McGriff
EMPLOYEE BENEFIT SOLUTIONS

It Benefits You

Your Employee Benefits Newsletter

October 2023

In This Issue:

Never settle for less: Brand new day for McGriff

At McGriff, as we hope you already know, we never settle for less. More than mere platitude, we believe in that mindset so much that we recently made "Never Settle For Less" our new tagline.

It was just one part of a pivotal milestone in our 100-year-old history, the relaunch of our organizational brand! Our new brand positioning supports a renewed commitment to growth, excellence, and the highest level of client service.

It encapsulates the determination and client-first DNA we're all about at McGriff. It embodies our people-focused, entrepreneurial, get-it-done culture – rooted in relationships and driven by collaboration. And it will pave the way for our future.

Along with the new tagline, we developed a new mission statement, brand pillars, a new look for our sales and marketing materials, and a lot more.

Branding is about creating an indelible impression – it's what we want friends like you to remember when you think of McGriff. It's created by every interaction, every touch, and every impression we make with clients and each other every day.

We have a compelling story to tell, and our new brand positioning provides the framework to help tell it. Let us know what you think.

Wellness Programs: Looking Back/Looking Forward

October 19, 2023 | 2:00 p.m. EST | 1.0 PDC SHRM/HRCI Credit

Wellness is evolving in multiple dimensions, yet wellness programs have not kept pace. Join the McGriff Peak Health Team to discuss how wellness is evolving to meet the changing workplace landscape. We will also revisit how to evaluate wellness program success by overviewing metrics that go beyond typical enrollment and interaction numbers to truly connect the dots between the program and an employer's health risk strategy.

Nirav Desai
Peak Health Managing Director

Register

Upcoming Compliance Deadlines

October

Medicare Part D Notices

The Centers for Medicare and Medicaid Services (CMS) requires plan sponsors that provide prescription drug coverage to furnish Part-D-eligible individuals with a notice disclosing the creditable or noncreditable status of their coverage by October 14, 2023.

If a health plan's open enrollment period begins on or before October 14, plan sponsors can meet this requirement by including the Medicare Part D notice in the plan's open enrollment materials.

December

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

Generally, the plan administrator provides the Summary Annual Report (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

Initial No Gag Clause Attestation Deadline

The Consolidated Appropriations Act of 2021 (CAA) prohibits plans and issuers from entering into agreements with health care providers, third-party administrators (TPAs) and other service providers that would restrict the plan or issuer from providing, accessing or sharing certain information about provider pricing and quality of care as well as de-identified claims.

Plans and issuers must annually submit an attestation of compliance with these requirements – or "Gag Clause Prohibition Compliance Attestation (GCPCA)" – using the Centers for Medicare and Medicaid Services' (CMS) Health Insurance Oversight System (HIOS).

The first attestation, covering the period beginning December 27, 2020 through the date of the attestation, must be filed by December 31, 2023.

What Employers Need to Know - Gag Clause Prohibition Compliance Attestation Placemat

Fall into Savings for Parents with an FSA or HSA Plan

With kids back in school, chances are your calendar is once again filling with fall activities! As you recently ushered in a new school year it's possible you've spent money on some things that can be reimbursed using your FSA or HSA dollars. In this article, we'll discuss how you can use your Flexible Spending Account (FSA) or Health Savings Account (HSA) to buy or claim reimbursement for common back-to-school health-related expenses. You can buy more with your medical expense account than you might think!

Every family has unique needs, which means every family will spend their medical expense dollars differently! The great thing about flexible benefit plans is that they put you in the driver's seat to spend tax-free money on the specific health care needs of your family.

Let's first review the purpose of an FSA or HSA account. These types of accounts help with out-of-pocket health care expenses using the tax-free money you've set aside from your paycheck. Generally, medical expense funds are loaded onto a debit card, which you'll use to pay for eligible expenses. If you pay without your debit card, or if the store register doesn't have software to automatically flag your eligible purchases on your printed receipt, you'll need to submit a receipt for substantiation or reimbursement, whichever applies. Simply snap a photo and upload!

