McGriff
A Marsh & McLennan Agency LLC Company

It Benefits You

Your Employee Benefits Newsletter

December 2025

In This Issue:

December is a month that hosts a myriad of wonderful celebrations – but, did you know that International Mountain Day is December 11?

It may seem like an obscure holiday to observe, but the intent is to raise awareness around mountain health and conservation. After all, mountains provide 60-80% of the world's freshwater, which plays a key role in providing renewable energy and sustenance for 915 million people and even more living downstream.

We often relate mountains to massive challenges, immovable forces, or overwhelming workloads. Or, we may minimize problems by comparing them to "mole hills". Whatever size the mountain, it's always easier to scale it if you have the right attitude and partner support. At McGriff, we are proud to climb obstacles, map strategic routes and guide our clients through the employee benefits landscape.

Upcoming Compliance Deadlines

Dec
31

Gag Clause Prohibition Compliance Attestation

The Consolidated Appropriations Act of 2021 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 submit an attestation of compliance using the CMS Health Insurance Oversight System (HIOS). This annual requirement, covering the period through the date of the last attestation, must be filed by December 31. We have updated our McGriff recorded tutorial to assist employer group health plan sponsors if their carrier/TPA is not willing to complete the attestation on their behalf.

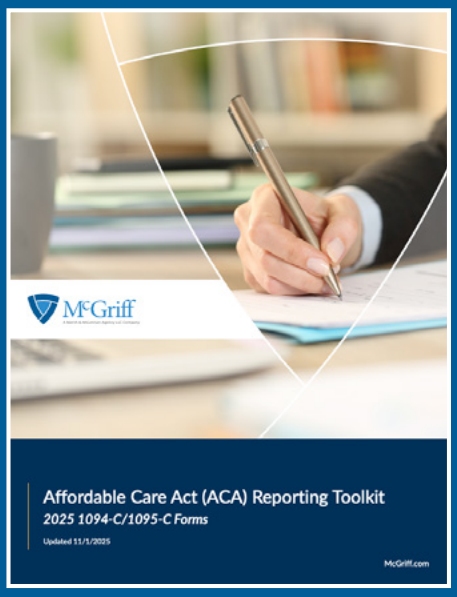
McGriff Affordable Care Act (ACA) Reporting Toolkit: 2025 1094-C / 1095-C Forms

Each year, Applicable Large Employers and employers sponsoring self-funded medical plans (regardless of size) must complete required Affordable Care Act (ACA) reporting pursuant to Internal Revenue Code Sections 6055 and 6056.

McGriff has updated its comprehensive ACA Reporting Toolkit to assist in the many questions that arise for employers when completing these requirements, both when reporting on their own as well as when coordinating with their chosen ACA reporting vendor.

The 2025 McGriff ACA Reporting Toolkit includes:

- a review of the Employer Shared Responsibility mandate;
- a review of the fundamentals of ACA reporting requirements;
- a Step-by-Step guide to completing the IRS 1094-C and 1095-C forms;
- deadlines for IRS filing, as well as furnishing to forms to individuals, and the Paperwork Burden Reduction Act alternative methods;
- numerous examples of common scenarios for coding 1095-C forms; and
- an overview of state reporting requirements.



Click on the image above to access the toolkit.

Laura Clayman, JD, SHRM-CP
McGriff EH&B Compliance Officer

Don’t Forget State Individual Mandates and Reporting Requirements!

While individual health insurance is no longer required at the federal level, a number of jurisdictions, including California, Massachusetts, New Jersey, Rhode Island and Washington, D.C., have enacted their own individual mandates requiring residents to maintain qualifying health coverage or face a state tax penalty.

