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In This Edition:

CBIZ Benefits & Insurance Services

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2020 Benefit Plan Limits

On November 6, 2019, the IRS released the 2020 inflationary (cost of living) adjustments relating to several types of benefits. Below are select highlights of **IRS Revenue Procedure 2019-44** (also see related IRS News Release, ***IRS provides tax inflation adjustments for tax year 2020***).

Flexible Spending Account (FSA) Cap. The amount that can be contributed to a health flexible spending account (FSA) through voluntary salary reductions for plan years beginning in 2020 will increase to $2,750, up from $2,700 in 2019.

Qualified Transportation Fringe Benefits. With regard to transportation expenses reimbursed by an employer and excludable from the employee's income under a qualified transportation program, the limits for 2020 slightly increase from 2019:

	2020	2019
Commuter Highway Vehicle (van pooling) and Any Transit Pass	$270	$265
Qualified Parking	$270	$265

As a reminder, the Tax Cuts and Jobs Act (TCJA) suspended the employer's deductibility of qualified transportation expenses, effective January 1, 2018. The tax exclusion available to employees remains applicable. For tax-exempt entities, the unrelated business income tax is assessed on these amounts. In addition, the TCJA suspended the qualified bicycle commuter benefit from December 31, 2017 through December 31, 2025. An employer sponsoring a qualified bicycle fringe benefit plan can still take a tax deduction (up to $20 per month, or $240 annually) for reimbursing participating employees who use a bicycle for traveling between their home and place of employment. However, these amounts can no longer be excluded from the employee's income.

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Qualified Adoption Assistance Reimbursement Program (IRC §137). An employer-provided adoption assistance program that meets the qualifications of IRC §137, allows participants to recover expenses relating to adoption, such as reasonable adoption fees, court costs, attorney's fees and traveling expenses. Below are the exclusion limits and AGI phase-out limits for 2020 and 2019:

	2020	2019
Exclusion Limit	$14,300	$14,080
AGI Phase-out Limits	Between $214,520 and $254,520	Between $211,160 and $251,160

Health Savings Accounts. The 2020 annual limits applicable to health savings accounts were released earlier this year (see *HSA Inflationary Adjustments for 2020, Benefit Beat*, 6/6/19).

Archer Medical Savings Accounts. The Archer MSA pilot project ended on December 31, 2007; therefore, no new MSAs could be established after that date. For existing MSAs, the annual deductible limits of a high deductible health plan used in conjunction with an Archer medical savings account for 2020 are slightly increased:

	2020		2019	
	Single	*Family*	*Single*	*Family*
HDHP Annual Deductible	Between $2,350 and $3,550	Between $4,750 and $7,100	Between $2,350 and $3,500	Between $4,650 and $7,000
Out-of-Pocket Expenses	$4,750	$8,650	$4,650	$8,550

Long-Term Care Premiums. The IRS limitations relating to eligible long-term care premiums includible as medical care, as defined by IRC §213(d) are:

Age at end of tax year	2020 Premium Limit	2019 Premium Limit
<40	$430	$420
>40 but <50	$810	$790
>50 but <60	$1,630	$1,580
>60 but <70	$4,350	$4,220
>70	$5,430	$5,270

Small Business Tax Credit (SBTC). Small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit, as established by the Affordable Care Act. To be eligible for the small business tax credit, the employer must employ fewer than 25 full-time equivalent employees whose average annual wages are less than $55,200 (indexed for 2020; the wage ceiling in 2019 is $54,200). The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $27,600 in the 2020 tax year (the phase-out wage limit in 2019 is $27,100). As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period.

