Dave Yost • Auditor of State

Bulletin 2017-001

Auditor of State Bulletin

Date Issued: **February 14, 2017**

To: **All Fiscal Officers and Independent Public Accountants**

From: **Dave Yost, Auditor of State**

Subject: **Governmental Accounting Boards Statement 77, Tax Abatement Disclosures**

Summary

Note: The following is only an overview. Governments preparing financial statements under generally accepted accounting principles (GAAP) or an other comprehensive basis of accounting (OCBOA) and their independent auditors are responsible for understanding of this Statement sufficiently to apply it to their financial statements and audit it, respectively. [1] Examples included in this bulletin are not all inclusive. Consult your legal counsel for applicability of tax abatement programs.

Background Information

The Governmental Accounting Standards Board (GASB) Statement No. 77, "Tax Abatement Disclosures," provides a definition of tax abatements which is for financial reporting purposes only and identifies required note disclosure related to tax abatements.

Local governments employ a variety of programs and policies that reduce the taxes an individual or entity otherwise would owe, with the intent of encouraging certain actions, such as constructing housing in a particular neighborhood or relocating/retaining businesses. The goal of GASB Statement No. 77 is to make tax abatement transactions more transparent, and to provide financial statement users with the information necessary to assess how tax abatements affect financial position and results of operations, including the future ability to raise resources and meet financial obligations.

The GASB issues an implementation guide (IG) each year to supplement the guidance found in the GASB pronouncements. The IG is organized in a question and answer format. This bulletin references specific questions related to tax abatement disclosures from the 2016-1 IG.

[1] You can view the entire statement at www.gasb.org.

This Statement applies to financial statements for reporting periods beginning after December 15, 2015. The Statement's provisions need not be applied to immaterial items. Governments should begin planning now to determine how to compile the information needed for these disclosures.

Tax Abatement Definition

For purposes of GASB Statement No 77, the definition of a tax abatement is as follows:

> A reduction in tax revenues that results from an agreement between one or more governments and an individual or entity in which (a) one or more governments promise to forgo tax revenues to which they are otherwise entitled and (b) the individual or entity promises to take a specific action after the agreement has been entered into that contributes to economic development or otherwise benefits the governments or the citizens of those governments. (GASB 77, paragraph 4)

This definition is important in distinguishing abatements from; for example, tax deductions, exemptions or credits, which often relate to a taxpayer's ***past*** actions such as deducting charitable donations made during the preceding year.

The transaction's substance, not its form or title, is a key factor in determining whether the transaction meets the above definition of a tax abatement.

Since this definition is fundamental to implementing GASB Statement No. 77, following is a discussion of the key elements of the definition:

Existence of an Agreement GASB 77 tax abatements result from an identifiable agreement between a government and a specific individual or entity. This agreement should have two components:

- Promise by the government to reduce taxes
- Promise from the individual or entity to subsequently perform a certain beneficial action

The agreement may be in writing or may be implicitly understood by the government and the individual or entity. (See GASB 77 paragraph B9 and B10)

Individual or Entity GASB 77 tax abatements have agreements with individuals or entities. If there are no individuals or entities required to perform an action that contributes to economic development or otherwise benefits the government or its citizens, the transaction does not meet the GASB 77 definition. (See IG 4.77)

Forgo Tax Revenue The GASB 77 definition is specific to tax revenue, including property, income, sales or other taxes levied by the local government. However, if there is a tax abatement agreement at the State level to forgo certain tax money, the local government would not disclose information about the tax abatement agreement if the local government revenue that is reduced is shared revenue, which is not considered to be taxes revenue to the local government. (See IG 4.80)

Agreement Precedes Reduction GASB 77 requires the agreement precede the performance of the required action by the individual or entity. If the action is performed prior to the agreement, the transaction does not meet the GASB 77 definition. (See GASB 77 Paragraph B11)

Taxes Abated by Another Government

Governments can enter into agreements which abate their own taxes; however, a government's taxes can also be abated as a result of agreements that are entered into by another government. Both types of abatements require note disclosure, if they meet the GASB 77 definition.

Note Disclosure

As noted above, this standard requires note disclosure about tax abatements. It does not require recognizing abatements in the financial statements. The following discussion provides an overview of the disclosure principles and requirements. The specific principles and requirements are addressed in paragraphs 5 through 10 of GASB Statement No. 77. These disclosures encompass tax abatements resulting from both (a) the reporting government's agreements and (b) other governments' agreements, if they reduce the reporting government's tax revenues.

