Note from the Attorney General's Office:

The syllabus of 2015 Op. Att'y Gen. No. 2015-021, paragraphs 1 through 9, were modified in part, and followed in part, by 2017 Op. Att'y Gen. No. 2017-026.

Syllabus paragraph 10 of 2015 Op. Att'y Gen. No. 2015-021 was explained by 2017 Op. Att'y Gen. No. 2017-026.

June 30, 2015

The Honorable Dave Yost
Auditor of State
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The Honorable Chip McConville
Knox County Prosecuting Attorney
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SYLLABUS: 2015-021

1. A board of township trustees creates a plan, fund, or other arrangement established or maintained for the purpose of providing medical care for its employees when the township employer provides cash reimbursements to township officers or employees for premiums they pay for the purchase of an individual market hospitalization or health insurance policy, for Medicare Parts B or D, or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer, provided a township employer is subject to the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

2. A board of township trustees creates a "group health plan" for purposes of section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, when the township employer provides cash reimbursements to township officers or

employees for premiums they pay for the purchase of an individual market policy, for Medicare Parts B or D, or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

3. Moneys that a board of township trustees provides to township officers and employees to reimburse those officers and employees for the out-of-pocket health care insurance premiums for health care insurance coverage that the officers and employees obtain for themselves cannot be integrated with an individual health insurance policy for purposes of the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

4. A board of township trustees violates the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, if the township's employer payment plan is used to purchase health insurance coverage in the individual market, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

5. A board of township trustees violates the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, if the township's employer payment plan is used to reimburse Medicare Parts B or D premiums, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert. A township's employer payment plan may satisfy the annual dollar limit prohibition, however, if the premium reimbursements for Medicare Parts B or D are integrated with another group health plan according to the criteria set forth in IRS Notice 2015-17.

6. A township's employer payment plan that is integrated with a group health plan provided by or through an entity other than the township may comply with the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, if the requirements set forth in IRS Notice 2013-54 and Department of Labor Technical Release 2013-03 are satisfied, provided a township employer is subject to section 2711's annual

dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

7. A board of township trustees may reimburse township officers and employees for health care insurance premiums or Medicare Parts B or D premiums pursuant to R.C. 505.60(D) and R.C. 505.601 only to the extent that such reimbursements do not conflict with the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert. (2013 Op. Att'y Gen. No. 2013-022 modified, in part.)

8. A board of township trustees may provide township officers and employees a cafeteria plan pursuant to R.C. 505.603 only to the extent that the cafeteria plan is used to purchase health care insurance coverage that complies with section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

9. Whether a township employs fewer than fifty employees does not determine, for purposes of the annual dollar limit prohibition in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, whether a board of township trustees may provide reimbursements for health care insurance coverage to township officers and employees under R.C. 505.60(D) or R.C. 505.601 or whether it may provide a cafeteria plan to township officers and employees under R.C. 505.603, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

10. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), preempts the prohibition against in-term changes in the compensation of public officers that appears in Article II, Section 20 of the Ohio Constitution when compliance with that prohibition would make it impossible to comply with the requirements of section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11.

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June 30, 2015

OPINION NO. 2015-021

The Honorable Dave Yost
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The Honorable Daniel G. Padden
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Dear Auditor Yost and Prosecutors McConville and Padden:

In two separate requests, you have asked 14 questions about the authority of a board of township trustees to reimburse township officers and employees for out-of-pocket health care insurance premiums for health care insurance coverage that the officers or employees obtain for themselves and about certain provisions of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), (the "ACA") that may restrict a board's exercise of that authority. Your requests explain that many townships in Ohio rely on the statutory authority of their trustees under R.C. Chapter 505 to reimburse township officers and employees for premiums paid by the officers and employees for the purchase of health insurance policies that are not purchased by the townships. These reimbursements commonly are referred to as "employer payment plans."

Your specific questions, which we have consolidated, reordered, and rephrased for ease of discussion, are as follows:

1. Does a board of township trustees create a plan, fund, or other arrangement established or maintained for the purpose of providing medical care for employees when it provides township officers or employees cash reimbursement for premiums they pay:

a. for the purchase of an individual market hospitalization or health insurance policy;

b. for Medicare Parts B or D; or

c. for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer?

2. Does a board of township trustees create a "group health plan," as understood by pertinent provisions of the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act, the Employee Retirement Income Security Act, or the Public Health Service Act, when it provides township officers or employees cash reimbursement for premiums they pay:

   a. for the purchase of an individual market policy;

   b. for Medicare Parts B or D; or

   c. for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer?

3. Under the Patient Protection and Affordable Care Act, are the moneys used to reimburse insurance premiums able to be integrated with an individual health insurance policy?

4. Do townships' employer payment plans comply with the Patient Protection and Affordable Care Act prohibition against an annual dollar limit on essential health benefits?

5. May an Ohio township continue to reimburse township officers and employees for health and hospitalization insurance premiums or Medicare Parts B or D premiums pursuant to R.C. 505.60 or R.C. 505.601?

6. Is it still your opinion, as articulated in 2013 Op. Att'y Gen. No. 2013-022, that an Ohio township may reimburse a township officer or employee pursuant to R.C. 505.60 or R.C. 505.601 for Medicare Parts A, B, and D premiums so long as the reimbursement is authorized and effected in a manner fully consistent with the applicable provision of the Revised Code?

7. May an Ohio township continue to provide to township officers and employees a "cafeteria plan" pursuant to R.C. 505.603?

8. Does the number of employees employed by an Ohio township have an impact on whether it is permissible for a township to provide health and hospitalization insurance premium reimbursement pursuant to R.C. 505.60, R.C. 505.601, or a cafeteria plan pursuant to R.C. 505.603? Specifically, if a township employs fewer than fifty employees, may the township provide such reimbursements?

9. If an Ohio township that provides health and hospitalization insurance premium reimbursement under R.C. 505.601 elects to secure group health care and hospitalization coverage for township officers and employees, may such coverage be offered to and accepted by an elected officer of the township during his current term of office without preclusion under Article II, Section 20 of the Ohio Constitution? If so, in what manner?

10. If an Ohio township provides health and hospitalization insurance premium reimbursement to a township officer or employee who is not covered by the township's health care insurance plan offered under R.C. 505.60 because the officer or employee is denied coverage or elects not to participate in the plan, may the township's plan be offered to and accepted by such an officer during his current term of office without preclusion under Article II, Section 20 of the Ohio Constitution? If so, in what manner?

