McGriff
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It Benefits You

Your Employee Benefits Newsletter

April 2025

In This Issue:

We're in it for the long haul!

On April 21, nearly 30,000 participants will attempt to run 26.2 miles in the 129th Boston Marathon. The athletes complete intensive training plans, dietary changes, and mental preparations to go the distance and cross that finish line.

At McGriff, we realize our job is a marathon and not a sprint. We work year-round to ensure your benefit plan stays in the best possible shape to easily cross over the finish line during open enrollment and combat high-claim years using smart strategies and long-term planning.

Upcoming Compliance Deadlines

June 1

Prescription Drug Data Collection (RxDC) Reporting

Plan sponsors must report information about prescription drugs and health care spending to the Centers for Medicare & Medicaid Services (CMS) each year. Data for the 2024 reference (calendar) year is due by June 1, 2025. This reporting is required for fully insured and self-funded group health plans of all sizes.

July 31

PCORI Fee

Employers sponsoring a self-funded health plan are required by the Affordable Care Act (ACA) to submit an annual Patient Centered Outcomes Research Institute (PCORI) Fee. Fees are due on July 31 of the calendar year following the plan year for which the fees are calculated by filing on IRS Form 720 (e.g., the fee for a plan ending in 2024 is due on July 31, 2025).

July 31

Form 5500 (Calendar Year Plans)

Generally, a Form 5500 must be filed no later than the last day of the seventh month after the end of the plan year for ERISA pension and welfare benefit plans. For calendar-year plans, the deadline is July 31. With few exceptions, an employer must file a 5500 if any of its ERISA benefit plans had 100 or more covered participants on the first day of the plan.

RxDC Reporting: Compliance Steps for Plan Sponsors

Prescription Drug and Health Care Spending (RxDC) Reporting is the product of one of several healthcare transparency-related provisions contained in the Consolidated Appropriations Act, 2021 (CAA). Section 204 of the CAA requires group health plans or health issuers (insurers) 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.

Insurers and third-party administrators (TPAs) are expected to provide much of the reporting, but group health plans are ultimately responsible for ensuring that the necessary information is submitted. As a result of these rules, group health plan sponsors must report or ensure that certain information related to health plan spending, via an "RxDC" report, is submitted to CMS by June 1 each year for the prior year's data.

While the Agencies expressly allow and expect that third parties such as TPAs, Pharmacy Benefit Managers (PBMs) and health insurers to provide much of the information, 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.

Compliance Steps for Plan Sponsors

For group health plan sponsors, a key compliance step is coordinating with vendors to determine how they will assist plan sponsors in meeting their reporting obligations, as most group health plans will lack the necessary information to report on their own. This consideration should also extend to changing or onboarding new vendors, ensuring that reporting responsibilities are clearly defined well in advance. The Departments have provided an internet portal via the CMS Health Insurance Oversight System (HIOS) where RxDC reports must be submitted. The HIOS portal can be accessed from the CMS webpage, which also provides a user manual, frequently asked questions, and other resources.

Beyond that, the actions plan sponsors will need to take will vary based on their group health plan's structure, the level of insurer or TPA involvement, and other factors, making a one-size-fits-all checklist impractical. That said, there are some relatively simple steps that plan sponsors can take to prepare.

Fully insured plans – Plan sponsors will need to confirm who will submit the required data via the CMS HIOS portal. Fully insured plan sponsors will generally be able to rely on insurers for this step but should verify whether the insurer will be submitting all or a portion of the data on the sponsor's behalf. Even where insurers will submit information on a plan's behalf, they will generally need additional information from plan sponsors such as employer versus member premiums. To that end, plan sponsors should be alert to insurer communications requesting any additional information, noting any deadlines imposed by the insurer.

Fully insured groups can shift liability to the insurer. 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…." What is sufficient to constitute that

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written agreement has not been explained. 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 sponsors from liability should the insurer fail to report the requisite information. Certainly, a signed agreement between the plan sponsor and insurer is preferred and encouraged as a best practice; although, practically speaking, a mass communication may be the only assurance plan sponsors are able to obtain from their insurers.