QSEHRA Payments and Reimbursements. A qualified small employer health reimbursement arrangement, known as a "QSEHRA", allows eligible small employers (those employing fewer than 50 employees and who do not offer health coverage) to reimburse health insurance premium for individual coverage purchased either through or outside the marketplace. Such arrangement must meet certain criteria, specifically, the QSEHRA:

1. Must be funded solely by the eligible small employer; no salary reduction contributions can be made under this arrangement; and,
2. Provides, following the employee's proof of coverage, for the payment or reimbursement for medical care expenses, as defined in IRC Section 213(d)), including premium for health coverage through the individual market, incurred by the eligible employee or his/her family members. For 2019, the annual amount of payments and reimbursements is capped at $5,150 for employee-only, or $10,450 for arrangements that provide for payments or reimbursements for the employee's family members. Both of these limits are subject to inflationary adjustments. Accordingly, beginning in 2020, the total amount of payments and reimbursements is increased to $5,250 for employee-only; $10,600 for family coverage). As a reminder, the total amount of permitted benefits received under a QSEHRA must be reported in Box 12, using Code FF of the Form W-2.

Increase in Tax Information Reporting Penalties. The IRS can assess penalties when certain tax information is not provided on a timely basis.

Specifically, penalties may be assessed for failure to file information returns or provide payee statements, such as the Form W-2 and Form 1099, and notably, the Affordable Care Act's Forms 1094 and 1095, or related payee statements. Beginning in 2020, the total penalty cap will increase as follows:

- The penalty for failure to file a correct information return is increased to $280 (up from $270 in 2019) for each return for which the failure occurs, with the total penalty cap of $3,392,000 (up from $3,339,000 in 2019) for a calendar year.
- The penalty for failure to provide a correct payee statement is increased to $280 (up from $270 in 2019) for each statement for which the failure occurs, with the total penalty cap of $3,392,000 (up from $3,339,000 in 2019) for a calendar year.

Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

2020 Pension and Retirement Plan Limits

On November 6, 2019, the IRS released the 2020 cost of living adjustments (IRS Notice 2019-59) applicable to defined benefit and defined contribution plans (highlights below). Notably, the majority of all limits have increased from 2019.

	2020	2019
Defined benefit plan annual limit	$230,000	$225,000
Defined contribution plan annual limit	$57,000	$56,000
Elective deferral limit for purposes of cash or deferred arrangements (401(k) plans) and tax-sheltered annuities (403(b) plans)	$19,500	$19,000
Maximum deferral limit for 457 plans	$19,500	$19,000
>Age 50 catch-up contribution limit to 401(k), 403(b) or 457(b) plans	$6,500	$6,000
Maximum deferral limit for SIMPLE plans	$13,500	$13,000
>Age 50 catch-up contribution limit to SIMPLE plans	$3,000	$3,000
Minimum compensation considered in determining eligibility for a SEP (simplified employee pension)	$600	$600
Threshold for highly compensated employee (HCE)	$130,000	$125,000
Key employee compensation limit for top heavy plan purposes	$185,000	$180,000
Annual compensation limit	$285,000	$280,000

Also see related IRS News Release: *401(k) contribution limit increases to $19,500 for 2020; catch-up limit rises to $6,500*.

2020 Medicare Premiums and Deductibles

The Centers for Medicare & Medicaid Services (CMS) announced the 2020 premiums and deductibles for the Medicare Part A and Part B programs (also see Medicare's *2019 and 2020 Costs at a Glance*). Following are highlights of the changes.

Medicare Part A - Premium and Deductible

- Generally, there is no monthly Part A premium for those with 40+ quarters of Medicare-covered employment. Individuals who have at least 30 quarters of coverage can buy Part A for $252 in 2020 (up from $240 in 2019); those with less than 30 quarters can buy Part A for $458 per month in 2020 (up from $447 in 2019).
- Part A deductibles in 2020 will increase to $1,408 for first 60 days of inpatient care; an additional $352 coinsurance per day for 61st through 90th day, and an additional $704 per day coinsurance beyond the 90th day.