11. Is your response to the previous two questions affected by the fact that any coverage changes offered to an elected officer would be made only to ensure compliance with recent changes in federal law? If so, how is your response affected?

We begin with the state and federal laws that are relevant to answering to your questions.

Reimbursing Township Officers and Employees for Out-of-Pocket Health Care Insurance Premiums under R.C. 505.60, R.C. 505.601, and R.C. 505.603

Townships have been granted several options for providing health care benefits for township officers and employees. 2008 Op. Att'y Gen. No. 2008-018, at 2-199. R.C. 505.60 authorizes a board of township trustees to provide health care insurance coverage for township officers and employees, as well as their immediate dependents, in various manners. *See also* 2012 Op. Att'y Gen. No. 2012-027, at 2-235 to 2-236; 1992 Op. Att'y Gen. No. 92-068, at 2-283 (modified, in part, on other grounds by 2005 Op. Att'y Gen. No. 2005-038). Among the available options, a board of township trustees may procure and pay for "the cost of insurance policies that may provide benefits for hospitalization, surgical care, major medical care, disability, dental care, eye care, medical care, hearing aids, prescription drugs, or sickness and accident insurance, or a combination of any of the foregoing types of insurance for township officers and employees." R.C. 505.60(A); *see also* 2008 Op. Att'y Gen. No. 2008-018, at 2-200.

If a township officer or employee is denied coverage under a health care plan procured by the township under R.C. 505.60(A), or if an officer or employee elects not to participate in the township's health care plan, R.C. 505.60(D) authorizes a board of township trustees to reimburse a township officer or employee for out-of-pocket premiums attributable to insurance benefits described in R.C. 505.60(A) that the officer or employee otherwise obtains. R.C. 505.60(D) limits the reimbursement to no more than "an amount equal to the average premium paid by the township for its officers and employees under any health care plan it procures under this section."

A township that does not procure an insurance policy or group health care services pursuant to R.C. 505.60 also may reimburse a township officer or employee for any out-of-pocket premium attributable to coverage for insurance benefits described in R.C. 505.60(A) that the officer or employee otherwise obtains. R.C. 505.601. The board of township trustees shall establish a maximum monthly or yearly payment amount for each officer or employee beyond which the township will not reimburse the officer or employee. R.C. 505.601(B).

Finally, R.C. 505.603(A) authorizes a board of township trustees to offer health care benefits to township officers and employees through a cafeteria plan so long as the township first adopts a policy authorizing an officer or employee to receive a cash payment in lieu of a benefit otherwise offered to township officers or employees under R.C. 505.60, R.C. 505.601, or R.C. 505.602.[1] The cash payment may not exceed twenty-five percent of the cost of premiums or payments that a board of township trustees would otherwise pay for benefits for the officer or employee under "another health insurance or health care policy, contract, or plan in the case of a health benefit" that is offered by the board. R.C. 505.603(A).

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[1] A "cafeteria plan," sometimes referred to as a "section 125 plan," is a type of employee benefit plan governed by section 125 of the Internal Revenue Code. 26 U.S.C.A. § 125 (West 2015). Specifically, the term "cafeteria plan" refers to a plan under which employees are permitted to elect between cash and a variety of nontaxable benefits, such as payment of health care insurance premiums or contributions to a dependent care account. 26 U.S.C.A. § 125(d)(1) (defining "cafeteria plan" as a written plan under which all participants are employees and the participants may choose among two or more benefits consisting of cash and qualified benefits). Often, employees agree to permit their employers to deduct the cost of selected benefits directly from their wages on a pre-tax basis. Employers then either deposit the money into an account for each employee (*e.g.*, a dependent care account) or pay the money directly to a benefit provider (*e.g.*, an insurance company).

The Patient Protection and Affordable Care Act and the Public Health Service Act

The ACA "greatly expanded the scope of federal regulation over health insurance provided through employment-based group health plans, as well as coverage sold in the individual market."[2] Jennifer A. Staman, Cong. Research Serv., R41624, *Enforcement of Private Health Insurance Market Reforms Under the Affordable Care Act* (Jan. 8, 2014), *available at* https://www.hsdl.org/?view&did=749209. Many of the changes made by the ACA were incorporated into preexisting federal laws, including the Public Health Service Act (PHSA), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code (IRC). Patient Protection and Affordable Care Act, 124 Stat. 119; *see also Florida v. U.S. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1249 (11th Cir. 2011), *aff'd in part, rev'd in part on other grounds sub nom. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) (the ACA "contain[s] hundreds of new laws about hundreds of different areas of health insurance and health care" that are distributed throughout many different statutes and titles in the United States Code).

The ACA is divided into ten titles. Patient Protection and Affordable Care Act, 124 Stat. 119; *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012). Your questions relate to Title I of the ACA, which includes various insurance provisions (also referred to in the ACA as "market reforms"). Patient Protection and Affordable Care Act, 124 Stat. at 130-271. Title I of the ACA amends Title XXVII of the PHSA, including the addition of new PHSA sections 2711 through 2719. *Id.*; *see also* Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 St. Louis U.J. of Health L. & Pol'y 27, 30-31 (2011) (the ACA "extensively amends and reconfigures Title XXVII [of the PHSA], but builds upon its foundation").

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[2] Shortly after enactment of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), (the "ACA"), the United States Congress enacted the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). The Health Care and Education Reconciliation Act amended certain provisions of the Patient Protection and Affordable Care Act. Although your request refers to the Health Care and Education Reconciliation Act, the provisions of law relevant to your questions were enacted as part of the Patient Protection and Affordable Care Act and were not amended by the Health Care and Education Reconciliation Act. Therefore, the Health Care and Education Reconciliation Act is not relevant to your questions and we need not address, in substance, the provisions of that law.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act are sometimes referred to in combination as the "Affordable Care Act" or the "ACA." For the purpose of this opinion, "ACA" refers only to the Patient Protection and Affordable Care Act.

Among its many changes, Title I of the ACA imposes a prohibition on lifetime or annual limits on the dollar value of certain benefits. Patient Protection and Affordable Care Act, § 1001(5), as amended by § 10101, 124 Stat. at 130-31, 883-84. This annual dollar limit prohibition is the subject of your questions. The ACA's annual dollar limit prohibition is enacted in PHSA section 2711, codified as 42 U.S.C.A. § 300gg-11(a) (West 2015):

> (1) In general
> A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—
> (A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or
> (B) … annual limits on the dollar value of benefits for any participant or beneficiary.

