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Friday News Brief

Preferred Benefits Services Agency, Inc.

EEOC Expected to Publish New Wellness Rules in 2019

The Equal Employment Opportunity Commission (EEOC) recently announced its plans to issue new proposed rules on permissible wellness incentives under the Americans with Disabilities Act (ADA) by the end of 2019.

In May 2016, the EEOC issued final rules addressing how the ADA applies to employer-sponsored wellness programs. The final rules included a 30% limit for wellness incentives. A federal court vacated this incentive limit, effective Jan. 1, 2019. Consistent with this court ruling, the EEOC removed the incentive limit from its final wellness rules.

The EEOC was expected to issue new proposed rules by June 2019, but the rules have been delayed. The EEOC's spring regulatory agenda includes a deadline of December 2019 for the proposed rules.

Until the EEOC issues new wellness rules, employers should carefully consider the level of incentives they use with their wellness programs. Employers should also watch for any developments related to the EEOC's wellness rules.

Final Wellness Rules

Under the ADA, an employer may make disability-related inquiries and require medical examinations after employment begins only if they are job-related and consistent with business necessity. However, these inquiries and exams are permitted even if not job-related and consistent with business necessity if they are part of a **voluntary wellness program**.

The ADA does not define the term "voluntary" in the context of wellness programs are permissible under the ADA and, if so, in what amount. On May 17, 2016 the EEOC issued final rules that describe how the ADA applies to employer-sponsored wellness programs. These rules became effective on **Jan. 1, 2017**.

The EEOC's final rules restricted incentives offered to an employee who answers disability-related questions or undergoes medical examinations as part of a wellness program. The restriction was **30 percent** of the total cost for self-only health coverage.

New EEOC Rules

The EEOC has indicated that it will publish new proposed rules on employer-sponsored wellness programs in the future. These proposed rules are expected to provide guidance to employers on the permissible incentive limits for wellness plans that ask for health information or include medical exams.

It is not clear, however, when these proposed rules will be released. The EEOC's regulatory agenda from Fall 2018 stated that the rules would be issued by June 2019. However, the EEOC's Spring 2019 regulatory agenda includes a deadline of December 2019 for these new rules.

It is likely that this delay has been largely attributable to the status of the EEOC's membership The EEOC, a bipartisan commission comprised of presidentially appointed members, has been waiting for the confirmation of two members (including a commission chair) and a general counsel. On May 15, 2019, the EEOC's new chair, Janet Dhillon, was sworn in, making it more likely that the EEOC will issue new wellness rules in 2019. However, it is possible that the wellness rules will continue to be delayed.

Source: Zywave

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This Week's HR News...

Recent Settlement Highlights Importance of Gender-Neutral Application of Parental Leave Policies

On May 30, 2019, JPMorgan Chase agreed to pay $5 million to settle a class action lawsuit brought by male employees who requested paternity leave under company policy and were granted less leave than their female counterparts. The case, which was filed in federal court in the Southern District of Ohio, is believed to be the largest settlement ever recorded in a U.S. parental leave discrimination lawsuit.

The United States has no laws at the federal level that guarantee paid parental leave to workers after they have a new child. Nevertheless, some employers offer paid parental leave policies as a matter of company policy.

"Although the company's policy was gender-neutral on its face, problems arose with how the company…"

In this case, the company offered "primary caregivers" sixteen weeks of paid parental leave and offered "non-primary caregivers" two weeks of paid parental leave.

The policy itself did not include any gender-specific terminology regarding who qualified for primary and non-primary caregiver status. Although the company's policy was gender-neutral on its face, problems arose with how the company put the policy into practice.

The plaintiff in the lawsuit was a financial crimes investigator. After his child was born in May 2017, he requested 16 weeks of paid parental leave as a primary caregiver. The company denied his request, and allegedly informed him of the informal "policy" that restricted fathers' eligibility to be primary caregivers.

The plaintiff could not demonstrate that his wife had returned to work, however, because she was a teacher and had the summer off. Shortly after his request was denied for the full parental leave, the plaintiff filed a discrimination charge with the EEOC.

He alleged that the company only treated fathers as primary caregivers if they could demonstrate that their spouse or domestic partner had either returned to work or was medically incapable of any childcare, whereas mothers were always considered primary caregivers.

The company did eventually grant the plaintiff the full 16 weeks of primary caregiver parental leave under its policy, and then clarified its policy to ensure equal access to all employees seeking to serve as the primary caregiver to their new child, regardless of gender. By that point, however, the plaintiff had retained an attorney and proceeded to file the nationwide class action lawsuit at issue here.