"Oh, that counts?"

Check out these categories for specific items you might already be shopping for! You may even find some things to file reimbursement claims on. And parents, if you're paying for a health care-related item, expense or treatment for your child that isn't automatically considered a covered expense, consult with your child's pediatrician. There are a variety of health care-related expenses that gain eligibility with a Letter of Medical Necessity.

Beyond First Aid Supplies

Now is a great time for restocking your supply of first aid items at home and in your vehicle. For older kids who have flown the nest, it's also a good idea to check-on their supplies. And no, a variety box of bandages isn't enough! Take stock of the following items: general first aid supplies, antibiotic ointments, anti-itch creams, bandages, cold packs, SPF 15+ sunscreen, thermometers, Pedialyte, juvenile incontinence supplies, cough drops, and OTC medications for cold and flu, pain relief and allergies.

Athletic and Sporting Activities

Do your children play sports, dance, cheer or tumble? Purchase the following items with your tax-advantaged accounts: hot and cold packs, a wide range of wraps, athletic tapes, elastics, back and limb supports, belts and wraps, arch supports, rehydrating solutions, and athletic jock supporters. Equipment used to treat a specific medical condition for your child is also considered eligible.

Vaccines

Medical plans typically provide these for free. Should you incur a co-pay or a fee for the visit itself, remember to pay for it using your FSA or HSA card.

Sleep Aid Items

Ah, back-to-school bedtime routines and shorter daylight hours. Many children use natural melatonin to aid in sleep readiness, and some need a prescription to help them stay asleep. Others may sleep with the assistance of a CPAP machine or a doctor recommended humidifier. A sleep aid is a qualifying expense.

Acne Treatments

Often a matter of trial and error, dermatology treatments can be expensive because it is for each person. If your child needs medication, cleansers or light therapy, use your FSA or HSA account.

Feminine Hygiene Products

Yes, they're eligible! Use your FSA or HSA funds to pay for the following items: liners and pads, tampons, menstrual cups and cleansers, period underwear (specifically designed for menstruation), yeast and anti-fungal treatments.

Do Plan Dollars Expire?

FSA Plan Dollars

FSA dollars do expire but check with your employer. Many offer either a grace period for spending plan dollars into March of the following year OR a carry-over allowance of $610, a limit set by the IRS. You won't have both options, and may have neither, so it's important to know what your company offers.

FSAs have a defined plan year, so once your coverage period expires, all unused FSA funds will be lost without the options above.

The FSA maximum participant contribution for 2023 is $3,050.

HSA Plan Dollars

HSA dollars never expire and will remain in your account until you decide to use them. Unspent money in your HSA account will simply roll over into your account for the next year.

The 2023 HSA maximum participant contribution is $3,850 for individual coverage, and $7,750 for family coverage.

Vision, Dental and Hearing Treatments and Supplies

Do your children wear prescribed corrective vision contacts or prescription eyewear? If so, make sure you're paying for these with your tax-advantaged accounts. Exams, cleaning and storage supplies, drops, eye equipment and corrective procedures such as LASIK and PRK are eligible. *Safety glasses are currently not eligible.

Reading Material for the Visually Impaired

Account funds can cover the cost difference between the standard printed edition of a book and the Braille or audio edition of the same materials.