Thus, section 2711 of the PHSA generally prohibits "group health plans" that offer group or individual health insurance coverage[3] from imposing lifetime or annual limits on benefits.[4] 42 U.S.C.A. § 300gg-11(a)(1).

A "group health plan" is defined, for purposes of section 2711 of the PHSA,[5] as "an employee welfare benefit plan (as defined in section 3(1) of [ERISA] to the extent that the plan provides medical

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[3] "Health insurance coverage" means "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." 42 U.S.C.A. § 300gg-91(b)(1) (West 2015).

[4] Penalties may be imposed for failing to comply with section 2711 of the Public Health Service Act (PHSA). Section 2723(b) of the PHSA, 42 U.S.C.A. § 300gg-22(b) (West 2015), imposes penalties in certain circumstances on certain types of plans as set forth therein. The maximum penalty is $100 "for each day for each individual" with respect to a failure to comply. 42 U.S.C.A. § 300gg-22(b)(2)(C)(i).

[5] Section 1551 of the ACA, 124 Stat. at 258, states that the definitions in section 2791 of the PHSA, codified in 42 U.S.C.A. § 300gg-91, apply to Title I of the ACA unless otherwise provided. The definition of "group health plan" in section 2791 of the PHSA is distinct from the term "health plan" used in Title I of the ACA. A "group health plan" may include fully funded as well as self-insured (also referred to as self-funded) plans. 79 Fed. Reg. 59130 (Oct. 1, 2014). The term "health plan" does not include self-insured group health plans. 42 U.S.C.A. § 18021(b)(1) (West 2015) (Patient Protection and Affordable Care Act, § 1301, 124 Stat. at 162-63); *see also* 79 Fed. Reg. 59130, n.9 (Oct. 1, 2014).

care … and including items and services paid for as medical care) to employees or their dependents … directly or through insurance, reimbursement, or otherwise."[6] 42 U.S.C.A. § 300gg-91(a)(1) (West 2015). The definition of "group health plan" incorporates the definition of "employee welfare benefit plan" found in section 3(1) of ERISA, 29 U.S.C.A. § 1002(1) (West 2015). An "employee welfare benefit plan" is defined, in part, as "any plan, fund, or program … established or maintained by an employer … to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment." 29 U.S.C.A. § 1002(1). An "employer" is defined to mean any "person" acting in that capacity. 29 U.S.C.A. § 1002(5). "Person," in turn, is defined for purposes of that section to mean "an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization." 29 U.S.C.A. § 1002(9).

Certain agencies of the federal government that enforce the relevant provisions of the ACA, the PHSA, and ERISA appear to have adopted the position that the term "group health plan," as defined in 42 U.S.C.A. § 300gg-91(a), includes plans offered by local government employers pursuant to state or local laws, or that some or all of those provisions apply for other reasons as referenced below. In nearly identical notices addressing the application of the ACA's market reforms to employer premium reimbursements, the United States Department of Labor and the Internal Revenue Service (IRS) have stated that the applicability date of the notices would be extended for employer payment plans provided by local government employers:

> If legislative action by any State [or] local … government entity is necessary to modify the terms of a pre-existing [health reimbursement account] … an employer payment plan, or other similar arrangement, *sponsored by any State [or] local … government entity, as an employer*, to avoid a failure to comply with the market reforms (including action to terminate such arrangement) and such action may only be taken by a State [or] local … government entity legislative body, the applicability date of the portions of this notice under which such arrangement would otherwise fail to comply with the market reforms is extended.

IRS Notice 2013-54 (Sept. 13, 2013); Dep't of Labor Technical Release No. 2013-03 (Sept. 13, 2013). These extension notices may rest on the presumption that plans offered by local government employers are group health plans and therefore are subject to the ACA's market reform directives, or

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[6] "Medical care" includes amounts paid for "(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body" and "(C) amounts paid for insurance covering medical care referred to in subparagraph[] (A)." 42 U.S.C.A.§ 300gg-91(a)(2).

on provisions of 42 U.S.C.A. § 300gg-21 (West 2015). 42 U.S.C.A. § 300gg-21(a)(1) states that the requirements of subparts 1 and 2[7] of Part A of Title XXVII of the PHSA, of which the annual dollar limit prohibition of section 2711 is a part, "shall apply" with respect to a "plan that is a nonfederal governmental plan."[8]

Although the federal agencies that enforce the relevant provisions of the federal laws addressed in this opinion appear to take the position that the definition of a group health plan includes plans offered by local government employers, the Attorney General, as legal representative of the State of Ohio, is advancing a position in current litigation that the definition of "group health plan" in 42 U.S.C.A. § 300gg-91(a) does not itself encompass plans provided by state and local government employers. *See Ohio v. United States*, No. 2:15-cv-00321, Plaintiffs' Motion for Summary Judgment (S.D. Ohio filed May 15, 2015). Whether the reading of the federal law adopted by the federal agencies is valid is not a matter that can be resolved in an opinion of the Attorney General. *See* 2009 Op. Att'y Gen. No. 2009-036, at 2-248; 1999 Op. Att'y Gen. No. 99-007, at 2-55; 1989 Op. Att'y Gen. No. 89-043, at 2-183 n.1; 1988 Op. Att'y Gen. No. 88-007, at 2-21 to 2-22; 1985 Op. Att'y Gen. No. 85-007, at 2-25; *see also* 2001 Op. Att'y Gen. No. 2001-032, at 2-193 (the Attorney General will refrain, in rendering opinions, from exercising discretion on behalf of other public officials). Responsibility for implementing and enforcing the ACA, which includes section 2711 of the PHSA, has been delegated to the United States Departments of Labor, Treasury, and Health and Human Services, among others. *See, e.g.*, 75 Fed. Reg. 37188, 37195, and 37222 (June 28, 2010) (describing authority of Departments of Treasury, Labor, and Health and Human Services to adopt interim final regulations). For the limited purpose of this opinion, we address the issues of law relevant to your questions that would be implicated should the definitional position of the federal agencies relating to the scope of "group health plan" be found to be correct.