The lesson here is straightforward: if employers are going to offer paid parental leave, simply having gender-neutral terminology in the formal policy document may be insufficient to prevent claims of gender-based discrimination. Employers need to consider how these policies are put into practice and whether employees' gender plays a part in how much paid leave the employees actually receive.

Source: Vorys, Sater, Seymour & Pease LLP

Opioid Prescriptions Continue to Decline

A new report from the AMA Opioid Task Force finds that for the fifth year in a row, not just the number of prescriptions, but also the recommended dosage for opioids has fallen. And while there's more to do, doctors are pushing lawmakers to take additional action, such as removing barriers to treatment.

So says a report from the American Medical Association, which highlighted some of the results from the task force's data. The number of prescriptions for opioids, for instance, dropped by more than 80 million, or 33 percent nationally, in the period between 2013 and 2018. Just between 2017 and 2018, opioid prescriptions fell by 12.4 percent—20 million fewer.

In addition, prescription opioid total morphine milligram equivalents have fallen 43 percent since 2011, falling 17.1 percent in

This Week's HR News...

2018—with each state in the country recording a drop in opioid prescriptions over the last five years.

Prescription monitoring is up, with more than 460 million queries made in 2018—that's more than triple the number made in 2016—to keep tabs via states' prescription drug monitoring programs.

The demand for naloxone—the opioid overdose antidote—is up, with the number of prescriptions for it rising from 136,395 in 2016 to almost 600,000 in 2018.

The report acknowledges that there's more to be done, particularly since the Centers for Disease Control and Prevention estimate that more than 130 Americans die after overdosing on opioids, mostly heroin and illicitly distributed versions of fentanyl.

"We need help from policymakers to ensure that more people have access to treatment," says AMA President-elect Patrice A. Harris, MD, who also is chair of the task force. "Physicians are responding to the epidemic and we are seeing results. But we cannot enforce parity laws, or eliminate administrative barriers without the help of state and federal authorities, and that's what is limiting treatment now."

The taskforce has issued a number of recommendations, including:

- The removal of punitive policies, prior authorization barriers, step therapy and other methods that impose delays or obstacles to medication-assisted treatment for opioid use disorder
- Removing administrative and other barriers from comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs
- Additional support for assessment, referral and treatment for co-occurring mental health disorders
- Enforcement of state and federal laws that require insurance parity for mental health and substance-use disorders
- Improved access to evidence-based treatment; and reforms in the civil and criminal justice system
- More help to ensure access to medication-assisted treatment and other forms of proven quality care

Source: Benefits Pro

Workers Want Fully Paid Medical Insurance, Survey Reveals

Fully paid medical insurance topped the list of perks that workers said they don't have, but want, in a recent survey by industrial supply company Zoro. A four-day workweek and fully paid dental insurance followed.

About 73% of the 1,003 workers surveyed said they have access to a bank of paid time off; those without such a benefit, however, weren't terribly interested in it—they said they'd want an unlimited plan instead.

After a PTO bank, the most common benefits to which workers had access were a 401(k), free coffee and partially paid medical insurance. Workers were least likely to have nap breaks, unlimited PTO and a company car.

"...workers value more practical benefits that improve their lives, such as…"

To attract and retain talent in an employee-driven labor market, employers have tried offering trendier perks, from free beer to nap rooms to pet-friendly premises. But research has shown that, as tantalizing as these perks might be, workers value more practical benefits that improve their lives, such as financial well-being programs and student-loan repayment assistance. A 2018 Randstad U.S. survey found that healthcare coverage was the most important employee benefit, followed by retirement savings programs.

Parsing out which benefits will keep workers on board is a complicated process; attempts at new benefits may be hit or miss, but a data-driven approach can help HR make the case for changes. The promise of more personalized benefits packages, which can take into account geography in addition to other characteristics, might also help improve the relevance of what employers offer.

Source: HR Dive

Tips for Preparing Form 5500

At this time of year, many employers and benefit advisors begin preparing Form 5500, the annual report required for most employee benefit plans.

Form 5500 must be filed with the federal government within seven months after the end of the plan year. For calendar-year plans, that means the plan's 2018 Form 5500 is due **July 31, 2019**.

The following are the most frequently asked questions received by ThinkHR about Form 5500 for employer-sponsored health and welfare plans.

Is Form 5500 required for our plan?