Medicare Part B - Premium and Deductible

The annual deductible in 2020 will increase to $198, up from $185 in 2019. The monthly premium will increase to $144.60 for 2020, up from $135.50 in 2019. However, the amount of monthly premium is adjusted based on revised income levels, as follows:

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Income-related monthly adjustment amount	Total monthly premium amount
≤ $87,000	≤ $174,000	$0.00	$144.60
> $87,000 and ≤ $109,000	> $174,000 and ≤ $218,000	$57.80	$202.40
> $109,000 and ≤ $136,000	>$218,000 and ≤ $272,000	$144.60	$289.20
> $136,000 and ≤ $163,000	>$272,000 and ≤ $326,000	$231.40	$376.00
>$163,000 and <500,000	>$326,000 and <$750,000	$318.10	$462.70
≥ $500,000	≥ $750,000	$347.00	$491.60

For high-income beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate return, the Medicare Part B premiums in 2020 are:

Amount of Income	Income-related monthly adjustment amount	Total monthly premium amount
≤ $87,000	$0.00	$144.60
> $87,000 and <$413,000	$318.10	$462.70
≥ $413,000	$347.00	$491.60

The monthly premium for Medicare Advantage (Part C) and Part D coverage vary by the selected plan. For 2020, the estimated Medicare Advantage average monthly premium will decline to $23.00 ($26.87 in 2019). The basic Part D premium is also expected to fall from $32.50 in 2019 to $30.00 in 2020. Additional information about these limits was **released** earlier this year.

Informational Form 5500 Issued for 2019 Plan Reporting

The Department of Labor (DOL), together with the Internal Revenue Service and Pension Benefit Guaranty Corporation, released advanced informational versions of the 2019 Form 5500 series. As a reminder, plan administrators of welfare benefit and pension plans subject to ERISA, with certain exceptions, must file an annual return/report to the DOL on the Form 5500.

The 2019 information-only version of the 5500 forms, schedules and instructions is available for viewing on the **DOL's website**. There have been minor changes to the 2019 form; of particular note:

- *Business code – multiemployer plans.* With regard to entering in the appropriate business code for a multiemployer plan in Line 2d of the Form 5500, the instructions clarify that a plan sponsor must use the business code that bests describes the nature of its business and more specifically, the predominant industry in which active participants are employed.
- *Administrative penalties.* The instructions reflect the increase in penalty for plan administrators who fail or refuse to file a complete or accurate Form 5500. Such penalty has been increased to up to $2,194 per day for penalties assessed after January 23, 2019, for violations occurring after November 2, 2015.

The Form 5500s and appropriate schedules are to be completed and filed electronically via DOL's EFAST2 website (**http://www.efast.dol.gov**). The Form, together with the relevant schedules, must be filed with the DOL's Employee Benefit Security Administration (EBSA) as quickly as possible, but no later than the last day of the seventh month following the close of the plan year.

HHS Increases Penalties for Compliance Failures

Employee benefit plans are subject to oversight by several government regulatory agencies including Health and Human Services (HHS), and the Departments of Labor and Treasury. These governing agencies may adjust certain monetary civil penalties for compliance failures.

HHS released its annual **inflationary adjustments for civil penalties** relating to violations of the HIPAA privacy, security and breach rules, failure to provide the summary of benefits and coverage to plan participants, as well as violations relating to the Medicare secondary payor rules. Following are highlights of the changes. These penalties became effective on November 5, 2019.

HIPAA Privacy, Security and Breach Violations

HHS regulates entities subject to the HIPAA Administrative Simplification laws; specifically, covered entities, which include health care providers, health care clearinghouses, and health plans, as well as business associates. In the event of a breach of unsecured health information of individuals, one of the obligations of the covered entity is to provide notification of the breach to affected individuals, as well as notify the media and HHS in certain circumstances. Failure to adhere to these rules by a covered entity could result in civil penalties.