Our answers to your questions therefore are made with reference to the federal government agencies' disputed understanding of the term "group health plan," as reflected in syllabus paragraphs one through nine of this opinion. As is evident from the Attorney General's complaint and briefing in

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[7] We note that 42 U.S.C.A. § 300gg-21(a)(1) (West 2015) refers to the requirements of "subparts 1 and 2" of the PHSA. Part A of Title XXVII of the PHSA, however, is divided into subparts "I" and "II." It appears that the reference to "subparts 1 and 2" in 42 U.S.C.A. § 300gg-21(a)(1) was intended to refer to subparts "I" and "II" of Part A of Title XXVII of the PHSA.

[8] A "non-Federal governmental plan" is defined as "a governmental plan that is not a Federal governmental plan." 42 U.S.C.A. § 300gg-91(d)(8)(C). A "governmental plan" is defined, in relevant part, as "a plan established or maintained for its employees by the Government of the United States, *by the government of any State or political subdivision thereof*, or by any agency or instrumentality of any of the foregoing." 29 U.S.C.A. § 1002(32) (emphasis added); *see also* 42 U.S.C.A. § 300gg-91(d)(8)(A) (defining "governmental plan" by referring to the definition set forth in 29 U.S.C.A. § 1002(32)); 42 U.S.C.A. § 300gg-91(d)(8)(B) (defining "Federal governmental plan").

the *Ohio v. United States* case cited above, that is not a position that the Attorney General shares. That is, the conclusions in those syllabus paragraphs incorporate, without adopting, the federal agencies' premise that a plan offered by an Ohio township is encompassed within the definition of a "group health plan" as set forth in 42 U.S.C.A. § 300gg-91(a), and thereby is subject to the annual dollar limit prohibition set forth in section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11.

Applicability of Section 2711 of the Public Health Service Act, as Enacted by the ACA

Questions one through four of your inquiry concern the applicability of the annual dollar limit prohibition set forth in section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11, to cash reimbursements paid by a board of township trustees to township officers or employees for health care insurance premiums. You first ask whether a board of township trustees creates a plan, fund, or other arrangement established or maintained for the purpose of providing medical care for employees when it provides township officers or employees cash reimbursement for premiums the officers or employees pay: (a) for the purchase of an individual market hospitalization or health insurance policy; (b) for Medicare Parts B or D; or (c) for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer. A "group health plan" for purposes of section 2711 of the PHSA incorporates the ERISA definition of an "employee welfare benefit plan," which is defined as "*any plan, fund, or program* … established or maintained by an employer … to the extent that such plan, fund, or program was established or is maintained for the purpose of providing" its participants certain types of benefits, including medical, surgical, or hospital care benefits. 29 U.S.C.A. § 1002(1) (emphasis added); *see also* 42 U.S.C.A. § 300gg-91(a).

The Departments of Labor, Treasury, and Health and Human Services directly addressed the first part of your question, regarding premium reimbursements for the purchase of an individual market hospitalization or health insurance policy, in November 2014. These Departments jointly prepared written guidance addressing questions about the application of the ACA to employer payment plans and other similar arrangements through which an employer reimburses medical expenses up to a certain amount. Dep'ts of Labor, Treasury, and Health and Human and Services, *FAQs about Affordable Care Act Implementation (Part XXII)* (Nov. 6, 2014). The Departments stated: "[i]f the employer uses an arrangement that provides cash reimbursement for the purchase of an individual market policy, *the employer's payment arrangement is part of a plan, fund, or other arrangement established or maintained for the purpose of providing medical care to employees*, without regard to whether the employer treats the money as pre-tax or post-tax to the employee." *Id.* (emphasis added). Accordingly, if a board of township trustees provides cash reimbursements to township officers or employees for premiums the officers or employees pay for the purchase of an individual market policy, the board of township trustees creates a plan, fund, or other arrangement established or maintained for the purpose of providing medical care for its employees, provided a township employer is subject to the annual dollar limit prohibition set forth in section 2711 of the PHSA as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Although the federal agencies have not directly addressed this question with respect to reimbursements for Medicare Parts B or D premiums or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer, we believe that the federal agencies are likely to reach the same conclusion regarding these types of premium reimbursements based on the Departments' conclusion regarding reimbursements for premiums for the purchase of an individual market plan. As in the case of cash reimbursements for premiums for the purchase of individual market policies, cash reimbursements for Medicare Parts B or D premiums or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer may reasonably constitute a "plan, fund, or other arrangement" that is established and maintained to provide medical care for township officers and employees. Therefore, a board of township trustees that provides cash reimbursements to township officers or employees for Medicare Parts B or D premiums or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer thereby creates a plan, fund, or other arrangement established or maintained for the purpose of providing medical care for its employees, provided a township employer is subject to the annual dollar limit prohibition set forth in section 2711 of the PHSA, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Consequently, a board of township trustees creates a plan, fund, or other arrangement established or maintained for the purpose of providing medical care for its employees when the township employer provides cash reimbursements to township officers or employees for premiums they pay for the purchase of an individual market hospitalization or health insurance policy, for Medicare Parts B or D, or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer, provided a township employer is subject to the annual dollar limit prohibition set forth in section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

You also ask whether a board of township trustees creates a "group health plan" for purposes of federal law when it provides cash reimbursements to township officers and employees for premiums the officers and employees pay: (a) for the purchase of an individual market policy; (b) for Medicare Parts B or D; or (c) for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the employing township. Although you refer specifically to "the Affordable Care Act," the Health Care and Education Reconciliation Act, ERISA, or the PHSA, the definition of "group health plan" that is relevant for purposes of determining whether a board of township trustees may provide cash reimbursement to officers and employees for premiums they pay is the definition set forth in the PHSA, 42 U.S.C.A. § 300gg-91(a). *See also* 42 U.S.C.A. § 18111 (West 2015) (Patient Protection and Affordable Care Act, § 1551, 124 Stat. at 258) (ACA applies definitions set forth in 42 U.S.C.A. § 300gg-91 to Title I of the ACA, which includes section 2711 of the PHSA).

With respect to premium reimbursements for the purchase of an individual market policy, the Departments of Labor, Treasury, and Health and Human Services have advised, as follows, that cash reimbursements to employees for premiums the employees pay for the purchase of an individual market policy are considered group health plans:

> This notice reiterates the conclusion in previous guidance addressing employer payment plans, including Notice 2013-54 … that employer payment plans are group health plans that will fail to comply with the market reforms that apply to group health plans under the [ACA]. For this purpose, an employer payment plan … refers to a group health plan under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy or directly pays a premium for an individual health insurance policy covering the employee.