Under the Employee Retirement Income Security Act of 1974 (ERISA), Form 5500 must be filed annually for employer-sponsored welfare plans with 100 or more participants as of the beginning of the plan year. To count the number of participants, include covered employees, retirees, and primary COBRA beneficiaries, but do not include dependents.

"Filing is due within seven months after the end of the plan year."

Welfare plans include plans for medical, dental, vision, life, accident, and disability benefits, as well as health flexible spending accounts (HFSAs) and health reimbursement arrangements (HRAs). If the plan includes group insurance coverage, information about the insurance policy must be reported on Schedule A as part of the Form 5500 filing.

Most welfare plans are *unfunded*, which means all benefits are paid through group insurance contracts, or directly from the employer's general assets, or a combination of both. In that case, the filing will be comprised of the three-page Form 5500 only, or the Form 5500 with one or more Schedules A if the plan includes group insurance coverage. No other schedules apply.

On the other hand, if the plan is *funded* (e.g., a benefits trust), or part of a multiple employer welfare arrangement (MEWA), Form 5500 may be required whether or not there are at least 100 participants. Additional schedules also may be required. Funded plans and MEWAs are uncommon and outside the scope of this article.

The following plans are exempt from ERISA; therefore, Form 5500 ***does not apply***:

- Plans sponsored by governmental employers and certain church plans;
- Most voluntary plans (e.g., employee-pay-all after-tax insurance plans without any employer endorsement, sponsorship or contribution);
- Payroll practices (e.g., unfunded vacation and sick pay); and
- Plans maintained solely to comply with state workers' compensation, unemployment, and weekly disability insurance laws, without providing additional benefits.

When is Form 5500 due and how is it filed?

Form 5500 and any required schedules must be filed electronically using the Department of Labor (DOL) EFAST2 electronic filing system. Paper filings are no longer accepted. To prepare and file the form and any schedules, you may use approved third-party vendor software or the DOL's web-based filing system IFILE.

Filing is due within seven months after the end of the plan year. For instance, for calendar-year plans, the due date is July 31 of the following year (or the next business day if July 31 falls on Saturday or Sunday).

Can the due date be extended?

Yes, the filling due date can be extended by up to two and one-half months. To obtain the extension, complete and file Form 5558 *Application for Extension of Time* no later than the original due date. Form 5558 is simple. Complete Part I to identify the plan. In Part II, do not check the box on line 1 (unless this year will be the first time you are filing a Form 5500 for the plan in question). In line 2, enter a date that is not more than two and one-half months after the original due date for Form 5500. For instance, for a calendar-year plan, the 2018 Form 5500 due date is July 31, 2019 so the latest extension you can request is October 15, 2019. The signature line can be left blank. Submit Form 5558 by U.S. mail or overnight delivery; instructions are included with the form.

In very rare cases, the IRS denies the request. Normally, the IRS does not respond which means

Tips for Preparing Form 5500

the extension is automatically granted. Later on, when filing Form 5500, be sure to check the appropriate box in Part 1, D, to indicate that the due date was extended by filing Form 5558.

Part III, line 8, asks for codes. What are the correct codes?

For a welfare plan, do not enter any codes on line 8a. Refer to page 20 in instructions for 2018 Form 5500 for the index of Plan Characteristic Codes, then enter the appropriate code(s) on line 8b. Codes for welfare benefits, including health plans and group life and disability insurance, begin with "4".

For instance, if Form 5500 is for a welfare plan comprised solely of two medical plans (PPO and HMO), an HFSA, and an HRA, the appropriate code would be 4A (health, other than vision or dental). If the plan also included dental, life insurance, and AD&D, the appropriate codes would be 4A, 4B, 4D and 4L.

Part III, lines 9a and 9b, ask about funding arrangements and benefit arrangements. Please explain.

On both lines, check the box for "Insurance" if the plan includes coverages provided through one or more group insurance policies (e.g., group life, medical, STD, LTD). Check the box for "General assets of the sponsor" if the plan includes any self-funded or uninsured coverages (e.g., HFSA, HRA, or other self-funded health plan). Many employers offer insured plans along with an HFSA, in which case both boxes will be checked.

Do not check the boxes for 412(e)(3) contracts or trusts; these are uncommon arrangements requiring tax professionals or plan trustees to prepare the form.

When is Schedule A required?