Disclosures for tax abatements may be provided individually or may be aggregated. If tax abatements are disclosed individually, the disclosure should include a brief description of the quantitative threshold the government used to determine which agreements to disclose individually.

Disclosure should commence in the period in which a tax abatement agreement is entered into and continue until the tax abatement agreement expires, except in cases where the government made commitments other than to reduce taxes as part of the tax abatement agreement. In these instances, disclosures should be made until the government has fulfilled the commitment.

This Statement requires governments that enter into agreements for the abatement of taxes to include the following in their note disclosures (see paragraph 7 of GASB 77 for more specific information):

- Brief descriptive information, including the name and purpose of the abatement, the tax being abated, the authority under which tax abatements are provided, eligibility criteria, the mechanism by which taxes are abated, provisions for recapturing abated taxes, and the types of commitments made by tax abatement recipients;

- The gross dollar amount of taxes abated during the period;

- Commitments made by a government, other than to abate taxes, as part of a tax abatement agreement; and,

- Amounts received or receivable from other governments in association with the foregone tax revenue.

Disclosure information for tax abatements resulting from agreements entered into by the reporting government should be organized by major tax abatement program and may disclose information for individual tax abatement agreements within those programs.

Tax abatement agreements of other governments which result in the reduction of the tax revenues of the reporting government should be organized in the reporting government's disclosures by the government that entered into the tax abatements agreement and the specific tax being abated. Governments may disclose information for individual tax abatement agreements of other governments within the specific tax

being abated. For those tax abatement agreements, a reporting government should disclose (see paragraph 8 of GASB 77 for more specific information):

- The names of the governments that entered into the agreements and the specific taxes being abated;

- The gross dollar amount of taxes abated during the period; and,

- Amounts received or receivable from other governments in association with the foregone tax revenue.

If information is omitted because it is legally prohibited from being disclosed, include a description of the general nature of the omitted information and the specific source of the legal prohibition.

Potential GASB 77 Tax Abatement Programs and Sources of Information

Although not an exhaustive list, some of the more common programs with the *potential* for GASB 77 tax abatements include:

- Community Reinvestment Areas (CRAs)
- Enterprise Zone Agreements
- Tax Increment Financing Agreement (TIFs)
- Income Tax

Most TIFs will not meet the GASB 77 definition of a tax abatement. In most TIFs, the property owner is still making compensation payments in the same amount as the property tax, so the revenue is not forgone, it is; however, redirected and restricted as to use. However, TIFs should still be reviewed as there is still the potential for a TIF to meet the definition.

In order to accumulate the necessary information for the GASB 77 note disclosure for taxes abated by the local government, first identify the tax abatement programs offered by the local government and review the corresponding agreements to identify the ones meeting the GASB 77 definition. In order to determine the amount of property taxes abated, look at the appropriate property tax information. The Form C utilized for CRA annual reporting may provide some tax information. Also, the County Auditor's office may be able to provide additional information. If the government abates income taxes, the local government's records should be the best source of information.

In order to accumulate the necessary information for the GASB 77 note disclosure for taxes abated by another government, first, contact the local governments with the ability to abate your taxes to determine what information they can provide. Also, the County Auditor's office may be able to provide some information.

Audit Considerations - Evaluating Disclosure Misstatements

While a government's management is responsible for the contents of the financial report, an independent auditor's primary responsibility is to report on whether the basic financial statements, including the notes thereto, are presented fairly in accordance with the financial reporting framework. GASB codification 2300.108 indicates notes to the financial statements provide necessary disclosure of material items, the omission of which would cause the financial statements to be misleading.

As noted in GASB No. 77, the disclosure requirements "improve financial reporting by giving users of financial statements essential information that is not consistently or comprehensively reported to the public at present. Disclosure of information about the nature and magnitude of tax abatements will make these transactions more transparent to financial statement users. As a result, users will be better equipped to understand (1) how tax abatements affect a government's future ability to raise resources and meet its financial obligations and (2) the impact those abatements have on a government's financial position and economic condition."