IRS Notice 2015-17 (Feb. 18, 2015) (footnote omitted).

> If the employer uses an arrangement that provides cash reimbursement for the purchase of an individual market policy … the arrangement is group health plan coverage within the meaning of [IRC] section 9832(a), [ERISA] section 733(a)[,] and [PHSA] section 2791(a), and is subject to the market reform provisions of the [ACA] applicable to group health plans.

Dep'ts of Labor, Treasury, and Health and Human and Services, *FAQs about Affordable Care Act Implementation (Part XXII)* (Nov. 6, 2014).

> [A health reimbursement arrangement (HRA)] is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses … incurred by the employee, or his spouse, [or] dependents … up to a maximum dollar amount for a coverage period….. HRAs generally are considered to be group health plans within the meaning of [IRC] § 9832(a), § 733(a) of [ERISA], and § 2791(a) of [the PHSA] and are subject to the rules applicable to group health plans.

IRS Notice 2013-54 (Sept. 13, 2013); Dep't of Labor Technical Release No. 2013-03 (Sept. 13, 2013).

The Department of Treasury has reached the same conclusion for employer reimbursements to employees for Medicare Parts B or D premiums paid by the employees. "An arrangement under which an employer reimburses (or pays directly) some or all of Medicare Part B or Part D premiums for employees constitutes an employer payment plan … and if such an arrangement covers two or more active employees, is a group health plan subject to the market reforms." IRS Notice 2015-17 (Feb. 18, 2015).

The Departments have not advised whether cash reimbursements for premiums for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer constitute a group health plan. We believe the Departments are likely to reach the same conclusions that the Departments have reached regarding cash reimbursements for the purchase of an individual market policy and Medicare Parts B or D premiums. The IRS describes an employer payment plan as a plan in which employees are reimbursed "for premiums they pay for health insurance (either through a qualified health plan *in the Marketplace or outside the Marketplace*)." IRS, *Employer Health Care Arrangements*, *available at* www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements (last visited June 18, 2015) (emphasis added). The IRS states that "these employer payment plans are considered to be group health plans subject to the market reforms, including the prohibition on annual limits for essential health benefits." *Id.* A board of township trustees that reimburses township officers and employees for premiums the officers and employees pay for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer thereby reimburses township officers or employees for health insurance premiums purchased "outside the marketplace." Thus, such cash reimbursement provided by a board of township trustees is considered an employer payment plan, which in turn is considered by the IRS to be a group health plan subject to section 2711's annual dollar limit prohibition, provided a township employer is subject to the annual dollar limit prohibition, as the federal Departments assert.

The Departments also have advised that employer payment plans, which are considered group health plans, include arrangements funded by an employer that reimburse employees for medical care expenses. Dep'ts of Labor, Treasury, and Health and Human and Services, *FAQs about Affordable Care Act Implementation (Part XXII)* (Nov. 6, 2014); IRS Notice 2013-54 (Sept. 13, 2013); Dep't of Labor Technical Release No. 2013-03 (Sept. 13, 2013). "Medical care," for purposes of the definition of a group health plan applicable to section 2711 of the PHSA, includes expenses paid directly or through insurance or reimbursement. 42 U.S.C.A. § 300gg-91(a)(1); *see also* 26 U.S.C.A. § 213(d). Thus, a board of township trustees reimburses township officers or employees for medical care expenses when the township reimburses township officers and employees for premiums the officers and employees pay for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer. Accordingly, the premium reimbursement is an employer payment plan and constitutes a group health plan for purposes of section 2711 of the PHSA, provided a township employer is subject to the annual dollar limit prohibition, as the federal Departments assert.

We thus conclude that a board of township trustees creates a "group health plan" for purposes of section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11, when the township employer provides cash reimbursements to township officers or employees for premiums they pay for the purchase of an individual market policy, for Medicare Parts B or D, or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Your third question asks whether moneys that a board of township trustees provides to township officers and employees to reimburse those officers and employees for the out-of-pocket health care insurance premiums for health care insurance coverage that the officers and employees obtain for themselves may be integrated with an individual health insurance policy. The Departments have concluded that employer payment plans "cannot be integrated with individual market policies to satisfy the market reforms." Dep'ts of Labor, Treasury, and Health and Human and Services, *FAQs about Affordable Care Act Implementation (Part XXII)* (Nov. 6, 2014). An employer payment plan "used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the annual dollar limit prohibition." IRS Notice 2013-54 (Sept. 13, 2013); Dep't of Labor Technical Release No. 2013-03 (Sept. 13, 2013). The federal guidance further explains that an employer payment plan that reimburses employees for premiums for individual market coverage

> will fail to comply with the annual dollar limit prohibition because (1) an employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

IRS Notice 2013-54 (Sept. 13, 2013); Dep't of Labor Technical Release No. 2013-03 (Sept. 13, 2013). *See also* Dep'ts of Labor, Treasury, and Health and Human Services, *FAQs about Affordable Care Act Implementation (Part XI)* (Jan. 24, 2013) ("[t]he Departments intend to issue guidance providing that for purposes of [PHSA] section 2711, an employer-sponsored HRA cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies and therefore will violate [PHSA] section 2711").

Accordingly, moneys that a board of township trustees provides to township officers and employees to reimburse those officers and employees for the out-of-pocket health care insurance premiums for health care insurance coverage that the officers and employees obtain for themselves cannot be integrated with an individual health insurance policy for purposes of the annual dollar limit prohibition set forth in section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Your fourth question is whether the townships' employer payment plans comply with the ACA's annual dollar limit prohibition. As previously explained, the federal Departments have concluded that premium reimbursements are considered "group health plans" and therefore are subject to the annual dollar limit prohibition of section 2711 of the PHSA.

The federal agencies have advised that an employer payment plan used to purchase health insurance coverage in the individual market is not integrated for purposes of satisfying the annual dollar limit prohibition. Therefore, a board of township trustees violates the annual dollar limit

prohibition set forth in section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11, if the township's employer payment plan is used to purchase individual market coverage, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Similarly, a township's employer payment plan may not be integrated with Medicare Parts B or D "because Medicare coverage is not a group health plan," IRS Notice 2015-17 (Feb. 18, 2015), provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments assert. If certain conditions are met, however, IRS Notice 2015-17 explains how premium reimbursements for Medicare Parts B or D may be integrated with another group health plan. An employer payment plan that reimburses Medicare Part B or D premiums

> is integrated with another group health plan offered by the employer for purposes of the annual dollar limit prohibition … if (1) the employer offers a group health plan (other than the employer payment plan) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value; (2) the employee participating in the employer payment plan is actually enrolled in Medicare Parts A and B; (3) the employer payment plan is available only to employees who are enrolled in Medicare Part A and Part B or Part D; and (4) the employer payment plan is limited to reimbursement of Medicare Part B or Part D premiums and excepted benefits, including Medigap premiums.