Schedule A must be filed with Form 5500 if any plan coverages are provided through group insurance contracts. In that case, the insurance company will provide the employer with information about the policy, and information about any commissions or fees, for use in preparing the schedule. Carriers are required to provide this information within 120 days after the end of the plan year. If the plan includes multiple group policies, such as separate policies for group life, PPO medical, HMO medical, dental, and vision, there will be a separate Schedule A for each one.

The group policy year usually is the same as the ERISA plan year, although that is not required so different dates may apply. Include Schedule A with policy information for the policy year that ends within the plan year. For instance, if the ERISA *plan year* is January 1 and the group *policy year* and renewal date is July 1, the 2018 Form 5500 will be filed for period January 1, 2018 through December 31, 2018 and include Schedule(s) A for the policy year July 1, 2017 through June 30, 2018.

Is Schedule C required?

Schedule C does not apply to *unfunded* welfare plans, which are the vast majority of welfare plans.

Schedule C is required only for certain large welfare plans that are funded through benefit trusts (e.g., a voluntary employees' beneficiary association (VEBA) or union trust), which is uncommon. In that case, Form 5500 and all required schedules should be prepared by tax professionals or plan trustees.

"Schedule A must be filed with Form 5500 if any plan coverages are provided through group insurance contracts."

More Information

See the following links for a sample Form 5500 for plan year 2018, instructions for completing the form, and helpful tips from the DOL:

- Sample 2018 Form 5500
- Instructions for 2018 Form 5500
- Form 5500 Filing Tips

Remember, the actual filing must be completed electronically using the DOL's EFAST system. Paper filings are not accepted. Lastly, if unable to file Form 5500 on time, complete, print, and mail Form 5558, *Application for Extension of Time*, for an automatic two and one-half month extension. Form 5558 must be mailed no later than the original due date for Form 5500.

Source: ThinkHR

Ask the Expert!

Question: Are amounts an employer reimburses employees for mileage taxable?

Answer: They may be; the type of reimbursement plan will dictate whether reimbursement for business travel is or is not taxable. Both accountable plans and non-accountable plans allow an employer to reimburse employees for their business expenses.

With an **accountable plan**, the reimbursement is **not** taxable to your employee. Amounts paid under an accountable plan are not wages and are not subject to income tax withholding and payment of Social Security, Medicare, and Federal Unemployment Tax Act (FUTA) taxes. Your reimbursement or allowance arrangement must meet all of the following conditions in order to qualify as an accountable plan:

- There must be a business expense incurred in connection with services performed as an employee of the employers. If not reimbursed by the employers, the expenses may be deductible by the employee from their taxable income.
- There must be adequate accounting by the employee. This means that the employee must give their employer a statement of expense, an account book, a diary, or a similar record in which they entered each use at or near the time it occurred, along with date, mileage, and the business purpose of the use.
- Excess reimbursements or advances must be returned within a reasonable period of time.

A **non-accountable plan** does not meet the three requirements for accountable plans and is subject to all employment taxes and withholding. Payments under a non-accountable plan occur if: (1) the employee is not required to substantiate expenses with receipts or other documentation in a timely manner; and (2) the employer advances an amount to the employee for business expenses and the employee is not required to, and does not, return any amount he or she does not use for business expenses in a timely manner.

Employers should also check with their state department of taxation to understand any state tax rules applicable to them.

For more detailed information on federal mileage reimbursement, see the IRS page containing Publication 463, Travel, Entertainment, Gift, and Car Expenses, and updates to this publication since its publication date.

Source: ThinkHR

Important Deadlines

Form 5500—The deadline for filing Form 5500 for calendar year plans (without extension) is **July 31, 2019**. Sponsors may file Form 5558, Application for Extension of Time to File Certain Employee Plan Returns, to obtain an extension until October 15, 2019.

Form 5500 Series

Form 5558, Application for Extension of Time to File Certain Employee Plan Returns

Summary of Material Modification (SMM) Deadline for calendar year plans made in 2018—A summary of material modifications (SMM) must be provided to participants and beneficiaries for changes made to a welfare benefit plan or pension plan no later than 210 days after the end of the plan year. For changes to calendar year plans made in 2018 that date is **July 30, 2019**.

PCORI Fee Deadline—The Affordable Care Act imposes a fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to help fund the Patient-Centered Outcomes Research Institute (PCORI). The fee, which is required to be reported only once per year on the second quarter Form 720, *Quarterly Federal Excise Tax Return*, and paid by its due date, July 31, is based on the average number of lives covered under the policy or plan.

Form 720, Quarterly Federal Excise Tax Return