There are four tiers of civil penalties that could be imposed; following are the inflation-adjusted amounts of potential penalties:

Violation category	Each violation (minimum to maximum)	All such violations of an identical provision in a calendar year (calendar year cap)
Did not know a violation occurred	$117 to $58,490	$1,754,698
Violation due to reasonable cause and not willful neglect	$1,170 to $58,490	$1,754,698

Potential Civil Penalties – HIPAA Privacy Rule Violations, cont'd

Violation category	Each violation	Calendar year cap
Violation due to willful neglect but corrected	$11,698 to $58,490	$1,754,698
Violation due to willful neglect and not corrected	$58,490 to $1,754,698	$1,754,698

Summary of Benefits and Coverage – Violations and Revised Templates

The Affordable Care Act requires all group health plans, including grandfathered plans, whether insured or self-funded, to provide a written summary of benefits and coverage (SBC) to plan participants. There are five instances in which the SBC must be provided: upon application, by the first day of coverage, within 90 days of special enrollment period, upon contract renewal and upon request. Failure to provide the SBC could result in HHS penalties, as well as penalties imposed by the Departments of Labor and Treasury. For HHS purposes, the potential civil penalty for willful failure to provide the SBC has been increased to $1,156 per failure (up from $1,128 in 2019).

Revised Summary of Benefits and Coverage (SBC) Templates for 2021

Separate from the HHS adjusted penalties, the Center for Consumer Information & Insurance Oversight (CCIIO) issued revised SBC template, uniform glossary and related materials on November 8, 2019. These documents are required to be used by plan sponsors and insurers for policy/plan years beginning on or after January 1, 2021 (relates to coverage for plan years beginning on or after that date). For plans and insurers that do not use an annual open enrollment period, the revised SBC template is to be used beginning on the first day of the first plan year that begins on or after January 1, 2021. All of these revised documents are available on **CCIIO's website** in 5 languages (English, Spanish, Chinese, Tagalog and Navajo).

Medicare Secondary Payor Rule Violations

In certain instances in which employer-provided health coverage is available, Medicare only pays after the employer plan pays. The rules governing these situations are known as the Medicare Secondary Payer Rules (MSP rules). These rules are generally applicable to the working aged, individuals with end stage renal disease and certain disabled individuals.

Working-aged rule violations. As background, the working aged MSP rule applies to employers with at least 20 full and/or part-time employees on each working day in each of 20 or more calendar weeks in the current or preceding calendar year. In this category, employer-provided health coverage is the primary payer and Medicare is the secondary payer for the working aged. The MSP working aged rules require benefits for individuals aged 65 and over in current employment status, as well as his/her spouse, aged 65 or older must be the same as those available to individuals under age 65. Further, these individuals must be given the same right to participate in the employer-sponsored plan as those individuals under age 65.

An individual who becomes entitled to Medicare due to age can, of his/her own volition, choose to decline or drop employer-sponsored coverage; thus, an employer cannot encourage or induce the individual to choose Medicare over its plan. The penalty for instances in which an employer or other entity offers any financial or other incentive to Medicare-eligible individuals to not enroll in a plan that would otherwise be primary has been increased to $9,472 per violation (up from $9,239 in 2019). Further, willful or repeated failures to provide timely and accurate information requested relating to an employee's group health insurance coverage could result in a $1,542 per violation penalty (up from $1,504 in 2019).

Violations of Medicare mandatory reporting requirement. Insurers, third party administrators and plan administrators of self-funded, self-administered health plans (known as, responsible reporting entities, "RRE") are subject to the **Medicare secondary payor reporting rule**. The purpose of this reporting obligation is to ensure that the Medicare secondary payor rules are properly administered. These entities are required to register with the Centers for Medicare and Medicaid Services (CMS) and accomplish the required reporting through its dedicated website. The penalty for failure to provide information that identifies situations where the group health plan is (or was) a primary plan to Medicare to the HHS Secretary pursuant to this reporting obligation has been lowered to $1,211 per failure ($1,181 in 2019).

