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The order directs government agencies to minimize the enforcement of the ACA's provisions, "to the maximum extent permitted by law." Specifically, agency heads involved with administration of the ACA are directed to grant waivers and exemptions, or implement delays, of provisions that impose a financial or regulatory burden on states, individuals, health insurers, healthcare providers, medical product companies and consumers. Interestingly, the executive order did not specifically refer to easing the burden on employers. In addition, the order provides that federal agency heads should allow states greater flexibility in implementing healthcare programs and encourage the development of a free and open market in interstate commerce.

The order does not provide specific relief or direction for employers, and employers should continue compliance efforts to provide minimum value and affordable health insurance to full-time employees. In addition, employers should continue to comply with the ACA's reporting requirements under Sections 6055 and 6056 of the Internal Revenue Code until further guidance is issued. Although the GOP has introduced an Obamacare repeal and replace bill called the American Health Care Act, which retroactively eliminates the employer mandate to January 1, 2016, it is far from certain whether such bill will become law or if the retroactive repeal of the employer mandate will survive to the final version. As of the date of this publication the repeal and replace bill is working its way through the House of Representatives, but faces significant opposition in the Senate in its current form. We expect to see changes as the bill moves through Congress and employers should stay tuned for future developments.

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Federal Judge Blocks Transgender and Abortion-related Protections Nationwide

On December 31, 2016, a federal judge issued an injunction against a rule issued by the U.S. Department of Health and Human Services (HHS) that prohibits discrimination on the basis of "gender identity" and "termination of pregnancy." The rule was to take effect for health and welfare plans and insurance providers for plan years beginning on or after January 1, 2017.

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in any health program or activity that is administered by or receives funding from HHS. The rule that is subject to the injunction was originally issued by HHS on May 13, 2016, and clarified that the ACA prohibition against discrimination "on the basis of sex" included protections against discrimination due to gender identity and termination of pregnancy.

A group of states and private healthcare providers with religious affiliations challenged the HHS rule in the District Court in the Northern District of Texas on the basis that the rule violated several federal laws and endangered religious freedom protections for healthcare providers that would be forced to provide gender transition services and abortions in violation of their religious beliefs and thwart their independent medical judgment. The government argued that the rule does not require the provision of a particular healthcare procedure but simply requires that covered entities provide health services and health insurance in a non-discriminatory manner.

In siding with the plaintiffs and issuing the injunction, Judge Reed O'Connor found that HHS exceeded its authority by extending anti-discrimination protections to transgender individuals and violated certain other laws, including religious freedom protections, with the application of the rule to pregnancy terminations.

In addition, Judge O'Connor held that the rule imposed an undue burden on healthcare providers by not providing a blanket exemption for health care organizations with a religious affiliation. In addition, the rule resulted in the practice of religious beliefs becoming more expensive in the form of penalties, fines and a loss of federal funding in the event of noncompliance.

Despite the injunction, the remainder of the rule implementing Section 1557 is as of the date of this publication still in full effect. It is important to note that only the gender identity and termination of pregnancy protections were enjoined from enforcement and covered entities should continue to comply with all other aspects of the law. In addition, similar gender identity protections are still potential issues for employers under other federal laws. The Equal Employment Opportunity Commission (EEOC) could continue to interpret Title VII's sex discrimination prohibition to include gender identity, which is not affected by the injunction. And, a similar Department of Labor (DOL) regulation issued by the Office of Federal Contract Compliance Programs (OFCCP) prohibits federal contractors from discriminating on the basis of gender identity. We are continuing to monitor developments in this area and will provide updates on any legislative changes or enforcement policies impacting these protections under the new administration.

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New IRS Guidance: The Taxability of Fixed Indemnity Health Plan Benefits

On January 20, 2017, the IRS released a memorandum clarifying the tax treatment of benefits paid pursuant to fixed indemnity health plans. According to this new guidance, benefits paid under a fixed indemnity health plan that is employer-provided or for which premiums are paid by the employee on a pre-tax basis (through a Section 125 cafeteria plan) are taxable as income to the employee. On the other hand, benefits paid under a fixed indemnity health plan for which premiums are paid with after-tax dollars are not taxable to the employee. Employers will need to evaluate their current practices to ensure the best tax treatment is provided to employees.