Auditors opine not only on amounts but also on assertions related to disclosures. Auditors should use their professional judgment when evaluating a tax abatement disclosure misstatement or omission considering quantitative (such as the gross reduction in tax revenues that results from the agreement) and qualitative factors (such as identified in the preceding paragraph) related to the disclosure misstatements or omissions.

Auditors should document their evaluation and conclusions in their working papers.

Applicability to Non-GAAP Entities

Governments that prepare OCBOA financial statement (i.e. GAAP look-alike) will need to include the GASB 77 disclosures in their financial statements. Governments not *statutorily* required to prepare GAAP financial statements that prepare regulatory basis financial statements (i.e. AOS basis) will not need to include the GASB 77 disclosures in their financial statements but may include disclosures, if management chooses. However, governments *statutorily* required to prepare GAAP statements that choose to prepare regulatory financial statements instead, will need to make the GASB 77 disclosures in their notes to the financial statements.

Resources Available on the Auditor of State's Website

The Auditor of State's Office has a FAQ document related to GASB 77's implementation available on our website at http://www.ohioauditor.gov/references/gasb77.html. This document will be updated as further information becomes available.

Questions

If you have any questions regarding the information presented in the Bulletin, please contact Local Government Services at the Auditor of State's Office at (800) 345-2519. Questions from IPAs should be directed to the AOS Center for Audit Excellence at (800) 282-0370.

Dave Yost • Auditor of State

CLARIFIED
Bulletin 2017-002

Auditor of State Bulletin

Date Issued: **April 19, 2017**

To: **Ohio Townships and Independent Public Accountants**

From: **Dave Yost, Ohio Auditor of State**

Subject: **Board of Township Trustees' Authority to Reimburse for Health Care Premiums**

Background Information

Attached are a copy of 2017 Ohio Attorney General Opinion 2017-007, formally issued on March 13, 2017, and a copy of the 21st Century Cures Act, a recent amendment to the Federal Patient Protection and Affordable Care Act (ACA). This bulletin references the opinion and the ACA as they relate to reimbursement of healthcare premiums for township trustees in Ohio. Since the Attorney General opinion was issued after the beginning of a fiscal year, the Auditor of State has determined that a grace period should be provided to allow townships time to comply with this requirement and allow individuals an opportunity to make alternative arrangements for healthcare coverage. As such, the Auditor of State will not issue findings for recovery in accordance with Opinion 2017-007 and the guidance in this Bulletin until audits to be performed on FY18.

Ohio Revised Code Section 505.60

An Ohio township is a creature of statute, and a board of township trustees is permitted to exercise only those powers granted, expressly or impliedly, by the state legislature.[1]

In 2017 Op. Att'y Gen. No. 17-007, Ohio Attorney General Mike DeWine (OAG) reaffirmed that venerable, general principle and addressed the following question:

> Whether R.C. 505.60(D) permits a township to reimburse a township officer or employee for out-of-pocket premiums attributable to health care coverage for his immediate

[1] 2017 Op. Att'y Gen. No. 2017-007, citing *In re Petition of Incorp. of Vill. Of Holiday City*, 70 Ohio St. 3d 356, 369, 639 N.E.2d 42 (1994).

> dependents when the township officer or employee elects single coverage participation in the township's health care plan and does not elect coverage for his immediate dependents.

Division (A) of Section 505.60 of the Ohio Revised Code grants a board of township trustees the authority to provide health insurance coverage to its officers and employees. That section provides that, if a board of trustees secures any insurance policies pursuant to the enactment, the board must "provide uniform coverage under these policies for township officers and full-time employees and their immediate dependents, and may provide coverage under these policies for part-time township employees and their immediate dependents . . ."

Division (D) of Section 505.60 of the Ohio Revised Code addresses the authority of a board of township trustees to reimburse its officers and employees for out-of-pocket premiums attributable to health care coverage that he or she otherwise obtains. Section 505.60(D) provides that:

> If any township officer or employee is denied coverage under a health care plan procured under this section or if any township officer or employee elects not to participate in the township's health care plan, the township may reimburse the officer or employee for each out-of-pocket premium attributable to the coverage provided for the officer or employee and their immediate dependents for insurance benefits described in division (A) of this section that the officer or employee otherwise obtains, but not to exceed 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.