What this means for employers is that, besides any federal reporting obligations you may have under the Affordable Care Act, you may have state reporting requirements as well:

Jurisdiction		Distribution to Employees	Reporting to the State
California	What:	Federal 1095-B or 1095-C	Federal 1094/1095-B or 1094/1095-C
	When:	January 31, 2026	March 31, 2026
Massachusetts	What:		Health Insurance Responsibility Disclosure (HIRD)
	When:		December 15, 2025
	What:	Form MA 1099-HC	Form MA 1099-HC
	When:	January 31, 2026	January 31, 2026
New Jersey	What:	Federal 1095-B or 1095-C or State NJ-1095	Federal 1095-B or 1095-C or State NJ-1095
	When:	March 2, 2026	March 31, 2026
Rhode Island	What:	Federal 1095-B or 1095-C	Federal 1095-B or 1095-C or State File
	When:	March 2, 2026	March 31, 2026
Vermont	Individual Mandate but currently no employer state reporting requirement		
District of Columbia	What:	Federal 1095-B or 1095-C	Federal 1094/1095-B or 1094/1095-C
	When:	March 2, 2026	April 30, 2026

Employers should proactively assess whether they have employees residing in a state with an individual mandate and carefully determine whether they have state-specific coverage and reporting obligations.

For fully insured plans, the carrier or insurer will often complete this reporting on behalf of the employer. However, since it is ultimately the employer’s responsibility to ensure compliance, employers must confirm the state’s specific requirements and the insurer’s role well in advance of the filing deadlines. Self-funded employers are generally responsible for their own state reporting; although some Third-Party Administrators (TPAs) may be willing to assist with the process.

Did You Know?

All employers with six or more employees in Massachusetts must file the annual Health Insurance Responsibility Disclosure (HIRD) form no later than December 15, 2025.

Christy Showalter, JD, MBA
McGriff EH&B Compliance Officer

Set Your Self-Funded Health Plan Up for Success in 2026

When it comes to benefits strategy, you can't overstate the importance of actionable data analysis.

For example, there's no better time than the first quarter of a new plan year to review your open enrollment outcomes and compare them with your forecasts for the upcoming year. That comparison is an ideal way to analyze your plan's performance and prepare for the future.

Data analytics will help you identify what's driving costs in your health plan so you can address them. Key trends we're seeing contributing to price increases include behavioral health, specialty pharmacy, chronic conditions, and cancer care.

Mental health benefits continue to be top of mind for employers, including barriers to access. Recent data shows an increase of 45% in utilization of behavioral health services between January 2023 and December 2024.[1]

By seeing who is and isn't using mental health benefits, you can better support those in need and potentially make these benefits more accessible and affordable. Using your data in the right way in this important area is another example of how you can ultimately serve your employees in potentially life-changing ways.

Another major trend affecting many employers is the continued rise in chronic condition prevalence – especially diabetes. Between 2021 and 2023, 11.3% of adults were diagnosed with diabetes, an increase from 9.7% in 1999, according to new estimates from the National Health and Nutrition Examination Survey (NHANES).[2] Compounding this rise in diabetes prevalence is the continued popularity of GLP-1 drugs like Ozempic, Mounjaro, Wegovy and Zepbound. Some of these drugs have been around for nearly a decade, primarily for diabetes management. But in the last 24 months, they've become much more popular for weight loss. Manufacturers are also exploring their use for other conditions like heart disease, sleep apnea, and dementia. With similar new drugs expected in 2026, including oral medication options, demand is not expected to fade anytime soon.

For all these reasons and more, employers must have a clear strategy when it comes to coverage. Most of the medications mentioned above have a retail cost exceeding $1,000 per prescription. Net costs – after rebates – range from $500 to $800. Without access to data, companies will struggle to make informed decisions about how to cover these drugs. But by analyzing historical information alongside workforce demographics, you're better equipped to make decisions that suit your needs.

Whether it's the market trends we've covered here that are driving your plan spending or others, reviewing your data will help you chart a clear course and achieve better outcomes in 2026. You can't afford to guess when it comes to whether or not your benefits plan is working. Let data be your guide on the way to meeting both your financial and employee engagement goals. Make your benefits package targeted and meaningful to your workforce!