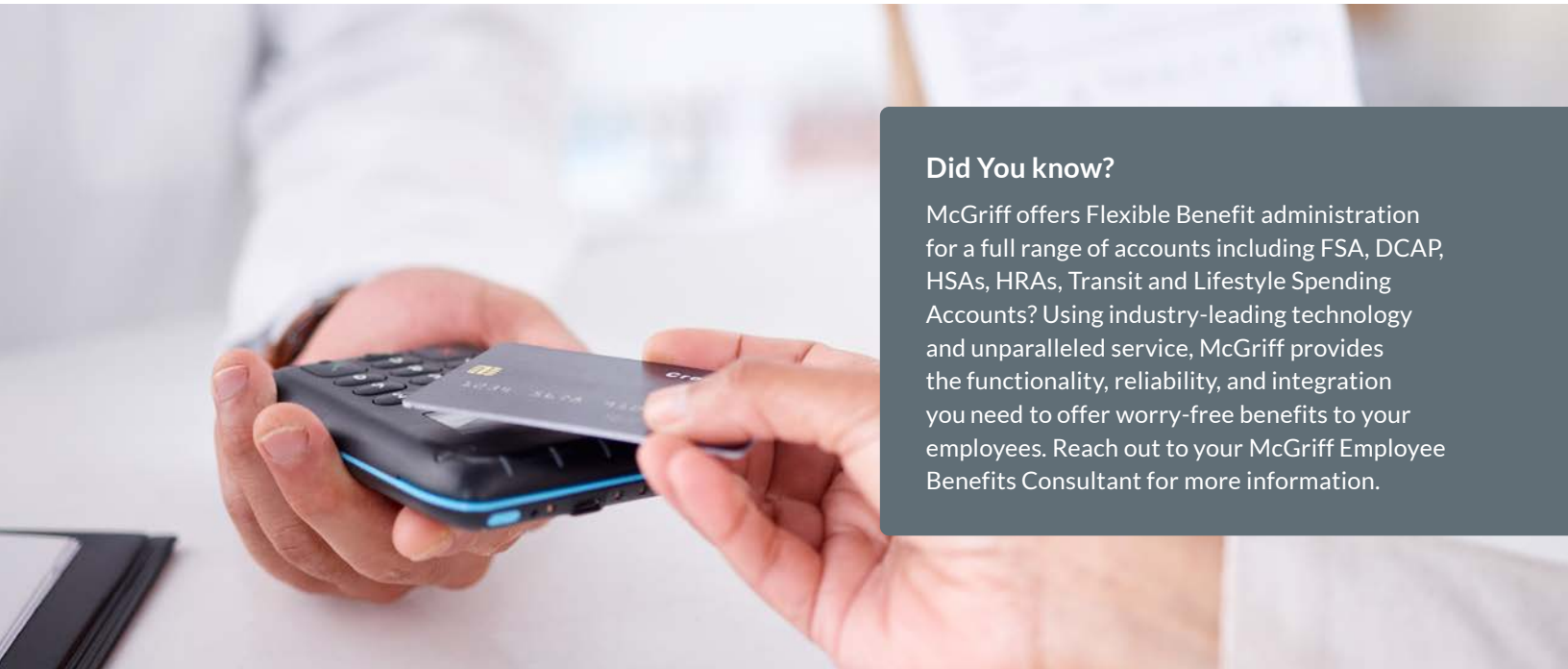
Dental Expenses and Devices

Many people forget to use their account to pay for out-of-pocket expenses associated with their child's dental care. Aside from fillings and cleaning, your child may also have orthodontia expenses. Braces, night guards for teeth grinding, and other forms of corrective dental devices, including light therapy fall into the eligible expense category. *Toothpaste, unless prescription, is not eligible.

Hearing Assistance

If you incur out-of-pocket expenses for aids, batteries or exams, those are all eligible. Ear drops and wax removal products are also eligible OTC products.

Holly Murrah
McGriff Flex & COBRA Development Executive



Did You know?

McGriff offers Flexible Benefit administration for a full range of accounts including FSA, DCAP, HSAs, HRAs, Transit and Lifestyle Spending Accounts? Using industry-leading technology and unparalleled service, McGriff provides the functionality, reliability, and integration you need to offer worry-free benefits to your employees. Reach out to your McGriff Employee Benefits Consultant for more information.

The Actuarial Impacts of Long COVID: An Emerging Challenge for Insurance Providers

Long COVID, also known as post-acute sequelae of SARS-CoV-2 infection (PASC), has become a significant concern as the COVID-19 pandemic persists. While much attention has been focused on the health implications of the virus, the actuarial impacts of long COVID are starting to emerge as a substantial challenge for insurance providers.