IRS Notice 2015-17 (Feb. 18, 2015). Therefore, a board of township trustees violates the annual dollar limit prohibition set forth in section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11, if the township's employer payment plan is used to reimburse Medicare Parts B or D premiums, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert. A township's employer payment plan may satisfy the annual dollar limit prohibition, however, if the premium reimbursements for Medicare Parts B or D are integrated with another group health plan according to the criteria set forth in IRS Notice 2015-17.

Finally, a township's employer payment plan that is integrated with another group health plan, including a plan provided by or through an entity other than the township employer, may comply with the annual dollar limit prohibition set forth in section 2711 of the PHSA if certain requirements are satisfied, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert. IRS Notice 2013-54 and Department of Labor Technical Release 2013-03 set forth the conditions under which an employer payment plan may be integrated with another group health plan for purposes of complying with section 2711's annual dollar limit prohibition. These notices specifically state that integration does not require that the employer payment plan and the coverage with which it is integrated "share the same plan sponsor [or] the same plan document or governing instruments." IRS Notice 2013-54 (Sept. 13, 2013); Dep't of Labor Technical Release 2013-03 (Sept. 13, 2013). They further note that

an employer payment plan may comply with the annual dollar limit prohibition if, among other things, the plan is offered to employees who are enrolled in other group coverage, "such as a plan maintained by the employer of the employee's spouse." IRS Notice 2013-54 (Sept. 13, 2013); Dep't of Labor Technical Release 2013-03 (Sept. 13, 2013). Accordingly, a township's employer payment plan that is integrated with a group health plan provided by or through an entity other than the township may comply with the annual dollar limit prohibition set forth in section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11, if the requirements set forth in IRS Notice 2013-54 and Department of Labor Technical Release 2013-03 are satisfied, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Ability of Townships to Provide Premium Reimbursements Pursuant to R.C. 505.60 or R.C. 505.601, or to Provide a "Cafeteria Plan" under R.C. 505.603

Questions five through eight of your inquiry concern the authority of a board of township trustees to provide premium reimbursements or cafeteria plans to township officers and employees under R.C. 505.60, R.C. 505.601, and R.C. 505.603. First, you ask whether a board of township trustees may reimburse officers and employees for health and hospitalization insurance premiums or Medicare Parts B or D premiums pursuant to R.C. 505.60 or R.C. 505.601. You also ask the related question of whether it remains our view, as articulated in 2013 Op. Att'y Gen. No. 2013-022, that an Ohio township may reimburse a township officer or employee pursuant to R.C. 505.60 or R.C. 505.601 for Medicare Parts A, B, and D premiums so long as the reimbursement is authorized by and effected in a manner fully consistent with the applicable provision of the Revised Code. Next you ask whether an Ohio township may provide to township officers and employees a "cafeteria plan" pursuant to R.C. 505.603. These questions present, *inter alia*, issues of federal preemption, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

We discussed federal preemption in the context of the ACA in 2014 Op. Att'y Gen. No. 2014-033. The Supremacy Clause of the United States Constitution provides that "the Laws of the United States … shall be the supreme Law of the Land; and the Judges in every state shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. The Supremacy Clause grants Congress the power to preempt the operation of state laws that conflict with federal statutes. *See, e.g.*, *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372 (2000); *Talik v. Fed. Marine Terminals, Inc.*, 117 Ohio St. 3d 496, 2008-Ohio-937, 885 N.E.2d 204, at ¶20.

Express preemption occurs when Congress enacts a statute with an explicit preemption provision. *Talik v. Fed. Marine Terminals, Inc.*, 117 Ohio St. 3d 496, at ¶21. Implied "conflict preemption," in the absence of express preemption, may occur when there is a conflict between federal and state law. *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. at 372; *see also Talik v. Fed. Marine Terminals, Inc.*, 117 Ohio St. 3d 496, at ¶23; 2014 Op. Att'y Gen. No. 2014-033, at 2-292 to

2-294. "Conflict preemption occurs where it is impossible for a party to comply with both state and federal law or where state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" 2014 Op. Att'y Gen. No. 2014-033, at 2-292 (quoting *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. at 372-73).

Title I of the ACA states that "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C.A. § 18041(d) (West 2015). We explained in our 2014 opinion that it is appropriate to apply the principles of conflict preemption to determine whether a state law is preempted by the ACA:

> The ACA states that it does not preempt state laws that do not prevent the application of Title I of the ACA. 42 U.S.C.A. § 18041(d) (West 2014). The reasonable inference is that the ACA does preempt state laws that prevent its application, *i.e.*, the ACA preempts state laws when their operation conflicts with the ACA's application.

2014 Op. Att'y Gen. No. 2014-033, at 2-294. This conclusion finds support in the few cases that have discussed the ACA's preemption clause set forth in 42 U.S.C.A. § 18041(d). In these cases, the courts considering the language of 42 U.S.C.A § 18041(d) have found the principle of implied conflict preemption dispositive of the issue before them. *See Mo. Ins. Coal. v. Huff*, 947 F. Supp. 2d 1014, 1019 (E.D. Mo. 2013); *Coons v. Geithner*, No. CV-10-1714-PHX-GMS, 2012 WL 6674394, at **1-3 (D. Ariz. Dec. 20, 2012). In another case, although the court noted that the ACA contains an express preemption provision, the court explained that "only those state laws that 'hinder or impede' the implementation of the ACA" are preempted. *St. Louis Effort for Aids v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015).

Conflict preemption is found by the courts "where it is impossible for a private party to comply with both state and federal law." *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. at 372; *see also* 2014 Op. Att'y Gen. No. 2014-033, at 2-292. When there is a conflict between state and federal law, "state law is displaced only 'to the extent that it actually conflicts with federal law.'" *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 476 (1996) (quoting *Pac. Gas and Elec. Co. v. State Energy Res. Conservation and Dev. Comm'n*, 461 U.S. 190, 204 (1983)); *see also* 2014 Op. Att'y Gen. No. 2014-033, at 2-296.