As a reminder, beginning January 1, 2020, RREs must include information relating to prescription drug coverage for an individual who is Medicare-eligible and currently employed, or is the spouse or family member of a worker who is covered by a prescription drug plan (see *MSP Reporting Rule expanded to include Prescription Drug Coverage, Benefit Beat,* 9/12/19).

Nevada's "Leave for Any Purpose" Law Clarified

As summarized in our prior *Benefit Beat* article, eligible employees in Nevada are entitled to accrue 0.01923 hours of paid leave for each hour worked, up to 40 hours per benefit year that can be used for "any purpose". The law takes effect on January 1, 2020.

On October 4, 2019, the Nevada Labor Commissioner issued an advisory opinion together with FAQs (**AO 2019-02 Paid Leave**) to clarify certain aspects of this law. Of particular note, this guidance addresses how to determine employer size and the requirement to include information about the leave benefit in the employer's workplace policies.

The law applies to private sector employers employing 50 or more employees working 20 or more work weeks (which need not be consecutive) in the state of Nevada, including a joint employer or successor in interest. To provide clarification on how to determine employer size, the Labor Commissioner uses a method similar to that used for FMLA purposes. Specifically, all employees, both full-time and part-time, are counted. Not counted are employees who work outside of Nevada, temporary, seasonal and on-call employees. An FAQ clarifies that a *temporary employee* is one who works less than 90 days on an occasional or temporary basis, whether paid by the employer or a temporary employment agency or a training school. A *seasonal employee* is one who typically works less than 90 days for a specific season, such as during a holiday season. An "*on-call employee*" is one who works on an hourly or daily basis based on employer need; this also applies to *per-diem* employees. However the Commissioner cautions that the employer should keep careful records of hours worked. For example, if a project ends up lasting longer than originally anticipated, an individual thought to be temporary might, in fact, become entitled to the benefits of the law.

An employer who provides at least the same amount of paid leave for the same purposes, and under the same conditions as required by the law, will satisfy the requirements of the law. The Labor Commissioner advises those employers who do not offer comparable benefits to amend their current paid leave program information contained in existing handbook or other employment policy document by January 1, 2020 to reflect the changes. Further, it is recommended to have employees sign a statement acknowledging receipt of the information.

Employers are encouraged to maintain a basic recordkeeping system to track accrual of leave, leave taken by employees, hours worked, rates of pay, and other basic employee information in order to comply with the requirement to provide an accounting of the hours of paid leave available for use by an employee on each payday.

With regard to notice obligations, employers are required to post information informing employees of the paid leave benefits in a conspicuous location in each workplace maintained by the employer. The Labor Commissioner provides a model **workplace posting** that can be used for this purpose. Further, information about the paid leave program is included in Section 15 of the list of "**Rules to Be Observed by Employers**" which is required to be part of an employer's workplace posting.

Paid Sick Leave Updates in San Antonio and Duluth

San Antonio Ordinance Delayed by Court Order

Practically on the eve of its effective date, the San Antonio paid sick and safe leave ordinance is stayed. On November 22, 2019, Bexar County Judge Peter Sakai imposed a temporary injunction on the ordinance, which was to take effect December 1, 2019. For background relating to this ordinance, see our prior *Benefit Beat* articles from November, 2019, August, 2019, July, 2019 and September, 2018.

Employers will want to review where they are in the process of establishing policies that would be compliant with the ordinance. Employers may want to work with legal counsel to determine whether they can suspend their efforts or whether it would be most prudent to proceed.

As a reminder, two other cities in Texas, namely, Austin and Dallas, have enacted paid sick leave ordinances. The Austin Ordinance was stayed by injunction entered on August 17, 2018 and is proceeding to the Texas Supreme Court. The Dallas Ordinance, despite challenges, took effect August 1, 2019, but penalties for failure to comply, generally, will not be imposed until April 1, 2020.