The OAG explained in 2017 Op. Att'y Gen. No. 17-007 that a plain reading of Section 505.60(D) reveals "two alternative conditions precedent." In general terms, a "condition precedent" is an act or event that must happen before something else can occur.[2] As such, the OAG opined that, under the unambiguous language of Section 505.60(D), townships are permitted to reimburse an officer or employee for out-of-pocket health care costs attributable to the coverage which the officer or employee secures for himself or herself and his or her immediate dependents from a source other than the township, only if one of the following two conditions precedent exists:

1. The township officer or employee has been denied coverage under a health care plan that has been procured by the township and offered to its officers and employees pursuant to Section 505.60; or
2. The township officer or employee has elected not to participate in the township's health care plan.

It is the OAG's opinion that, if a township officer or employee elects to receive individual coverage under a township's health care plan, the township is not permitted to reimburse the township officer or employee, or his or her dependents for the out-of-pocket premium costs of health care coverage secured from a source other than the township for his or her immediate dependents. In

[2] *See* "condition precedent," CONDITION, Black's Law Dictionary (10th ed. 2014).

such a scenario, neither of the two alternative conditions precedent has occurred, and, therefore, such reimbursement is impermissible.

It is the conclusion of the OAG, therefore, that Section 505.60(D) of the Ohio Revised Code does not grant a board of township trustees the authority to provide reimbursement to an officer or employee "for out-of-pocket premiums attributable to health care coverage otherwise obtained for the officer or employee's immediate dependents when the officer or employee elects to participate in the township's health care plan, but elects not to participate in the township's health care plan for his immediate dependents."

Ohio Revised Code Section 505.601

The potential reimbursement by employers of health insurance premiums incurred by an employee for coverage secured through another source involves implications under the Affordable Care Act (ACA). Section 505.601 provides generally that the board of trustees of an Ohio township which does not procure group health care coverage and provide it to its officers and employees may reimburse its officers and employees for premiums attributable to coverage secured from another source. That enactment contains specific limitations and procedural requirements which are incident to the reimbursement process.

As indicated in AOS Bulletin 2015-002, the Internal Revenue Service and the Department of Labor have interpreted the ACA as prohibiting the longstanding practice of Ohio townships of providing health insurance premium reimbursement to township officers and employees. Under the Federal interpretation, employers affording such reimbursement are subject to substantial financial penalty. In 2015 Op. Att'y Gen. No. 15-021, the OAG indicated, in part, that such premium reimbursement by employers is not permissible under the ACA unless the practice has been integrated with a qualifying group health care plan offered by the employer. Since the release of AOS Bulletin 2015-002 and 2015 Op. Att'y Gen. No. 15-021, however, the Federal 21st Century Cures Act (the Act), a recent amendment to the ACA, was signed into law with an effective date of January 1, 2017. The Act creates an exception for "Qualified Small Employer Health Reimbursement Arrangements." Qualified, eligible employers who make health care reimbursements through such an arrangement are now exempt from the ACA's requirements applicable to group health care plans, and premium reimbursements by qualifying employers is permissible without threat of penalty.

To qualify for the exception, a township must be an "eligible employer." An eligible employer is any employer which employs fewer than 50 full-time or full-time equivalent (FTE) employees, and which does not offer a group health plan to any of its employees. The Act contains specific provisions related to the calculation of full-time and FTE employment. In addition, all of the following must be applicable to the offered reimbursement program:

1. It is provided uniformly to all eligible employees;
2. It is funded solely by the eligible employer;
3. No salary reduction contributions are made under the reimbursement plan; and

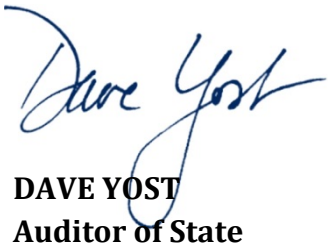
4. Payments and reimbursements for any year do not exceed $4,950.00 per employee ($10,000 if the arrangement provides for payments or reimbursements for family members of employee)

Any township which is an eligible employer, and provides reimbursement to its officers and employees in in a manner consistent with the requirements established in the Act may offer reimbursements under Section 505.601 of the Ohio Revised Code in full compliance with state and Federal law, and without threat of sanction.

The Act is effective as to the years beginning after December 31, 2016. As stated in the background the AOS will not issue findings for recovery in accordance with Opinion 2017-007 and the guidance in this Bulletin until audits performed for periods beginning after December 31, 2017.