R.C. 505.60(D) and R.C. 505.601 broadly authorize a board of township trustees to reimburse township officers and employees for out-of-pocket premiums for health care coverage if the officer or employee is denied coverage under a health care plan procured by the township, if the officer or employee elects not to participate in the township's health care plan, or if the township does not provide health care insurance coverage pursuant to R.C 505.60. Depending on the specific facts, a township's reimbursement to township officers or employees for health care insurance premiums may violate section 2711 of the PHSA, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments assert. A board of township trustees may not reimburse officers or employees for health care insurance premiums without violating section 2711 of

the PHSA if the coverage is obtained through an individual market policy or through Medicare Parts B or D, and again on the condition that a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments assert. Thus, some types of premium reimbursements that may be provided by a board of township trustees violate section 2711 of the PHSA, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments assert. When it is impossible to comply with section 2711 of the PHSA and to provide premium reimbursement under R.C. 505.60(D) or R.C. 505.601, then section 2711 of the PHSA and R.C. 505.60(D) and R.C. 505.601 are in conflict and the PHSA preempts the state laws.

A board of township trustees may, however, reimburse officers or employees for health care insurance premiums for Medicare Parts B or D if the Medicare Parts B or D coverage is integrated with another group health plan that meets the requirements set forth in IRS Notice 2015-17, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments assert. Additionally, a township may reimburse township employees for premiums for health care insurance coverage if the coverage is integrated with another group health plan and if that group health plan satisfies the requirements set forth in IRS Notice 2013-54 and Department of Labor Technical Release 2013-03, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments assert. Therefore, there are circumstances under which the premium reimbursements authorized by R.C. 505.60(D) and R.C. 505.601 may be provided by a board of township trustees without conflicting with section 2711 of the PHSA, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Accordingly, a board of township trustees may reimburse township officers and employees for health care insurance premiums or Medicare Parts B or D premiums pursuant to R.C. 505.60(D) and R.C. 505.601 only to the extent that such reimbursements do not conflict with the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

You also ask whether, pursuant to the advice in 2013 Op. Att'y Gen. No. 2013-022, a board of township trustees may reimburse a township officer or employee pursuant to R.C. 505.60 or R.C. 505.601 for Medicare Parts A, B, and D premiums so long as the reimbursement is authorized and effected in a manner consistent with the applicable provision of the Revised Code. Medicare premiums may be reimbursed as described in 2013 Op. Att'y Gen. No. 2013-022 and without violating section 2711's annual dollar limit prohibition if the Medicare Parts B and D premiums are integrated with another group health plan that meets the requirements set forth in IRS Notice 2015-17. That is, Medicare premiums may be reimbursed to the extent that the reimbursements do not violate section 2711 of the PHSA. If there is a conflict between the annual dollar limit prohibition set forth in section 2711 of the PHSA and the provision of Medicare premium reimbursements pursuant to R.C. 505.60(D) or R.C. 505.601, the PHSA preempts exercise of the authority conferred upon a board of

township trustees by R.C. 505.60(D) and R.C. 505.601. We thus modify the advice provided in 2013 Op. Att'y Gen. No. 2013-022.

You next ask whether a board of township trustees may provide township officers and employees a "cafeteria plan" pursuant to R.C. 505.603. The ACA prohibits the use of a cafeteria plan to purchase an individual market plan inside the marketplace. Patient Protection and Affordable Care Act, § 1515, 124 Stat. at 258 (codified at 26 U.S.C.A. § 125(f)(3)). Therefore, a board of township trustees may not provide a cafeteria plan that is used by township officers or employees to purchase an individual market plan inside the marketplace, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert. The Departments have not advised whether reimbursements for other types of health care insurance premiums are permitted under a cafeteria plan. However, if a cafeteria plan is determined to be a group health plan as defined by the ACA, 42 U.S.C.A. § 300gg-91(a), then the same limitations and requirements apply to cafeteria plan payments as apply to other types of premium reimbursements. Accordingly, a board of township trustees may provide township officers and employees a cafeteria plan pursuant to R.C. 505.603 only to the extent that the cafeteria plan is used to purchase health care insurance coverage that complies with section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Finally, you ask whether the number of employees employed by an Ohio township bears upon whether a board of township trustees is permitted, under section 2711 of the PHSA, to provide health and hospitalization insurance premium reimbursements as authorized by R.C. 505.60 or R.C. 505.601 or a cafeteria plan as authorized by R.C. 505.603. Specifically, you ask whether a board of township trustees that employs fewer than fifty employees is permitted, under section 2711 of the PHSA, to provide reimbursements as authorized by R.C. 505.60, R.C. 505.601, and R.C. 505.603. No language in section 2711 of the PHSA or elsewhere in the PHSA or the ACA limits application of the annual dollar limit prohibition to employers with fifty or more employees. Rather, section 2711 applies broadly to "group health plans." 42 U.S.C.A. § 300gg-11. Although "small employer" and "large employer" are defined for purposes of the PHSA, 42 U.S.C.A. § 300gg-91(e)(2), (4), the annual dollar limit prohibition in section 2711 of the PHSA is not limited to large employers. Therefore, whether a township employs fewer than fifty employees does not determine, for purposes of the annual dollar limit prohibition in section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11, whether a board of township trustees may provide reimbursements for health care insurance coverage to township officers and employees under R.C. 505.60(D) or R.C. 505.601 or whether it may provide a cafeteria plan to township officers and employees under R.C. 505.603, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

Article II, Section 20 of the Ohio Constitution

Your remaining questions ask about the application of Article II, Section 20 of the Ohio Constitution to a township's provision of health care insurance coverage to a township officer during his current term of office. Article II, Section 20 declares that "[t]he general assembly, in cases not provided for in this constitution, shall fix the term of office and the compensation of all officers; but no change therein shall affect the salary of any officer during his existing term." The cost of health care insurance is part of a public officer's compensation for purposes of Article II, Section 20. 2014 Op. Att'y Gen. No. 2014-033, at 2-290. The prohibition in Article II, Section 20, therefore, applies to changes in the health care insurance benefits provided by a township to township officers that work an in-term change in an officer's compensation. *See* 2014 Op. Att'y Gen. No. 2014-033, at 2-290.