1. *pwc Health Research Institute. Medical Cost Trend: Behind the numbers 2026.* https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

2. *Gwira JA, Fang S, Bull-Otterson L, et al. Prevalence of Total, Diagnosed, and Undiagnosed Diabetes in Adults: United States, August 2021–August 2023. NCHS Data Brief No. 516. Centers for Disease Control and Prevention; 2024. Accessed October 22, 2025.* https://www.cdc.gov/nchs/products/databriefs/db516.htm

Nick Pearce, FCA, ASA, MAAA
McGriff EH&B Insights & Analytics Practice Leader

Employer's Guide to Planning a Holiday Party

Workplace holiday parties are experiences that many employees look forward to each year. Holiday parties are also a great way to hold tradition within your workplace and allow colleagues and even guests to celebrate one another's accomplishments. Offering a holiday party could help with employee retention or even help build camaraderie in the workplace. They also provide an opportunity to build workplace culture outside of normal office hours or just give a break from the standard workday. However, there can also be high costs and a level of risk associated with these events, including inappropriate behaviors and lack of inclusivity.

There are a variety of ways employers can host a workplace holiday party, and there's a lot that goes into properly planning the event in order to stay within a budget and avoid liabilities. Whether the party is virtual, at your workplace or at a venue, it's necessary to take proactive steps and plan accordingly. This can include coordinating and organizing several aspects, such as invitations, attendance, catering, external relations and budget, to name a few.

This Employer's Guide to Planning a Holiday Party is a resource that can help employers plan your organization's next or first-ever holiday party!

This guide is republished with permission from Zywave.com.

Balancing Benefits and Budgets: Compliance Considerations for Implementing Spousal Surcharges and Carve-Outs in Group Health Plans

Employers sponsoring group health plans often look for ways to control rising healthcare costs. One strategy is imposing restrictions or additional premiums on spousal coverage. This is especially relevant for plans with generous dependent coverage or where many employees elect family coverage. Two common approaches are spousal surcharges and spousal carve-outs. These strategies, however, raise important compliance and administrative considerations under federal laws like the Affordable Care Act (ACA), Health Insurance Portability and Accountability Act (HIPAA), Employee Retirement Income Security Act (ERISA), and applicable state laws.

Spousal surcharges

A spousal surcharge requires employees to pay an extra premium if their spouse is covered under the employee's plan but has access to health insurance through their own employer and chooses not to enroll. This surcharge encourages spouses to use their own employer's coverage, which may help reduce costs for the sponsoring employer.

Spousal carve-outs

Spousal carve-outs are restrictive provisions that limit or remove spousal coverage. Common types include:

1. Complete elimination of spousal coverage
2. Excluding spouses with access to other employer-sponsored coverage
3. Excluding spouses unless they enroll in their own employer's plan, making the employee's plan secondary

Compliance Considerations

Affordable Care Act (ACA)

According to the ACA's Employer Shared Responsibility mandate, or "pay or play" rules, any Applicable Large Employer (ALE) who does not offer specific types of coverage to full-time employees and their dependents may be subject to a tax penalty. Spousal carve-outs and surcharge

Continued...

provisions generally do not affect an employer's "pay or play" analysis because the law does not require employers to offer coverage to spouses.

In some cases, a spousal exclusion may benefit the employee if the additional cost to add the spouse exceeds what the spouse would pay on the Exchange with a premium tax credit (PTC). However, if the employer offers an opportunity to enroll in coverage, this may eliminate the spouse's ability to receive a PTC if the coverage to the employee (and dependents) is considered affordable under the ACA.

A spousal surcharge might affect a plan's grandfathered status if the employer adds a surcharge that reduces the employer contribution by more than five percent for any tier of coverage compared to what the employer contribution was on March 23, 2010.[1]

HIPAA special enrollment rights

As required by HIPAA, plans must allow special enrollment outside open enrollment for qualifying events. Implementing a spousal carve-out triggers a special enrollment opportunity for the spouse to enroll in their own employer's plan mid-year. This is not the case for a surcharge. The employee may have to pay the higher spousal surcharge until the next enrollment period for the spouse's employer-sponsored plan.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) generally requires group health plans sponsored by employers with 20 or more employees in the prior year to offer employees and their families a temporary extension of health coverage in certain instances where coverage would otherwise end. COBRA continuation coverage must be offered when coverage ends due to qualifying events. Loss of coverage due to a spousal carve-out is not a COBRA qualifying event for the spouse.