Self-funded plans – While self-funded plan sponsors can also enter into agreements with vendors to complete these requirements, ultimately, they cannot shift liability for compliance.

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 TPA is more likely to have the data related to prescription drug and health care expenditures and the 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 is it possible for a plan to meet all of its Section 204 reporting obligation by having multiple entities submit files on its behalf. At least for the initial rounds of reporting, many vendors gave 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 want to allow vendors to assist in this way. Vendors will have specific deadlines that must be met by plan sponsors and should be carefully noted. Some vendors have historically charged fees in connection with preparing this information, with the level of fee dependent on complexity. One consideration when deciding who should report should be that, while the Agencies 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.

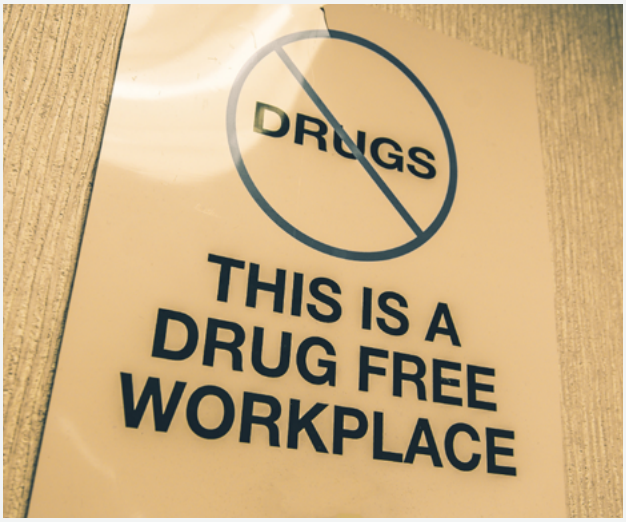
Plan sponsors should obtain contractual commitments, if possible, from any vendor providing such reporting on the plan's behalf. As stated previously, vendors may be unwilling to enter into a contractual agreement wherein they agree to bear liability for noncompliance. Because data is filed for a prior year (referred to as a "reference period" or "reference year" in the instructions), plan sponsors who changed insurers, TPAs, or PBMs should always confirm with the prior service provider – ideally before the transition – what assistance they will provide with the required reporting. This may include filing on behalf of the former client or by supplying the necessary information to the former client to complete the reporting themselves.

Reach out to your McGriff Benefits Consultant with questions on this upcoming reporting requirement.

Stephanie Raborn, JD
McGriff Employee Benefits Compliance Officer

McGriff Webinar Opportunities: A New Vision for Your Company's Drugfree Workplace Programs & Emerging Pharmacy and Managed Care

Employers are legally responsible for maintaining an effective drug-free workplace program – which can be a big challenge in this era of legalized marijuana, increasing drug abuse and the task of hiring and retention. Simultaneously, employers must also choose the right Pharmacy Benefit Manager for their organization to manage costs, ensure quality of care, and improve the health well-being of their employees.



Session 1 | April 10 | 2:00 pm EDT
1.0 PDC SHRM/HRCI

- Identify the four core components of an effective drug-free workplace policy
- Know how to institute a single or multistate compliant policy, taking into consideration each state's legal requirements
- Learn about testing technologies with short windows of detection that can expedite hiring, enhance retention, and provide operational and cost benefits

Presented by: Christine Clearwater, Senior Consultant Risk Management Services, Current Consulting Group, LLC

Register

Session 2 | April 17 | 2:00 pm EDT
1.0 PDC SHRM/HRCI

- Discuss emerging managed care trends
- Review pharmacy trends, including GLP-1 drugs
- Understand specialty medication and gene therapy

Presented by: Denise Cabrera, Senior Vice President, McGriff Pharmacy Practice Leader

Register

We are pleased to bring you webinars throughout the year featuring our internal experts and valued partners. Click here to see what topics we'll be covering in 2025!