Question nine asks whether a board of township trustees that does not provide group health care and hospitalization coverage and instead reimburses township officers and employees for health care insurance coverage that the officers and employees obtain for themselves under R.C. 505.601 is prohibited by Article II, Section 20 of the Ohio Constitution from offering group health and hospitalization insurance coverage to township officers during the officers' current terms of office. Question ten similarly asks whether a board of township trustees is prohibited by Article II, Section 20 of the Ohio Constitution from offering group health and hospitalization insurance coverage to township officers during the officers' current terms of office when the officers have not been covered by the township's health care insurance plan offered under R.C. 505.60 because the officers were denied coverage or elected not to participate in the plan. Finally, question eleven asks whether our answers to these questions are affected by the fact that any coverage changes offered to an elected officer would be made only to ensure compliance with recent changes in federal law. For the purpose of our answer to these questions, we continue to acknowledge that the federal Departments of Treasury, Labor, and Health and Human Services interpret the ACA and the PHSA to include plans provided by local government employers within the definition of group health plan.

Like questions five through eight, these questions present the issue of federal preemption, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments assert. The issue of federal preemption arises because coverage changes offered to an elected officer would be made in order to ensure compliance with the requirements of section 2711 of the PHSA. To the extent that a board of township trustees offers coverage changes to elected officers during the officers' current terms in order to comply with the ACA, specifically section 2711 of the PHSA, we must address whether the prohibition of Article II, Section 20 of the Ohio Constitution conflicts with, and therefore is preempted by, the ACA.

We addressed the question of whether the ACA preempts the prohibition set forth in Article II, Section 20 of the Ohio Constitution in 2014 Op. Att'y Gen. No. 2014-033. We reiterate the rationale and conclusions of that opinion, as they apply to the questions you have asked concerning Article II, Section 20 of the Ohio Constitution. As explained in our 2014 opinion, the Ohio Supreme Court has taken several different approaches in deciding whether an in-term change to an officer's compensation

is one prohibited by Article II, Section 20 of the Ohio Constitution. 2014 Op. Att'y Gen. No. 2014-033, at 2-291. As in the 2014 opinion, however, it is not necessary to review those approaches nor do we have to determine whether a particular change to a township plan constitutes an in-term change in compensation for purposes of Article II, Section 20. 2014 Op. Att'y Gen. No. 2014-033, at 2-291. Depending on the specific facts, some in-term changes to a health care insurance plan provided to a township officer may be prohibited by Article II, Section 20. *See generally* 2014 Op. Att'y Gen. No. 2014-033, at 2-291. As explained in the 2014 opinion, however, the ACA preempts the application of Article II, Section 20 of the Ohio Constitution when these provisions conflict. 2014 Op. Att'y Gen. No. 2014-033, at 2-295 to 2-296.

Under the Supremacy Clause of the United States Constitution, state constitutional provisions are preempted to the extent they conflict with federal statutes. 2014 Op. Att'y Gen. No. 2014-033, at 2-292. We again rely on the principles of conflict preemption. *See generally* 2014 Op. Att'y Gen. No. 2014-033, at 2-294 to 2-296. State laws, including a state constitutional provision, are preempted to the extent that a township cannot comply with the mandates of both federal and state law. *See id.* Therefore, the ACA preempts the prohibition against in-term changes in the compensation of public officers that appears in Article II, Section 20 of the Ohio Constitution when compliance with that prohibition would make it impossible to comply with the requirements of section 2711 of the PHSA, 42 U.S.C.A. § 300gg-11.

Conclusions

Based on the foregoing, it is my opinion, and you are hereby advised as follows:

1. A board of township trustees creates a plan, fund, or other arrangement established or maintained for the purpose of providing medical care for its employees when the township employer provides cash reimbursements to township officers or employees for premiums they pay for the purchase of an individual market hospitalization or health insurance policy, for Medicare Parts B or D, or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by or through an entity other than the township employer, provided a township employer is subject to the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

2. A board of township trustees creates a "group health plan" for purposes of section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, when the township employer provides cash reimbursements to township officers or employees for premiums they pay for the purchase of an individual market policy, for Medicare Parts B or D, or for the purchase of health and hospitalization insurance coverage through a group insurance plan provided by

or through an entity other than the township employer, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

3. Moneys that a board of township trustees provides to township officers and employees to reimburse those officers and employees for the out-of-pocket health care insurance premiums for health care insurance coverage that the officers and employees obtain for themselves cannot be integrated with an individual health insurance policy for purposes of the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

4. A board of township trustees violates the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, if the township's employer payment plan is used to purchase health insurance coverage in the individual market, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

5. A board of township trustees violates the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, if the township's employer payment plan is used to reimburse Medicare Parts B or D premiums, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert. A township's employer payment plan may satisfy the annual dollar limit prohibition, however, if the premium reimbursements for Medicare Parts B or D are integrated with another group health plan according to the criteria set forth in IRS Notice 2015-17.

6. A township's employer payment plan that is integrated with a group health plan provided by or through an entity other than the township may comply with the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, if the requirements set forth in IRS Notice 2013-54 and Department of Labor Technical Release 2013-03 are satisfied, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

7. A board of township trustees may reimburse township officers and employees for health care insurance premiums or Medicare Parts B or D premiums pursuant to R.C. 505.60(D) and R.C. 505.601 only to the extent that such reimbursements do not conflict with the annual dollar limit prohibition set forth in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert. (2013 Op. Att'y Gen. No. 2013-022 modified, in part.)

8. A board of township trustees may provide township officers and employees a cafeteria plan pursuant to R.C. 505.603 only to the extent that the cafeteria plan is used to purchase health care insurance coverage that complies with section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

9. Whether a township employs fewer than fifty employees does not determine, for purposes of the annual dollar limit prohibition in section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11, whether a board of township trustees may provide reimbursements for health care insurance coverage to township officers and employees under R.C. 505.60(D) or R.C. 505.601 or whether it may provide a cafeteria plan to township officers and employees under R.C. 505.603, provided a township employer is subject to section 2711's annual dollar limit prohibition, as the federal Departments of Treasury, Labor, and Health and Human Services assert.

10. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), preempts the prohibition against in-term changes in the compensation of public officers that appears in Article II, Section 20 of the Ohio Constitution when compliance with that prohibition would make it impossible to comply with the requirements of section 2711 of the Public Health Service Act, 42 U.S.C.A. § 300gg-11.

Very respectfully yours,

MICHAEL DEWINE
Ohio Attorney General