It is the AOS's recommendation that townships seek legal advice if questions arise regarding health care plans and reimbursement programs, and before undertaking the latter.

If you have any questions regarding this Bulletin please contact the AOS Center for Audit Excellence at (800) 282-0370 or the Legal Division at (800) 282-0370 or (614) 466-2929.



DAVE YOST
Auditor of State

March 13, 2017

The Honorable Paul J. Gains
Mahoning County Prosecuting Attorney
6th Floor Administration Building
21 West Boardman Street
Youngstown, Ohio 44503

SYLLABUS: 2017-007

R.C. 505.60(D) does not authorize a board of township trustees to reimburse a township officer or employee for out-of-pocket premiums attributable to health care coverage otherwise obtained for the officer or employee's immediate dependents when the officer or employee elects to participate in the township's health care plan, but elects not to participate in the township's health care plan for his immediate dependents.

MIKE DEWINE
OHIO ATTORNEY GENERAL

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March 13, 2017

OPINION NO. 2017-007

The Honorable Paul J. Gains
Mahoning County Prosecuting Attorney
6th Floor Administration Building
21 West Boardman Street
Youngstown, Ohio 44503

Dear Prosecutor Gains:

You have requested an opinion whether R.C. 505.60(D) permits a township to reimburse a township officer or employee for out-of-pocket premiums attributable to health care coverage for his immediate dependents when the township officer or employee elects single coverage participation in the township's health care plan and does not elect coverage for his immediate dependents.[1] You specifically ask the following questions:

1. Does the plain and ordinary meaning of the language, "elects not to participate," in R.C. 505.60(D) include the ability of the township officer or employee to elect any of the offered levels of participation which may include the township officer or employee, yet excludes one or more of the township officer or employee's dependents?

2. Must R.C. 505.60(D) be read to comport with its clearly intended purpose to increase the options available to township officers and employees to obtain health

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[1] When providing health care insurance plans to officers and employees, a township may present different categories of coverage options to the officer or employee. These options may include single or family coverage, but these options may not be the only options offered within a township's health care insurance plan. The terms "single coverage" and "family coverage" are not defined by statute. For purposes of this opinion, we understand election of "single coverage" to mean that the township officer or employee has elected health care insurance coverage for himself as an individual, and "the election of family coverage" to mean that the officer or employee has elected health care insurance coverage for himself and his immediate dependents. "While the term immediate dependents is not defined by statute, the term, used in its ordinary sense, includes [an officer or employee's] spouse and other members of the [officer or employee's] immediate family." 1992 Op. Att'y Gen. No. 92-068, at 2-282 (modified, in part, on other grounds by 2005 Op. Att'y Gen No. 2005-038). Accordingly, the election of family coverage may include the officer or employee's spouse, his children, or both his spouse and children.

care coverage in the most cost effective manner to both the townships and township officers and employees?

3. Does R.C. 505.60(D) expressly permit the reimbursement for immediate dependents of township officers or employees who elect single coverage participation in the township's health care plan, but who do not elect coverage for their dependents? Alternatively, is R.C. 505.60(D) limited to permit reimbursement of out-of-pocket premiums for the immediate dependents of township officers or employees only when the township officer or employee declines to participate in the township's health plan?

Insofar as these questions inquire as to the same issue, we have addressed your queries together.

A board of township trustees is a creature of statute and, therefore, possesses only those powers vested in it, either expressly or impliedly, by the General Assembly. *In re Petition of Incorp. of Vill. of Holiday City*, 70 Ohio St. 3d 365, 369, 639 N.E.2d 42 (1994); 2008 Op. Att'y Gen. No. 2008-018, at 2-199. Thus, whether a township officer or employee may be reimbursed by a board of township trustees for out-of-pocket premiums attributable to health care insurance coverage otherwise obtained by an officer or employee for his immediate dependents depends upon whether the General Assembly has expressly or impliedly authorized the board of township trustees to make such a reimbursement. *See* 1990 Op. Att'y Gen. No. 90-064, at 2-271 ("R.C. 505.60 allows the board to provide insurance for its officers and employees only in the manner specified in the statute; further, any arrangements incidental thereto are similarly restricted by the terms of the statute"); *see also State ex rel. Locher v. Menning*, 95 Ohio St. 97, 99, 115 N.E. 571 (1916) ("[t]he authority to act in financial transactions must be clear and distinctly granted" and any doubt concerning the authority to expend public funds must be resolved against the expenditure). Division (A) of R.C. 505.60 authorizes a board of township trustees to provide health insurance coverage to its officers and employees and their immediate dependents:

> As provided in this section and [R.C. 505.601[2]], the board of township trustees of any township may procure and pay all or any part of 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….