Long COVID is broadly defined as signs, symptoms, and conditions that persist or develop following the acute phase of a COVID-19 infection. These symptoms can include fatigue, shortness of breath, brain fog, joint pain, and other debilitating conditions that can significantly impact an individual's quality of life.*

While the prevalence and long-term effects of long COVID are still being studied, it is increasingly clear that it can have a profound impact on health and well-being. Below we will explore the related potential ramifications of long COVID on the insurance industry and how it may affect actuarial calculations.

Healthcare Costs

We see the actuarial implications of long COVID primarily in healthcare costs. Insurance providers must assess the financial implications of covering the medical expenses associated with long COVID, which may include specialist consultations, diagnostic tests, therapies, and medications. Given the potential long-lasting nature of the condition, insurers may face increased expenditures for an extended period.

Mortality and Morbidity Rates

Long COVID has also raised concerns regarding mortality and morbidity rates, which are crucial factors for actuaries in assessing risk and setting premiums. While COVID-19-related mortality rates have been extensively studied, the long-term effects of long COVID on mortality are still uncertain. Actuaries must closely monitor evolving data and research to understand the impact of long COVID on mortality and morbidity rates, since these factors directly affect insurance calculations.

Disability and Income Protection Insurance

Long COVID has significant implications for disability and income protection insurance providers. Individuals suffering from long COVID may experience a prolonged inability to work or reduced work capacity due to ongoing symptoms. Actuaries must evaluate the potential increase in disability claims and adjust policy premiums accordingly, considering the impact of long COVID on long-term disability risks.

Data Collection and Analysis

Accurate data collection and analysis are critical in assessing the actuarial impacts of long COVID. Insurance companies must collaborate with healthcare providers, researchers, and public health authorities to gather reliable data on the prevalence, severity, and duration of long COVID. Actuaries can use this data to estimate the potential increase in claims and adjust their calculations to ensure the financial sustainability of insurance products.

Risk Mitigation

Insurance providers can take several measures to mitigate the actuarial impacts of long COVID. This may include offering specialized coverage for long COVID-related conditions, promoting preventive measures to reduce the risk of infection, and collaborating with healthcare professionals to develop effective treatment strategies. Such proactive measures can help insurance companies manage risks associated with long COVID and maintain the viability of their insurance products.

As long COVID continues to affect individuals worldwide, insurance providers face new actuarial challenges. The implications of long COVID on healthcare costs, mortality rates, disability claims, and income protection policies require careful analysis and adaptation from actuaries.

Collaboration between insurers, healthcare providers, and researchers is essential in gathering reliable data to inform actuarial calculations and develop strategies to mitigate risks associated with long COVID. By staying proactive and responsive to this emerging challenge, insurance providers can continue to help support individuals suffering from long COVID while maintaining the financial sustainability of their offerings.

As long COVID continues to affect individuals worldwide, insurance providers face new actuarial challenges. The implications of long COVID on healthcare costs, mortality rates, disability claims, and income protection policies require careful analysis and adaptation from actuaries.

Collaboration between insurers, healthcare providers, and researchers is essential in gathering reliable data to inform actuarial calculations and develop strategies to mitigate risks associated with long COVID. By staying proactive and responsive to this emerging challenge, insurance providers can continue to help support individuals suffering from long COVID while maintaining the financial sustainability of their offerings.

R. Edward Johnson
McGriff Actuarial & Underwriting Practice Leader

*https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/post-covid-conditions.html

This article was previously published in HR Professionals Magazine. For your free digital subscription, go to hrprofessionalsmagazine.com/subscriptions.