How to Reduce Distractions & Help Employees Focus in the Workplace

If your workplace is anything like ours, there are distractions aplenty vying for your attention. Audible conversations. Constant notifications on computer screens and phones. Squeaky chairs. Laundry—if you work at home. Things going on in your personal life. Impromptu meetings.

Every workplace has distractions—some welcome, some not. Distractions aside, our minds are prone to wander. We can only stay focused for so long. When working to reduce distractions in the workplace and help your people focus, don't worry about every little disruption. You'll never create an environment free of distractions. Instead, focus on managing what's in your control and what's significantly disruptive to people's work. For the most part, you'll be addressing and changing behaviors.

Encourage Breaks Away from Where People Work

Falling prey to distractions could be a sign that one needs a break. Fact is, breaks boost productivity! We all need to rest and recharge during the day to do our best work. (And of course, many states require them.) We'd take a break from writing this article, but we did only just begin.

Encourage employees to get away from their workstations during the workday, even if only for a few minutes at a time. If possible, designate areas where employees can be quiet or loud without disturbing others. A quiet area could serve as a place for mindfulness exercises, yoga, or catching up on social media. A loud area would enable employees to chat about March Madness or whatever else is on their minds.

If you don't have a space on-site for people to gather where they won't disrupt their coworkers, perhaps there's a location nearby that would suffice.

Set Reasonable Expectations for Response Times

Sometimes work can be a distraction all on its own. The frequent beeps and pop-ups that accompany email and messaging app notifications can be difficult to ignore, especially if there's a chance the sender expects an immediate response.

Of course, not every message requires an immediate response, and we don't have to act like they do. If your employees tend to err on the side of responding quickly, or don't know how soon after receiving a message they are expected to respond, it might be helpful to set some ground rules for internal communication. These could include guidelines on how often to check various communication types (e.g., email, messaging app, text message) and how soon a response, if needed, is expected (e.g., 24 hours, within the hour, immediately). You might also indicate under what circumstances employees are allowed to turn off notifications or close communication apps so they can focus more effectively on the task at hand.

Limit Multitasking

Distractions sometimes show up because we invite them by taking on too much at once and multitasking when we really should be present with what's before us, whether that's a solo project or a meeting we're attending with others. The truth is, human brains don't multitask, they task-switch. And every time we task-switch, we lose time and productivity. Being able to focus despite distractions—essentially, resisting the urge to task-switch—is a skill. It takes work and practice and the support of management. To help employees build that skill, ask them to block time for individual tasks

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and projects. Encourage prioritizing that work during that time. And remind them that meetings are not an appropriate occasion to catch up on emails, scan news headlines, or scroll social media.

Encourage Scheduled "Do Not Disturb" Time

Speaking of focusing on the task at hand, you can also give employees permission to schedule "Do Not Disturb" or "Focus" time on their calendars. During these periods, employees should be able to work with the expectation that they won't be bothered except in a true emergency. They won't answer calls or emails or chats. No one should stop by their workstation unannounced, even just to say hello or ask a quick question. If that latter part isn't possible, give them permission to reserve a private room or work off-site. In any case, they're deliberately unavailable for the duration of that time, free to focus entirely on the work they've deemed important, empowered to ignore everything else.

Lead by Example

Simply telling employees that they can schedule downtime, wait to respond to messages, and take one task at a time won't necessarily make them believe they can safely do these things. They might not believe you if leadership doesn't do the same. It's important that managers also set aside time to shoot the breeze with coworkers, wait to respond to messages, schedule focused time, and be present in the moment.

Gather Feedback

Every workplace has its own set of distractions. To find out which are most prevalent in your workplace, ask employees. If they're not sure how to answer, ask them more specific questions like how they feel about noise levels in the workplace, the last time they got distracted and what caused it, or how quickly they feel they need to reply to messages from coworkers. To gather this feedback, anonymous surveys may be best given that employees will likely feel disinclined to admit when or how often they're getting distracted at work. Once you have this information, do what you can to help employees avoid distractions and focus on what's important.

