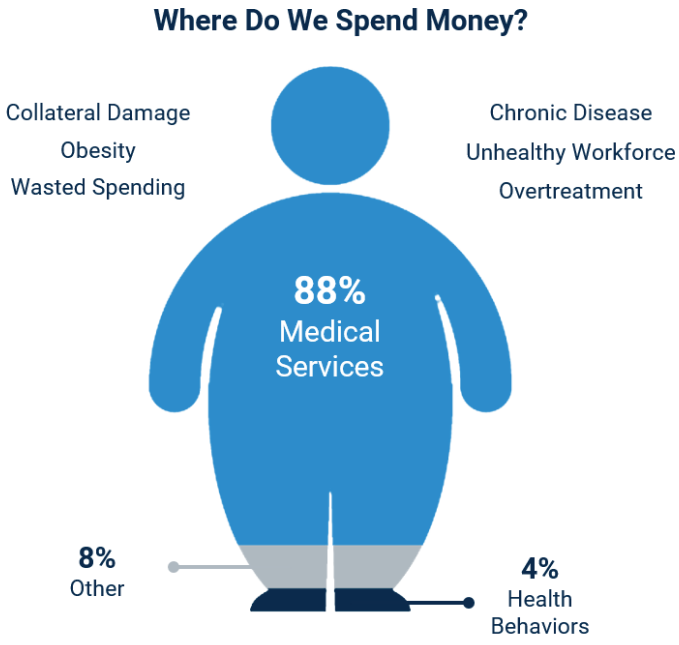
HR professionals have a difficult task in determining how to best allocate their benefits dollars to foster recruitment, retention, productivity, performance, and overall satisfaction. Invariably, the largest portion of the budget goes to healthcare, i.e., medical insurance.

The budgetary emphasis on medical care comes as no surprise. According to the Network for Excellence in Health Innovation, 88% of healthcare funds are spent on clinical care.1 The remainder is spent on other factors that influence health outcomes – health behaviors, the physical environment, and social and economic determinants of health.

Surprisingly for some but not for others, only 20% of health outcomes are actually attributable to clinical care.[2] Yet 30% of health outcomes are actually impacted by health behavior.

Within both the healthcare ecosystem and employer groups, a recognition of the strong impact of health behavior on outcomes has led to strategies such as increasing health literacy, health coaching, gamification / challenges, reminders, etc.

A cottage industry of wellness programs also has emerged around the holy grail of influencing health behaviors. Some solutions focus on broad healthcare behaviors, such as nutrition, exercise, and health literacy, while others focus on specific behaviors or conditions like smoking or diabetes.



The challenge for employers is that many of these programs fail to engage enough people or yield consistent, sustainable results. This can be frustrating for HR professionals who invest in a wellness program – even one that includes significant incentive dollars to drive participation – only to end up with lax participation or disappointing outcomes.

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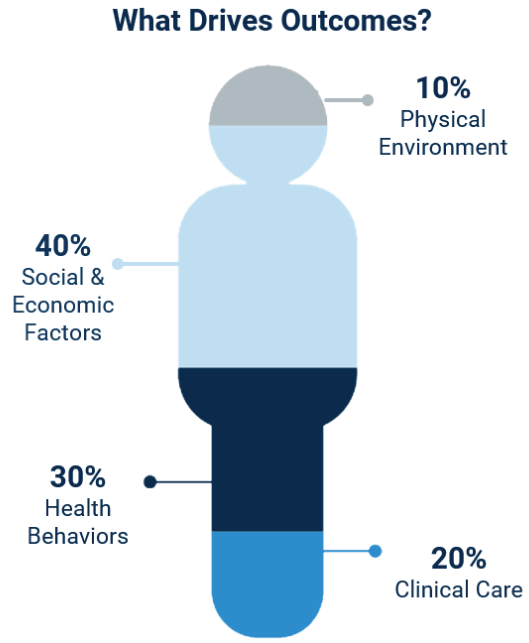
So, what should you look for in a wellness program intended to drive better health behaviors? There are several areas where behavior change strategies can fail:

- Failure to understand individual motivators
- Failure to understand context
- Failing to learn and adapt

Let's walk through each one.