2024 Open Enrollment Checklist

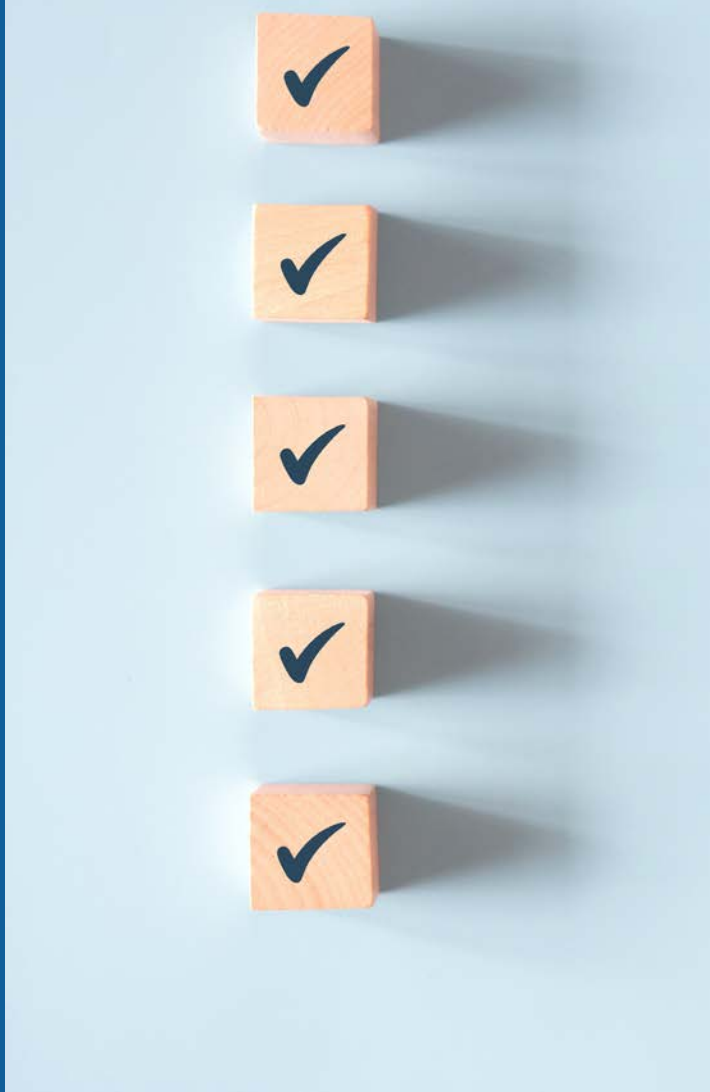
To get ready for open enrollment, employers who sponsor group health plans should be aware of the legal changes affecting the design and administration of their health plans for plan years beginning on or after Jan. 1, 2024. These changes include limits that are adjusted for inflation each year, such as the Affordable Care Act's (ACA) affordability percentage and cost-sharing limits for high deductible health plans (HDHPs). Employers should review their health plan's design to confirm that it has been updated, as necessary, for these changes.

In addition, any changes to a health plan's benefits for the 2024 plan year should be communicated to plan participants through an updated summary plan description (SPD) or a summary of material modifications (SMM).

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices, when applicable, such as the summary of benefits and coverage (SBC). Some participant notices must also be provided annually or upon initial enrollment. To minimize costs and streamline administration, employers should consider including these notices in their open enrollment materials.

Our McGriff Open Enrollment Checklist can help guide employers through plan design decisions and satisfy annual notice requirement.

This checklist is linked, with permission, from Zywave.com



Reference-Based Pricing: 10 Steps for a Successful Implementation

Health care affordability remains a monumental issue, presenting a daunting fiscal challenge for individual consumers, employers, and public budgets alike. Skyrocketing health care costs have introduced roadblocks to essential health services and prompted a vigorous search for new and robust strategies to mitigate this escalating crisis.

Reference-based pricing (RBP) has emerged as a compelling and progressive approach to this challenge. This innovative model, championed by disrupting self-insured employers, defines a maximum limit or "reference price" they're willing to pay for health care services. Different repricing entities use varying metrics, but this often ties the claim payment to a derivative of Medicare that results in the employer paying from 140% to 150% of Medicare, on average.

Opaque pricing shrouds the legacy health care sector. The actual costs of services have historically remained elusive for both patients and payers, often only disclosed post-provision. This murkiness precipitates pricing inconsistencies, engenders in efficiencies, and cultivates an environment ripe for bloated costs and rampant fraud.