As background, the value of employer-provided accident and health insurance coverage and benefits paid under such plans are not included in an employee's taxable income pursuant to Sections 105 and 106 of the Internal Revenue Code. Fixed indemnity health plans pay a fixed dollar amount for certain health-related events, such as office visits or hospital stays. The IRS is taking the position that amounts paid pursuant to a fixed indemnity health plan do not qualify for the income exclusion for benefits paid pursuant to employer-provided health and accident coverage because they are unrelated to the actual medical expense incurred by the individual, thus, those amounts must be included in the employee's taxable income.

The memorandum also addresses the tax treatment of payments made by employers under wellness programs that pay cash amounts to employees who access participation in the wellness program through pre-tax premium payments. The premium payments are then returned to the employees as fixed indemnity payments for participating in certain wellness programs or activities such as health screenings and risk assessments. These programs are often marketed as a method of both encouraging employee wellness and maximizing FICA savings through pre-tax payment of premiums and pre-tax reimbursement of the wellness expenses as a group health plan. The memorandum clarifies that the cash payments or other incentives provided to employees for participation in wellness activities rather than reimbursement for medical care are taxable payments to employees.

Employers who currently offer fixed indemnity plans or wellness programs reimbursing employees on a pre-tax basis for participation in wellness activities, should review their programs with tax counsel to ensure the treatment is consistent with the latest IRS guidance.

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New HRA Option for Small Employers

Effective for plan years beginning after December 31, 2016, certain small employers may provide a new form of stand-alone "qualified small employer health reimbursement arrangement" (QSEHRA) to employees. Section 18001 of the 21st Century Cures Act (CCA) adopted in December 2016 adds the QSEHRA option, and in doing so, overrules in part the Obama administration's rulings that prohibited employers from paying for individual health insurance policies or from contributing to health reimbursement arrangements (HRAs) for employees that are not integrated with a group health plan. While small employers may embrace the idea of again being able to offer premium assistance for individual policies or Medicare, the many legal and administrative requirements described below may be too much for many employers to manage on their own.

Eligible Plan Sponsors. Small employers that do not meet the definition of an "applicable large employer" for purposes of the Affordable Care Act's (ACA's) employer shared responsibility mandate are eligible to sponsor a QSEHRA. Generally, this means the employer has fewer than 50 "full-time equivalent" employees, taking into account all employees of related employers required to be treated as a single employer under the IRS controlled and affiliated service group rules. In addition, the employer sponsoring the QSEHRA may not simultaneously sponsor a group health plan for any of its employees, including executive- or management-only policies.

Benefit Requirements. The QSEHRA must be offered to all employees other than:

- Employees younger than age 25
- Employees who worked less than 90 days for the employer
- Part-time or seasonal employees
- Employees subject to a collective bargaining agreement
- Nonresident aliens with no domestic-earned income

In addition, benefits generally must be offered to all eligible employees on the same terms; however, the amount of benefits may vary based on the cost of insurance in connection with the age of an individual (or covered family members) and the number of family members covered.

Restrictions on Contributions. Similar to a traditional HRA, only the employer can contribute and no employee contributions (even pre-tax contributions through a cafeteria plan) are allowed. The employer contributions to each employee's QSEHRA are capped at $4,950 for an individual employee and $10,000 for employees with family coverage. The contribution limits are subject to annual inflation adjustments.

Tax Treatment. QSEHRA funds may only be used for reimbursing the cost of medical care defined in Section 213(d) of the Internal Revenue Code and will be tax free to the covered individual if the minimum essential coverage (MEC) requirements are satisfied. The reimbursements or payments from the QSEHRA, however, are subject to W-2 reporting in Box 12 (code DD) as the aggregate cost of employer-sponsored coverage.

Minimum Essential Coverage Requirement. Employees covered under a QSEHRA must maintain MEC for the entire duration of the coverage and provide proof of coverage in advance of participation. The employee must also provide notice to the Health Insurance Marketplace ("Exchange") that he or she is covered by a QSEHRA. Participation in a QSEHRA is not employer-sponsored MEC that will preclude an individual from receiving a premium tax credit for coverage in the Exchange, however, the CCA precludes employees from double-dipping on QSEHRA and federal premium assistance by including offset provisions.

Annual Notice Requirement. Employees covered by a QSEHRA must receive an annual notice including the following information: the annual contribution amount, a reminder to disclose the QSEHRA coverage on any Exchange application for coverage, and notice that if MEC is not maintained,

the employee may be subject to a tax penalty under the individual mandate and the QSEHRA reimbursements may be taxable. Generally, the notice must be provided at least 90 days before the start of the plan year for which the QSEHRA is offered and there is a $50 fine per employee (capped at $2,500 annually) for failing to do so. The CCA delayed compliance with the notice requirement until March 13, 2017, to account for the late adoption of the act in 2016, but this transition relief was indefinitely extended by the IRS until 90 days after the IRS issues further guidance.