Understanding Individual Motivators

Intuitively, we know that people are not all motivated by the same things. For many, it's economics. In the context of a wellness program, financial incentives can include cash, gift cards, medical insurance premium discounts, etc. Others are motivated by insight and education, e.g., knowing their lab work numbers and increasing their health literacy. For others, motivation might come through the competitive or social aspect of competing with colleagues or friends in a health challenge.

The big takeaway is that there is no single motivator that will work for everyone. From an HR standpoint, a wellness program or strategy should include a variety of motivators in order to reach a broad group of expected participants. Again, variety can come through financial incentives, insight and education, coaching, or gaming and social components.

On this topic, key questions for a wellness program will include:

- How does the program engage people whose health behaviors are motivated by different factors?
- What kinds of motivators are used and how effective have they proven to be?
- Which motivators will the employer have to fund or help manage?

Understanding Context

We know that every individual has their own unique wellness journey. So if a wellness program does not take that into account, relying instead on generic wellness strategies for motivation and education, it will not meet individuals where they are on their journey. The most effective programs include tools such as lab work, fitness tests, biometrics (e.g., blood pressure, heart rate, and waist circumference), fitness trackers, health risk assessments and/or interviews/coaching. All of these provide a clearer health snapshot of each individual so that guidance can be provided in the context of their specific risks and goals. The key is to go beyond mere information collection toward a program that actually uses data to help guide each individual along their journey.

On this topic, key questions for a wellness program will include:

- What does the program learn about participants in order to meet them where they are on their wellness journey?
- How does the program use individual information to create personalized wellness journeys?
- Is the information secure?

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Learning and Adapting

We know that as life situations change, people change. For example, a woman who has successfully lost weight may want to raise her game and run a race. An otherwise healthy individual could suddenly begin to struggle with mental health issues following a death in the family. Or maybe someone who has participated in several past health challenges may become bored with the idea and decide to no longer participate.

While we've pointed out that programs should take people's context into account, the fact that interests and goals change means that wellness programs cannot just rely on initial information as the only basis for the entire wellness journey. Programs must have an ongoing feedback loop to learn whether a wellness pathway is still effective, or a change is needed. Feedback loops could include intermittent questionnaires that check in on participants and their assessments of the program's effectiveness, trackers that determine whether people are reading their notifications or responding to behavioral nudges (e.g., to be more active), or human coaches who can check in with participants for one-on-one conversations about their journeys.

Of course, with newfound insights from the feedback loop, the program should adapt as needed to help people refocus, change motivators to reignite interest, and/ or create new goals and targets.

On this topic, key questions for a wellness program will include:

- How does the program establish an ongoing feedback loop to learn how participants are doing?
- How does the program use ongoing insights to improve the participant experience and journey?

Final Thoughts

Looking at the big picture of what makes a wellness program succeed, you'll notice that the failure points occur when there is less information about the individual and their wellness journey. What motivates them? Where are they now on their wellness journey? How can we use what we're learning to guide them toward their next steps? The goal is a program centered around personalized wellness. Each employee has their own unique wellness journey based on who they are and their unique life situations. As an HR leader, aim for a wellness framework that has the versatility to suit a broad range of individuals with different goals and motivations, and the flexibility to adaptively guide people along their individual health and wellness journeys.

References

[1]New England Healthcare Institute. The Boston Paradox, page 17

[2]University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

This article was previously published in the October edition of HR Professionals Magazine.

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Compliance Q&A: Reporting Prescription Drug and Health Care Spending

Questions: What steps do plan sponsors need to take to comply with the recent guidance on Prescription Drug and Health Care Spending? How do these rules fit into the larger picture of the recent healthcare transparency laws?

Summary:

One provision of the Consolidated Appropriations Act of 2021 (CAA) that has received less attention than perhaps it should is the requirements surrounding Prescription Drug and Health Care Spending Reporting.[1] Section 204 of the CAA requires group health plans or health issuers to submit general information regarding the plan or coverage, as well as detailed information surrounding prescription spending, total health care spending, and the impact of any prescription drug rebates, fees or other compensation affecting premiums and out-of-pocket costs.