Conversely, reference-based pricing strikes back as a transparent, market-oriented solution to determine fair prices for health care services. It offers a clear, objective standard that sidesteps the complexities and often inexplicable vagaries of the existing health care pricing structure. Over recent years, RBP has witnessed steady growth among those seeking to manage spiraling health care costs and promote unambiguous, transparent pricing. Departing from the conventional provider-centric model, RBP puts consumers at the helm, fostering price cognizance and championing value-driven health care consumption.

RBP programs regularly save employers and employees between 20% to 40% in their first year; however, as you might imagine, this approach is not for the casual health care consumer who's familiar and happy with their traditional HMO or PPO and unwilling to roll up their sleeves. If an employer embarks upon this venture with a casual, laissez-faire attitude, things will go wrong.

Click here to learn about the 10 Steps to Successful Reference-Based Pricing Implementation!

Craig Gottwals
McGriff Employee Benefits Consultant

McGriff Pharmacy Insights 3Q

Our quarterly Pharmacy Insights newsletter is designed to bring focus and understanding to topics related to managed care and pharmacy legislation. In this issue:

- Holistic Patient Centered Healthcare
- Digital Therapeutics: The Future of Healthcare
- McGriff Discount Drug Card
- Success Stories: Connected Care Models

Medicare Part D Notices – Due Before October 15

Each year, Medicare Part D requires group health plan sponsors to disclose to individuals who are eligible for Medicare Part D and to the Centers for Medicare and Medicaid Services (CMS) whether the health plan's prescription drug coverage is creditable.

Plan sponsors must provide the annual disclosure notice to Medicare-eligible individuals **before Oct. 15, 2023**—the start date of the annual enrollment period for Medicare Part D.

This notice is important because Medicare beneficiaries who are not covered by creditable prescription drug coverage and do not enroll in Medicare Part D when first eligible will likely pay higher premiums if they enroll at a later date. Although there are no specific penalties associated with this notice requirement, failing to provide the notice may be detrimental to employees.

Creditable Coverage

A group health plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this actuarial determination measures whether the expected amount of paid claims under the group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the Medicare Part D prescription drug benefit. For plans that have multiple benefit options (for example, PPO, HDHP and HMO), the creditable coverage test must be applied separately for each benefit option.

Model Notices

CMS has provided two model notices for employers to use: Model Creditable Coverage Disclosure Notice for when the health plan's prescription drug coverage is creditable; and Model Non-creditable Coverage Disclosure Notice for when the health plan's prescription drug coverage is not creditable.

Employers are not required to use the model notices from CMS. However, if the model language is not used, a plan sponsor's notices must include certain information, including a disclosure about whether the plan's coverage is creditable and explanations of the meaning of creditable coverage and why creditable coverage is important.

Notice Recipients

The creditable coverage disclosure notice must be provided to Medicare Part D-eligible individuals who are covered by, or who apply for, the health plan's prescription drug coverage. An individual is eligible for Medicare Part D if he or she:

- Is entitled to Medicare Part A or is enrolled in Medicare Part B; and
- Lives in the service area of a Medicare Part D plan.

In general, an individual becomes entitled to Medicare Part A when he or she actually has Part A coverage, and not simply when he or she is first eligible. Medicare Part D-eligible individuals may include active employees, disabled employees, COBRA participants and retirees, as well as their covered spouses and dependents.

As a practical matter, group health plan sponsors often provide the creditable coverage disclosure notices to **all plan participants**.

Timing of Notices

At a minimum, creditable coverage disclosure notices must be provided at the following times:

1. Prior to the Medicare Part D annual coordinated election period—beginning Oct. 15 through Dec. 7 of each year
2. Prior to an individual's initial enrollment period for Part D
3. Prior to the effective date of coverage for any Medicare-eligible individual who joins the plan
4. Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable Upon a beneficiary's request

Employers should confirm whether their health plans' prescription drug coverage is creditable or non-creditable and prepare to send their Medicare Part D disclosure notices before Oct. 15, 2023. To make the process easier, employers often include Medicare Part D notices in open enrollment packets they send out prior to Oct. 15.