State law issues

Some states prohibit marital status discrimination, which could affect the legality of spousal surcharges or carve-outs. ERISA generally preempts state laws for self-insured plans, allowing carve-outs or surcharges despite state restrictions. Employers should consult legal counsel to confirm compliance with state insurance and employment laws.

ERISA and Section 125 plan amendments

ERISA requires plan eligibility rules to be documented in the plan document and Summary Plan Description (SPD). Employers should amend these documents before implementing spousal surcharges or carve-outs. For example, if carrier documents indicate spouses are covered, those documents would need amendment; if silent, the wrap document should describe the spousal carve-out. Any amended plan document requires a corresponding SPD amendment or issuance of a Summary of Material Modifications (SMM). When reducing benefits, the SMM should be provided within 60 days of the change.[2]

Section 125 cafeteria plan documents may also need amendment if they promise spousal medical benefits.

Medicare Secondary Payer (MSP) rules

MSP rules require employers with 20 or more employees to offer the same group coverage to employees and spouses aged 65 and older as to younger employees. Surcharges or carve-outs targeting spouses eligible for Medicare may raise MSP compliance issues. Employers should consult legal counsel to avoid potential violations.

HR administrative and employee relations considerations

Implementing spousal surcharges or carve-outs creates administrative challenges. Employers should:

- Define what qualifies as other coverage (e.g., does a preventive-only MEC plan count?).
- Establish verification processes for spouse coverage eligibility (e.g., will affidavits be required from employees and spouses?).
- Decide on consequences for misrepresentation of spouse coverage status.
- Update employee handbooks, HR policies, and payroll systems to reflect changes.
- Communicate clearly and early with employees about eligibility rules, verification procedures, and potential penalties.

Continued...

Clear communication is important to help avoid employee dissatisfaction and complaints to the Department of Labor, which could lead to audits or investigations. Employers should provide sufficient time for employees to secure alternative spousal coverage.

Conclusion

As healthcare costs rise, more employers consider spousal surcharges and carve-outs to manage expenses. While these tools may help reduce costs, employers should carefully navigate federal and state legal requirements, update plan documents, and manage HR processes effectively. Transparent communication and legal consultation can be helpful for implementing these changes effectively.

This article was previously published in HR Professionals Magazine. For your free digital subscription, click here.

1. *Under the ACA, grandfathered plans do not have to comply with certain provisions of the law. Plans lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs for participants.*
2. *The ACA requires all health insurance sponsors to provide a Summary of Benefits and Coverage (SBC) to all plan participants. If any changes are made mid-plan year that affect the content of the SBC, the SBC must be amended and participants must be provided with at least 60 days' advance notice. The SBC generally does not require eligibility language; however, this should be confirmed when making significant changes to the plan.*

Anne E. Hensley, JD ARM
McGriff EH&B National Compliance Practice Leader

Navigating a Tough 2026 Medical and Pharmacy Reinsurance Market

Providing our clients with a clear view of the 2026 medical and pharmacy reinsurance market and the impact on your self-funded health plan is essential. The market is tightening significantly due to rising medical and pharmacy costs, evolving regulatory pressures, and changes in reinsurers' appetite for risk. But with the right preparation and strategy, you can protect your plan, control costs, and maintain coverage stability.

What's Driving the Market Tension?