Now, if you'll excuse us, there's a lovely little bird perched outside our office window, and we simply must pause to admire it.

This article was originally published by our strategic partner, Mineral, and is republished with permission.

No Good Deed Goes Unpunished: Continuation of Benefits During Leave

While this is certainly not the golden rule I live by in my personal life, in the world of human resources, sometimes "just being nice" can sadly prove this outlook true. I have seen this play out time and time again as an employer inadvertently put itself at risk by not having – or inconsistently applying – an established policy to determine how long to continue benefits during an employee's leave of absence (LOA).

Without an established LOA policy, it's difficult to tell an employee that benefits are being terminated in the middle of a leave – especially when the leave is due to the health condition of the employee or a loved one. It's easy to make an emotional decision rather than a sound business decision, but good intentions can lead to significant financial exposure and increased risk of complaints of discriminatory treatment.

Employers should consider not only the needs of the employee, but also the interplay of carrier contractual provisions, federal and state benefit regulations and the employer's own policies. It's critical that companies proactively establish a LOA policy – before a question arises. Has yours?

Carrier Contractual Provisions

Arguably, the most important consideration in developing a LOA policy is the determination of how long your insurance carrier has agreed to continue benefits when an employee is either on leave or not actively working full-time hours. Whether your plan is fully insured or self-funded, you want to be certain that the employee remains eligible under the terms of the

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contract or plan document before continuing coverage during a leave. It is becoming more common for carriers to request documentation relating to an employee's leave, particularly when there has been a large claim. If the carrier determines that the employee was ineligible for continued benefits, the employer could unexpectedly find itself financially responsible for claims incurred during or even after the leave.

Check your plan's eligibility and termination conditions to determine whether your plan document or contract with your insurance (or reinsurance) carrier specifies the maximum period of time coverage can be continued during an approved leave. Keep in mind that periods of coverage may vary from plan to plan (i.e., medical, life, disability) and for each type of leave (i.e., FMLA versus non-FMLA leave, and leave due to the employee's own illness versus leave for other reasons). Work closely with your benefits advisor to make sure these contractual provisions not only mirror your HR policies and intentions but also comply with the regulatory requirements outlined below to avoid unintentional financial and legal exposure.

Federal and State Leave Regulations

A related consideration is whether the employee's leave is protected by the Family Medical Leave Act (FMLA) or other state leave regulation. If yes, then the FMLA generally requires that the employee's health benefits be continued for the duration of the protected leave, up to 12 (or 26) weeks. State leave laws may require an even longer extension of coverage. Failure to provide benefits in compliance with these federal and state regulations could result in legal exposure.

You should work closely with your benefits advisor to determine if your plan documents provide for continued coverage in compliance with all applicable federal and state leave regulations. You don't want to be in a position where your plan document requires termination of coverage following 12 weeks of FMLA leave, while state law requires 16 weeks of benefits. It is also important to classify and document leaves of absence in a timely manner. Documentation may be important to prove compliance with the law's notification requirements or explain why coverage was continued while an employee was not actively working full-time hours.

The Affordable Care Act (ACA) and Stability Periods

Additionally, if you are an employer subject to the ACA, your choice of measurement method (monthly or look-back) may be a consideration in how long to continue benefits during a LOA. Eligibility for coverage under the monthly method is determined by current hours worked on a month-by-month basis and may be influenced by a LOA. Eligibility under the look-back method, however, is dependent on historical hours worked during a measurement period and is not generally impacted by a LOA (at least until the subsequent stability period). When an employee is classified as full-time during a stability period, coverage should continue to be offered through the end of the stability period, regardless of the number of hours worked (unless employment is terminated). This is, again, where it's important to work closely with your benefits advisor to ensure your plan documents have been updated to reflect your practices, including your measurement method and any applicable stability periods. Otherwise, the document's contractual terms and limits on continuation of coverage during a leave could force you to terminate coverage early – before the end of the stability period - potentially resulting in penalties under the ACA.