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[2] R.C. 505.60 operates independently of R.C. 505.601 and the statutes are mutually exclusive. 2005 Op. Att'y Gen. No. 2005-038, at 2-400 n.3. The township that is the subject of your inquiry offers health care insurance coverage to its officers and employees under R.C. 505.60(A). Accordingly, we limit our analysis to R.C. 505.60.

> If the board procures any insurance policies under this section, the board shall provide uniform coverage under these policies for township officers and full-time employees and their immediate dependents, and may provide coverage under these policies for part-time township employees and their immediate dependents, from the funds or budgets from which the officers or employees are compensated for services, such policies to be issued by an insurance company duly authorized to do business in this state. (Footnote added).

Division (D) of R.C. 505.60 authorizes the township to reimburse a township officer or employee for out-of-pocket premiums attributable to health care coverage for immediate dependents under certain conditions. R.C. 505.60(D) provides that:

> If any township officer or employee is denied coverage under a health care plan procured under this section or if any township officer or employee elects not to participate in the township's health care plan, the township may reimburse the officer or employee for each out-of-pocket premium attributable to the coverage provided for the officer or employee and their immediate dependents for insurance benefits described in [R.C. 505.60(A)] that the officer or employee otherwise obtains, but not to exceed 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.

The plain language of R.C. 505.60(D) specifies two alternative conditions precedent for a township officer or employee to receive a reimbursement of out-of pocket premiums attributable to health care coverage for the officer or employee's immediate dependents that the officer or employee otherwise obtains. The first condition is that the officer or employee is denied health care coverage under a health care plan procured under R.C. 505.60. The second condition is the officer or employee elects not to participate in the township's health care plan. The second alternative condition is relevant to answering your questions.

Whether a township may reimburse a township officer or employee for out-of-pocket premiums attributable to health care coverage that the officer or employee otherwise obtains for his immediate dependents depends, in part, upon the meaning of the phrase, "elects not to participate," in R.C. 505.60(D). The terms within this phrase are not defined by statute. Words and phrases not defined by statute "shall be read in context and construed according to the rules of grammar and common usage." R.C. 1.42. "To participate" means "to take part," or "to have a part or share in something." *Merriam-Webster's Collegiate Dictionary* 903 (11th ed. 2005). "Participation" is the "the act of participating," or "the state of being related to a larger whole." *Id*. The term, "not" as used in this phrase, is an adverb that serves as "a function word to make negative a group of words or a word." *Id.* at 848. Hence, the use of "not" before "to participate" when referring to the election of a health care plan offered by a township indicates that an election does not happen and no participation of any kind occurs. Accordingly, when a township officer or employee "elects not to participate" in a health care plan offered by a township, he elects not to participate in any part of a health care plan offered by the township.

R.C. 505.60(D) states plainly and unambiguously that an officer or employee that "elects not to participate" in the township's health care plan may be reimbursed. The language of the statute does not state that an officer or employee that elects single coverage under the township's health care plan rather than family coverage may be reimbursed for out-of-pocket premiums attributable to coverage otherwise obtained for his immediate dependents. The statute also does not state that the election of single coverage by an officer or employee of the township constitutes electing not to participate for the purpose of being eligible for such reimbursement.