Based on market research and ongoing conversations with carriers, here are the key forces reshaping reinsurance in 2026:

- ***Medical Cost Trends Remain Elevated:*** Expect medical inflation in the high single to low double digits, pushing up claim frequency and severity.
- ***Pharmacy Cost Volatility:*** Specialty drugs and rapid adoption of GLP-1 therapies are leading to a higher and more volatile pharmacy spend. Reinsurers are frequently pricing pharmacy risk separately and scrutinizing high-cost drug classes.
- ***PBM and Rebate Reforms Add Complexity:*** New state regulations and market demands for PBM transparency and rebate pass-throughs are creating short-term unpredictability in net drug costs, which reinsurers are factoring into underwriting.
- ***Capacity Is More Selective:*** While reinsurance capacity exists, carriers are more selective, requiring detailed claims data, higher attachment points, and tighter contractual warranties, especially for plans with heavy pharmacy exposure or limited data.

What This Means for Your Plan

Based on our market insights and renewal experience, here's what you should expect:

- ***Higher Stop-Loss Premiums:*** This is especially true if your plan has significant pharmacy spend or volatile claims history.
- ***More Rigorous Underwriting:*** Carriers will request detailed drug-level claims, PBM contracts, rebate schedules, and evidence of utilization management programs.
- ***Potential Capacity Constraints:*** For plans with large gene therapy claims or ambiguous PBM arrangements, some carriers may limit coverage or require higher retentions.
- ***Short-Term Volatility:*** PBM reforms may cause swings in net drug costs, so stress testing your pharmacy exposure is critical.

How We Help You Navigate This Market

As your broker and consultant, our role is to guide you through these challenges and position your plan for success. Here's how:

- ***Data Preparation and Transparency:*** We help you aggregate and validate your claims and pharmacy data in carrier-friendly formats to maximize underwriting credibility.
- ***Pharmacy Risk Modeling:*** Together, we run stress tests on pharmacy trends under multiple scenarios to quantify stop-loss exposure and inform renewal strategy. The goal is to understand the potential financial impact on the plan, identify vulnerabilities, and ensure the plan has adequate funding, risk management strategies, or stop-loss protections to handle adverse scenarios without jeopardizing its financial stability.
- ***PBM Contract Review:*** We assist in negotiating PBM transparency provisions, pass-through pricing, and audit rights to reduce uncertainty and improve reinsurer confidence.
- ***Carrier Selection and Negotiation:*** Leveraging market intelligence, we identify which carriers are competitive for your risk profile and negotiate terms to secure the best pricing and coverage.
- ***Benefit Design and Utilization Management:*** We advise on clinical governance, prior authorization protocols, and specialty drug management to demonstrate active risk control to carriers.
- ***Strategic Risk Financing:*** We evaluate options such as higher retentions, aggregate reinsurance, or captives to optimize cost and coverage balance.
- ***Employee Communication Support:*** We help you craft messaging related to benefit changes or utilization programs to ensure smooth adoption and minimize disruption.

Longer-Term Strategies to Consider

- ***Captive Formation or Expansion:*** If you have scale, captives can smooth renewals and retain underwriting profit.
- ***Invest in Clinical Programs:*** Chronic care management, mental health access, and surgical bundling reduce utilization and severity.
- ***Monitor PBM and Regulatory Changes:*** Stay agile to reprice and renegotiate as policies evolve.

Final Thoughts

The 2026 reinsurance market is challenging but not insurmountable. With proactive data management, transparent PBM contracts, rigorous pharmacy risk modeling, and strategic carrier engagement, we can secure the best possible terms and coverage for your plan.

At McGriff, we are committed to navigating this complex market alongside you by providing actionable insights, negotiating aggressively on your behalf, and helping you implement strategies that protect your financial risk while supporting your employees' health.

Please reach out at any time to discuss your renewal strategy or the evolving market. Together, we will ensure your plan is positioned for success in 2026 and beyond.

Ken Bowen, PAHM
McGriff EH&B Executive Underwriting Manager

McGriff Brings You Mineral!

December 18 | 2:00pm ET

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.

Join us to learn about these exciting features and many more within your McGriff-provided Mineral account.

Register

McGriff
EMPLOYEE BENEFIT SOLUTIONS

McGriff.com