In November of 2021, the Departments released an interim final rule, "Prescription Drug and Health Care Spending," implementing these provisions.[2] Subsequently, the Department of Health and Human Services (HHS) released supporting documents for the regulations, including a review of who must submit and when, data submission instructions, and examples of specific categories of reporting.[3] While insurers and third party administrators (TPAs) are expected to provide much of the reporting, group health plans are ultimately responsible for ensuring that the necessary information is submitted.

Detail:

Who Must Report

While the Departments are expressly allowing—and indeed expect—that third parties such as TPAs, Pharmacy Benefit Managers (PBMs) and health insurers will provide much of the reporting, the CAA ultimately places the responsibility for compliance on group health plans. There is no exception to the reporting requirement for small groups, grandfathered, or fully-insured group health plans. The interim final rule addresses the concept of a "reporting entity" by providing an expansive definition that includes essentially any entity submitting the necessary information on behalf of a plan. The rule also specifies that if a reporting entity such as a TPA or PBM has agreed to report the data on behalf of a self-insured entity and then fails to do so, the reporting entity that agreed to submit the data will be in violation of the rules.

Plan sponsors should discuss with insurers and/or TPAs to determine who will prepare and submit the necessary reporting for each plan. Agreements should be documented in writing.

Reporting Deadlines

Deadlines for information related to 2020 plans were generally applicable as of December 27, 2021. However, the Departments provided temporary and limited deferral of enforcement during the first year. Reporting will be made on a calendar year basis, with each reporting year referred to as a "reference year," i.e., the prior calendar year. Effectively, the deadline for both the 2020 and 2021 plan years is December 27, 2022. Thereafter, reporting will be due on June 1 of the year following the reference year. For example, reporting will be due for the 2022 reference year on June 1, 2023.

Information That Must be Included in the Reports

The interim final rule outlines several categories of information that must be submitted, including the following:

- General identifying information such as Federal Employer Identification Number (FEIN), plan year dates, covered lives and each state in which coverage is offered;

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- Health care spending by type of cost including hospital costs, primary and specialty care provider and clinical service costs, prescription drugs, and other medical costs;
- Average monthly premium amounts paid by employers on the participants' behalf, and the average premium paid by participants, beneficiaries and enrollees;
- "Top 50" drug lists, including the top 50 most frequently dispensed drug brands and number of paid claims for each, the top 50 most expensive drugs by total annual spend by the plan for each drug, and the 50 prescription drugs with the greatest increase in plan expenditures over the plan year;
- Prescription drug rebates, fees and any other applicable remuneration paid by drug manufacturers to the plan, issuer, or its administrators or providers, and any impact the rebates, fees and remuneration has on the cost of drugs under the plan; and
- A "Top 25" drug list of prescription drugs generating the highest rebate amounts.

*While this information must be reported to the Centers for Medicare & Medicaid Services (CMS), there is no requirement that this information be included on a public facing website or plan sponsors' internal benefits portal.

This data must be submitted via the CMS Health Insurance Oversight System (HIOS) through an RxDC, or prescription drug data collection, module. CMS has provided reporting instructions, including help desk contact information, which can be found at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

What Should Plan Sponsors Do Now?

Since the non-enforcement policy will end in December 2022, the Departments have strongly encouraged plans and issuers to prepare well in advance to comply. For group health plan sponsors, chief among these necessary compliance steps is communicating with carriers and TPAs about how they will assist with detailed reporting requirements, since few, if any, group health plans will possess the requisite information on their own. The actions plan sponsors will need to take will vary based on their group health plan's structure, the level of the insurer's or TPA's involvement, and other factors, such that a one-size- fits-all checklist is impracticable. That said, there are several steps that plan sponsors can take to prepare.

Fully-insured Plan Sponsors - Plan sponsors will need to confirm who will submit the required data via CMS's HIOS system through the RxDC module. Fully-insured plan sponsors will generally be able to rely on carriers for this step, but should verify whether the carrier will be submitting all or a portion of the data on the sponsor's behalf.