Compliance with Other Federal Laws. Unlike a traditional HRA, QSEHRAs are not group health plans and are thus exempt from the many group health plan mandates under federal law, including COBRA and HIPAA's portability and nondiscrimination rules. QSEHRAs are subject to HIPAA's privacy and security requirements, although QSEHRAs administered in-house by the employer may qualify for the small employer, self-administered exemption for self-funded plans. In addition, QSEHRAs are likely subject to ERISA's requirements for welfare benefit plans, including plan document, SPD and fiduciary requirements, although some benefits professionals have questioned whether this is the intent of the CCA. Because of this uncertainty, employers should discuss their ERISA compliance obligations with legal counsel and stay tuned for further guidance from the Department of Labor.

Because of the complex requirements, QSEHRA plan sponsors will likely need to engage a third-party administrator to assist with implementation and administration, education of employees, customer service during the plan year and notice requirements. In addition, for employers with low paid workers, consideration should be given to whether the employer's contributions are merely offsetting federal premium assistance that is currently available to employees in the Exchange. Owners and executives currently covered under executive-only group medical policies may also resist adopting QSEHRAs as it will result in a loss of those benefits. Employers will want to carefully weigh the costs and administrative burden of a QSEHRA program with the benefits that may be realized by their employees.

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HSA Corner: Handling HSA Contributions and Retroactive Medicare Coverage

The interaction between the health savings account (HSA) rules and the Medicare eligibility rules can be a tax trap for unsuspecting individuals who remain in the workforce past age 65. Medicare Part A coverage typically begins when an individual reaches age 65 and either enrolls in Social Security or independently elects to delay Social Security, but enrolls in Medicare Part A. For individuals who delay enrollment past age 65, coverage under Medicare is applied retroactively for six months (or retroactively to age 65, if earlier) upon either electing Medicare coverage or enrolling in Social Security, which automatically enrolls the individual in Medicare Part A. The concern is that an individual who is enrolled in Medicare is not eligible to make any contributions to an HSA during the period of the Medicare coverage. This can be an unwelcome surprise to employers and employees who delay Medicare enrollment past age 65 and are participating in employer-sponsored HSA coverage at retirement.

The IRS recently advised in an information letter (Number 2016-0082) that there are no exceptions to this HSA eligibility rule even though the Medicare coverage giving rise to the loss of HSA eligibility is applied retroactively. Employers and employees considering Medicare coverage should be aware of the issue and where possible adjust HSA contributions accordingly. Since many employers allow employees to make pre-tax HSA contributions through a cafeteria plan, mid-year changes may not be permitted or practical and employers likely would not have six months' advance notice that an employee is retiring or planning to enroll in Medicare. Thus, in most cases, the individual HSA holder will need to take action to ensure the contributions are

returned or otherwise withdrawn prior to the individual's tax return deadline for the year (or years) in which the ineligible HSA contributions are made to avoid a six percent excise tax.

In some cases, an individual may not know that there is an HSA eligibility issue in time to correct the problem. For example, an individual electing to enroll in Medicare after age 65 in May 2017 will have coverage under Medicare applied retroactively to November 2016. If the employee was enrolled in an HSA in 2016, there would be at least two months in which excess contributions could have occurred, but the tax return deadline for returning those contributions without payment of the excise tax has already passed (unless the individual obtained an extension for filing the return). The good news is that all HSA withdrawals after reaching the age for Medicare eligibility are exempt from the 20 percent penalty that normally applies if the funds are not used for qualifying medical expenses. Irrespective of penalties and excise taxes, amounts withdrawn from the HSA must be included in the individual's taxable income for the year of withdrawal.

The decision about when to enroll in Medicare for employees working past age 65 can impact not only HSA eligibility, but the COBRA rights of spouses covered under an employer's group health plan, for example, and certain rights under Medicare. Too often, these issues are not addressed until after the election to enroll in Medicare, when it is too late for a correction. With more and more employees remaining in the workforce past age 65, employers and their advisors should become familiar with the issues so that they know when to advise aging and retiring employees to seek professional guidance with respect to the appropriate steps to take in deciding when to enroll in Medicare.

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