If the creditable coverage disclosure notice is provided to all plan participants annually before Oct. 15 of each year, items (1) and (2) above will be satisfied. "Prior to," as used above, means the individual must have been provided with the notice within the past 12 months. In addition to providing the notice each year before Oct. 15, plan sponsors should consider including the notice in plan enrollment materials for new hires.

Method of Delivering Notices

Plan sponsors have flexibility in how they must provide their creditable coverage disclosure notices. The disclosure notices can be provided separately, or if certain conditions are met, they can be provided with other plan participant materials, like annual open enrollment materials. The notices can also be sent electronically in some instances.

As a general rule, a single disclosure notice may be provided to the covered Medicare beneficiary and all of his or her Medicare Part D-eligible dependents covered under the same plan. However, if it is known that any spouse or dependent who is eligible for Medicare Part D lives at a different address than where the participant materials were mailed, a separate notice must be provided to the Medicare-eligible spouse or dependent residing at a different address.

This article was reprinted, in part, from Zywave.com with permission.

Seven Tips for Effective Meetings

Are your meetings an occasion for collaboration, knowledge sharing, and getting things done? Or are they a waste of time and a cause of needless frustration? Follow these tips to make every minute count!

If you want to get a snapshot of your organization's effectiveness, look at your meetings. Are they efficient and productive? Do their results justify the time and expense? Are meetings an occasion for collaboration, knowledge sharing, and getting things done? Or are they a waste of time and a cause of needless frustration?

The answers to these questions matter. Meetings aren't cheap, so make each minute count. One employee's lost hour is bad enough. When meetings are a waste, the costs are multiplied. Too many bad meetings and you'll be seen as a company with poor resource management, and you may have the frustrated employees that usually come along with that reputation. So, how do you make every minute in a meeting count?

Write and distribute an agenda for each meeting ahead of time.

The agenda should list what topics will be discussed, who will lead each topic's discussion, and how much time will be allotted for each topic. At the meeting, stick to the agenda. Whoever leads the meeting should bring everyone back to the agenda if the discussion veers too far off-topic.

Invite only the people who need to attend the meeting.

If someone doesn't have something important to say or hear at the meeting, they probably don't need to be there. Remember, you are paying for these meetings, and the more people attend, the more the meetings cost.

Assign someone to take notes at the meeting.

Ideally, this person would not be heavily involved with leading the discussion and could focus on quickly and accurately recording what was said and decided. After the meeting, make the notes available in a shared space online so others can make additions or corrections they feel are important. If the meeting generated assignments or a to-do list, the notes can serve as a way to track progress on action items.

Stay focused on the agenda.

If a particular topic needs more discussion than allotted, you may want to table it for a future meeting. However, an agenda shouldn't always be the last word on what happens. If the agenda needs to be changed mid-meeting to get the most out of your time together, do it, but take care to record what changes were made and what still needs to be discussed later.

Consider the audience when preparing and presenting.

What do you want them to take away from the meeting? A general awareness of the status of a project? A detailed and nuanced understanding of an issue? The ability to deliver on an action item? Align the content and delivery style to what the audience needs.

End the meeting on time and with clear action items for the next meeting or follow-up discussion.

Every participant should have gained something from the meeting: information important for their work, a better understanding of something, a direction to take, or a task to do. If the meeting hasn't produced something, it probably didn't need to happen.

Train frequent presenters.

Public speaking involves a set of skills that may not come naturally to everyone asked to present. Even those who present frequently may benefit from feedback and coaching on their technique. Presenters prone to go off on tangents, ramble, or provide more detail than necessary could use help being more direct and concise. Those who tend to offer insufficient information, inadequately tie their points to the needs of the audience, or fail to explain their acronyms could use tips on explaining their ideas in more detail. There's no need to train every speaker at a meeting, but if regular presenters have a habit of saying too much or too little and aren't connecting effectively with their audience, a few pointers and practice sessions might do the trick.

Effective meetings require good organizational skills, but also good habits and discipline. If you put these tips into practice and commit to them, you'll be well on your way to meetings that provide the most bang for your buck.

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