Fully-insured groups can shift liability to the carrier. The regulations state, "if a health insurance issuer and a group health plan sponsor enter into a written agreement under which the issuer agrees to provide the information required... and the issuer fails to do so, then the issuer, but not the plan, violates the reporting requirements..." As to what is sufficient to constitute that written agreement has not yet been clarified. A generic email announcement stating what the carrier is willing to do probably would not, under a conservative reading of the rules, constitute a "written agreement" that would shield the plan sponsor from liability should the carrier fail to report the requisite

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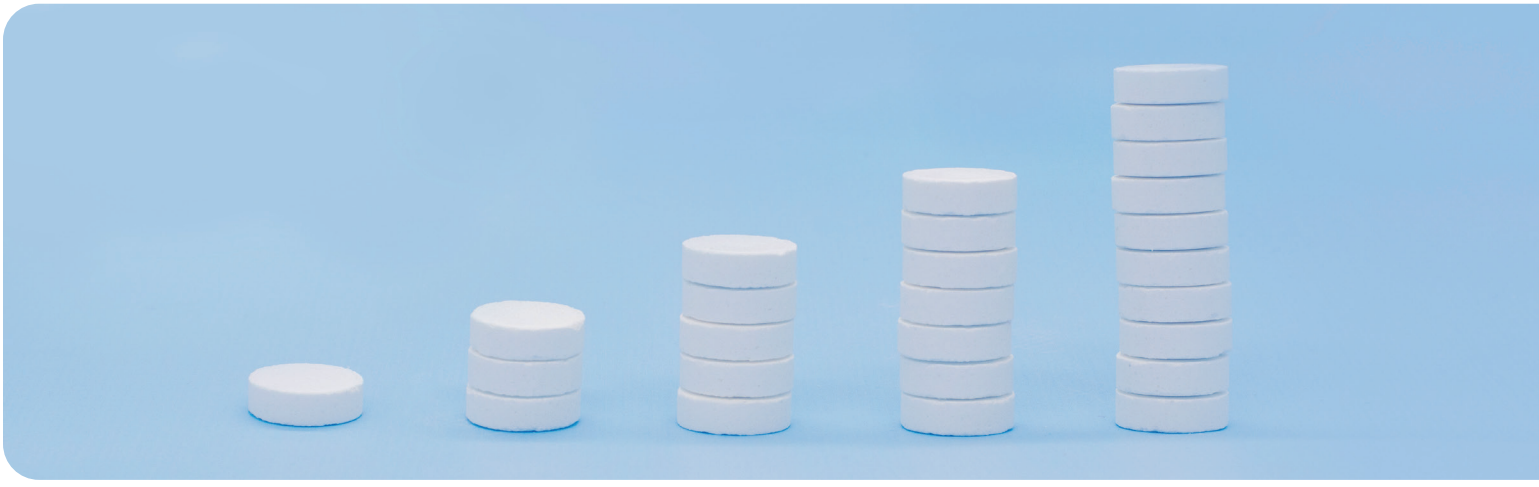

information. Certainly, a signed written agreement between the plan sponsor and carrier is preferred and encouraged as a best practice, although, practically speaking, a mass communication may be the only assurance many plan sponsors are able to obtain from the carrier. Clarification from the Departments on this point would be welcome.

Self-funded Plan Sponsors - While self-funded plan sponsors can also enter into agreements with vendors to complete these requirements, ultimately, they cannot shift liability for compliance. Therefore, more proactive action is prudent for self-funded plan sponsors.

First, because the necessary reporting information may reside with multiple sources, plan sponsors will need to determine which sources possess the required information. For example, while plan sponsors will typically have information on the average monthly premium paid by the plan and enrollees, the insurer or TPA is more likely to have the data related to prescription drug and health care expenditures and impact of rebates. While the insurer will often handle all prescription benefits for a fully-insured plan sponsor, self-funded plan sponsors–particularly those with carved-out prescription benefits–may have to coordinate the reporting process with not only the TPA but also their PBMs or even other vendors. Determining where the information is might be as simple as an email exchange with the relevant vendors, but this is an important step in the data collection process.