Employer Policies and Precedents

After considering the above issues, what if there's still no clear answer to how long benefits should be continued during a LOA? In this case, the decision may be left to the discretion of the employer, and internal policies or prior precedents will be determinative. To minimize risk and ensure consistency, it's even more important to have a policy in place that clearly addresses the maximum length of time an employee may be covered while on leave before COBRA is offered due to the reduction in hours worked. In developing this policy, keep in mind any contractual restrictions imposed by the carrier,

regulatory mandates and ACA compliance. Thinking through these questions before an employee goes on leave will help avoid emotional decisions related to benefits during the leave. And that will help ensure your good deeds are rewarded rather than punished.

Christy Showalter, JD, MBA
McGriff Employee Benefits Compliance Officer

Compliance Q & A: Retroactive Termination of Benefits Coverage

QUESTION: We just realized that a participant who has been ineligible for coverage for some time is still listed as an active employee on our group health plan. Can we terminate coverage back to when this person was first ineligible for coverage? If not, what do we need to consider now?

ANSWER: Because the Affordable Care Act (ACA) generally prohibits termination of coverage that has a retroactive effect, the plan administrator will likely need to terminate coverage prospectively instead of back to the original date of ineligibility for coverage. Many plan administrators choose to make the loss of coverage date the last day of the end of the current month in which the error is discovered and offer COBRA as of that date. The timing of COBRA should also be considered, and the plan administrator may need to work with the COBRA administrator and relevant carriers to avoid inadvertently self-insuring claims due to the error. The risk involved in these decisions can vary based on factors such as the length of time that has passed since eligibility was lost, the probability of the participant electing COBRA, and the carrier/vendors' willingness or ability to accommodate the desired approach.

Read the full Retroactive Termination of Benefits Coverage Compliance Q&A here.

Class-Action Lawsuits Target Health Plan Tobacco Surcharges

Numerous class-action lawsuits have recently been filed against employers alleging that health plan premium surcharges related to tobacco use violate federal compliance requirements. These lawsuits have been filed by current and former employees of major U.S. companies who have paid more in premiums due to their tobacco use, often hundreds of dollars more per employee per year.

Employers commonly require tobacco users to pay an additional charge for health plan premiums, whether they use cigarettes, cigars, e-cigarettes or smokeless tobacco. To comply with federal law, tobacco surcharges must be offered through a wellness program that meets the Health Insurance Portability and Accountability Act's (HIPAA) nondiscrimination requirements.

In general, the lawsuits assert that the health plans violated HIPAA's nondiscrimination rules by:

- Not offering a reasonable alternative standard to avoid the surcharge (or only applying the premium reduction on a prospective basis after completing the alternative standard)

- Not describing the availability of the alternative standard in all plan materials

The lawsuits request various forms of relief, including reimbursing employees who paid the surcharges with interest, disgorging any benefits or profits, and paying all attorney fees and costs.

Given the recent wave of litigation, employers that impose tobacco surcharges should review whether their wellness programs are administered in accordance with HIPAA's requirements, including making available a reasonable alternative standard to qualify for the full reward and communicating the surcharge to employees in all materials.

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McGriff Brings You Mineral!

April 15 | 2:00 p.m. EDT

McGriff is excited to provide our Employee Benefits clients with MINERAL – a robust web-based HR and compliance resource. Through your McGriff relationship, you have access to **Mineral Live**, a team of HR experts standing by to answer your questions or provide advice on virtually every HR or compliance-related issue; **Mineral Comply**, an award-winning online resource center for all of your workforce issues, including a Living Handbook Builder; and **Mineral Learn**, an incredible online training platform with more than 250 web-based courses for your employee training needs.

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