Updates to Duluth's Earned Sick and Safe Time Ordinance

The City of Duluth adopted an Earned Sick and Safe Time (ESST) Ordinance in May of 2018 that takes effect January 1, 2020 (see *City of Duluth Enacts Earned Sick and Safe Time law, Benefit Beat*, 6/7/18). With the effective date approaching, the City of Duluth has released **final rules** and updated **FAQs**.

Covered employers
The law applies to employers employing 5 or more employees without regard to where the employer is located. The law does not apply to state and local governments with the exception of the City of Duluth.

Covered employee
A covered employee is a full or part-time individual who works within the geographic boundaries of the city for more than fifty percent of his/her working time in a twelve month period or is based in the city of Duluth and spends a substantial part of his/her time working in the city and does not spend more than fifty percent of his/her work-time in a twelve month period in any other particular place. Independent contractors, student interns, seasonal employees and individuals covered by the federal Railroad Unemployment Insurance Act are not eligible for the benefit.

Accrual, Frontloading and Carryover
Employees earn one hour of earned sick and safe time for every 50 hours worked. Employees begin to accrue ESST on January 1, 2020. Individuals hired after January 1, 2020 begin to accrue ESST on his/her date of hire. An employee can begin using accrued ESST following 90 calendar days of employment.

Employees are entitled to accrue up to 64 hours of ESST per year. Accrued ESST carries over from year-to-year, subject to a 40-hour per year limit. Alternatively, an employer can frontload 40 hours of ESST at the beginning of each year. An employer that frontloads ESST does not have allow for carry over.

An employer may, with the written consent of an employee, provide compensation to an employee for accrued but unused ESST instead of carrying over ESST into the following year.

Use of leave
ESST can be used by employees in order to care for themselves or a family member in situations involving illnesses, injuries, physical or mental health conditions, domestic violence, sexual assault, or stalking.

For this purpose, *family member* means an employee's:
- Child, adopted child, adult child, foster child, legal ward, step child, or child for whom the employee is a legal guardian;
- Spouse or domestic partner;
- Sibling, stepsibling, or foster sibling;
- Parent, stepparent, mother-in-law, father-in-law;
- Grandchild, foster grandchild, grandparent, step-grandparent; or
- Any other individual related by blood or whose close association with the employee is the equivalent of a family relationship.

Coordination with employer's existing policy
An employer who has a paid time off (PTO) policy that meets or exceeds the minimum requirements of the Earned Sick and Safe Time Ordinance will be considered compliant with the Ordinance. If an employee has used all available time off for non-Ordinance reasons, the employer is not obligated to provide additional leave.

Collective bargaining agreements entered into prior to January 1, 2020 are deemed compliant. Collective bargaining agreements entered into on or after January 1, 2020 will need to have a substantially equivalent paid-leave policy.

Notice Requirements

- **Employee notification obligations.** The employer may require the employee to follow its usual and customary notice and procedures for absences. If the need for leave is unforeseeable, the employee must provide notice as soon as is practicable. When the leave of absence exceeds three consecutive days, the employer may require reasonable documentation to substantiate the need for leave.

- **Employer notice obligations.** Employers are required to notify their employees of their rights and protections under the Ordinance. Employers must post the notice in a conspicuous place where employees can reasonably be expected to see it. The City Clerk has prepared a **workplace notice** for an employer's use.

Record Retention
An employer must keep records documenting the total number of hours worked by each employee, the number of ESST hours accrued by each employee, and the number of ESST hours used by each employee for a period of three years.

An employer providing a PTO policy that meets the minimum requirements of the Ordinance, is not required to maintain records showing employee reasons for using PTO, only that the PTO was used and how much was used.

Enforcement and Internet Resources
The City Clerk is authorized to enforce the provisions of this Ordinance. Penalties for employer violations begin at $200 per violation and are cumulative.

Additional information relating to the Ordinance including FAQs, employer resources, tracking tools and checklists are available on the City Clerk's **website**.

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