Plan sponsors will also have to decide who will perform the reporting. Keep in mind that it is possible for a plan to meet its Section 204 reporting obligation by having multiple entities submit files on its behalf. Many vendors are giving clients the option to request their individual plan data to submit the reporting themselves, or to allow the vendor to perform at least a portion of the reporting on their behalf. And naturally, many plan sponsors will want to allow these third parties to assist in this way.

Vendors will have specific deadlines that must be met by plan sponsors and should be carefully noted. It is expected that vendors will charge fees in connection with preparing this information, with the level of fee dependent on the complexity of the pharmacy benefits. One consideration when deciding who should report should be that, while the Departments have encouraged aggregate submissions, multiple entities should not submit the same data for a plan, i.e., avoid "double reporting." So, in essence, plan sponsors should keep track of who is reporting what.

Plan sponsors should obtain contractual commitments, if possible, from any vendor providing such reporting on the plan's behalf. As stated above, vendors may be unwilling to enter into a contractual agreement wherein they agree to bear liability for noncompliance.

Because data is filed for a prior reference period, plan sponsors who changed carriers, TPAs or PBMs should always confirm with the prior service provider to verify the assistance they will provide with the required reporting–whether by filing on behalf of the former client or by providing necessary information to the former client to report for themselves.

Finally, and this suggestion is nothing new, plan sponsors should remain alert to the possibility of future guidance or clarification to the existing rules.

Penalties

The penalty for noncompliance can be steep with a possible IRS excise tax penalty of $100 per day per affected individual. The Department of Labor can also enforce compliance for ERISA plans, while the Department of Health and Human Services can enforce compliance on non-ERISA plans. While stakeholders have requested various forms of relief (such as additional time to submit the reporting information, sufficiency of general good-faith compliance efforts etc.), the relief provided thus far has been limited.

In recognition of the fact that many vendors would not have access to such information, the Departments announced limited non-enforcement relief relating to average monthly premium information for the 2020 and 2021 reference years. The instructions state that, "the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are reported in the RxDC report for the 2022 reference year and all future reference years."

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Conclusion:
While the CAA's prescription drug and health care reporting requirements ultimately place responsibility for compliance on group health plans, plan sponsors will need to lean heavily on carriers and TPAs in order to provide the necessary reporting. Because the data may be submitted by a variety of entities and the Departments have said their expectation is that many insurers, TPAs and PBMs will submit for the plans, sponsors should contact and negotiate with carrier and TPA partners to provide the necessary information. Group health plan sponsors should familiarize themselves with the law and existing guidance and work with vendors to ensure proper coordination of efforts.

References
[1]Section 204 of Division BB of the CAA, found at https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf
[2]Prescription Drug and Health Care Spending; https://www.govinfo.gov/content/pkg/FR-2021-11-23/pdf/2021-25183.pdf
[3]CMS-10788; https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10788

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McGriff November Webinar Opportunities

As part of McGriff's commitment to bring you information on regulatory updates, current trends and best practices, we invite you to the following webinars scheduled for this month. We hope you can join us for one or more of these educational opportunities!

Employee Benefits Road Trip: How to Avoid Compliance Potholes

November 17 | 2:00 pm EST | 1.0 PDC SHRM
To register, please click here.

Join your McGriff Compliance Tour Guides on an employee benefits road trip! We will explore such sights as the Affordable Care Act to COBRA and address some recent roadblocks that have popped up for employer plan sponsors. Let us help you navigate around compliance potholes relating to reporting and disclosure requirements, plan document issues, and everything in between!

Motivation Strategies for Increasing Employee Engagement

November 17 | 2:00 pm EST
To register, please click here.

Many companies are struggling with low employee engagement and the challenges it brings. Learn what it takes to create and sustain a workplace environment where employees are highly engaged and motivated for helping you achieve your business results. Presented by Truist Leadership Institute.

Monthly Mineral Demonstration

November 15 | 2:00 pm EST
To register, please click here.

McGriff is excited to bring you Mineral (formerly ThinkHR) — a robust web-based resource with live advisors, reliable content and interactive technology solutions that provides an end-to-end People Risk Management solution! If you are involved with HR compliance or employee issues at any level, this will be another valuable benefit from your trusted McGriff team that can save you time and money. Join us on for a brief overview of Mineral and its benefits available to you as an employee benefits client of McGriff.