There is a clear difference between the meaning of a "health care plan" provided by a township and "health care coverage" options provided within a township's health care plan. The General Assembly uses the term "coverage" in R.C. 505.60(A) ("the board shall provide uniform *coverage*"; "may provide *coverage* under these policies for part-time township employees and their immediate dependents") (emphasis added); R.C. 505.60(B) ("[t]he board may also provide *coverage* for any or all of the benefits described in [R.C. 505.60(A)]") (emphasis added); and R.C. 505.60(C) ("[a]ny township officer or employee may refuse to accept any *coverage* authorized by this section without affecting the availability of such *coverage* to other township officers and employees") (emphasis added). The General Assembly uses the term "plan" in R.C. 505.60(B)(1) ("[c]hoose between a *plan* offered by an insurance company and a *plan* offered by a health insuring corporation, and provided further that the officer or employee pays any amount by which the cost of the *plan* chosen exceeds the cost of the *plan* offered by the board") (emphasis added). The General Assembly uses both terms in R.C. 505.60(B)(2) ("[a]n addition of a class or change of definition of *coverage* to the *plan* offered under this division by the board may be made at any time that it is determined by the board to be in the best interest of the township") (emphasis added); R.C. 505.60(D) ("[i]f any township officer or employee is denied *coverage* under a health care *plan* procured under this section or if any township officer or employee elects not to participate in the township's health care *plan*, the township may reimburse the officer or employee for each out-of-pocket premium attributable to the *coverage* provided for the officer or employee and their immediate dependents for insurance benefits described in [R.C. 505.60(A)] that the officer or employee otherwise obtains") (emphasis added); and R.C. 505.60(F) ("[i]f a board of township trustees fails to pay one or more premiums for a policy, contract, or *plan* of insurance or health care services authorized under this section and the failure causes a lapse, cancellation, or other termination of *coverage* under the policy, contract, or *plan*, it may reimburse a township officer or employee for, or pay on behalf of the officer or employee, any expenses incurred that would have been covered under the policy, contract, or *plan*") (emphasis added).

The use of the two different terms reinforces the principle that the General Assembly was cognizant of the separate meaning of each word, and the choice of language was deliberate. *See Inglis v. Pontius*, 102 Ohio St. 140, 149, 131 N.E. 509 (1921) ("[i]t will be presumed that the general assembly had some purpose in mind in using both words instead of only one, and unless the words are inconsistent or contradictory it is the duty of the courts to give effect to both words"). A township health care plan will typically include multiple coverage options for an officer or employee. When an officer or employee selects among the different coverage options, whether a single coverage election or a family coverage election, he thereby participates in the township's health care plan under R.C. 505.60(D). Instead of stating "elects not to participate in the township's health care plan," the General

Assembly could have stated that the officer or employee "elects not to obtain coverage for his immediate dependents" in order to receive reimbursement for out-of-pocket premiums attributable to health care coverage otherwise obtained by the officer or employee for his immediate dependents. *See Lake Shore Elec. Ry. Co. v. P.U.C.O.*, 115 Ohio St. 311, 319, 154 N.E. 239 (1926) (had the General Assembly intended a term to have a particular meaning, "it would not have been difficult to find language which would express that purpose"). A board of township trustees is not authorized to make such a distinction that is not expressly delineated in the statute. Therefore, R.C. 505.60(D) does not authorize a board of township trustees to reimburse a township officer or employee for out-of-pocket premiums attributable to health care coverage otherwise obtained for the officer or employee's immediate dependents when the officer or employee elects to participate in the township's health care plan, but elects not to participate in the township's health care plan for his immediate dependents.

You suggest that the statutory analysis in 2005 Op. Att'y Gen. No. 2005-038 and the General Assembly's response to the conclusion in 2012 Op. Att'y Gen. No. 2012-027 permit us to read "elects not to participate" in R.C. 505.60(D) to mean that if an officer or employee elects for his immediate dependents not to participate in the township's health care plan, the out-of-pocket premiums attributable to coverage he otherwise obtains for his dependents remain reimbursable, even though he elects coverage for himself under the township's health care plan. 2005 Op. Att'y Gen. No. 2005-038 addressed the authority of a township to reimburse a township officer or employee for health care coverage he otherwise obtained through the health care plan of his spouse's employer. When 2005 Op. Att'y Gen. No. 2005-038 was issued, R.C. 505.60(C), now R.C. 505.60(D), authorized a township to "reimburse the officer or employee for each out-of pocket premium that the officer or employee *incurs* for insurance policies described in [R.C. 505.60(A)] that the officer or employee otherwise obtains." (Emphasis added.)[3] The Attorney General recognized that the meaning of "incurs" ordinarily is associated with liability for the costs for health care premiums required by a

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[3] In 2008 the General Assembly enacted Sub. H.B. 458, 127th Gen. A. (2008) (eff. Dec. 30, 2008), for the purpose of amending the language of R.C. 505.60 and reordering its provisions. Prior to the enactment of Sub. H.B. 458, the language of R.C. 505.60(C) declared, in part, that,

> [i]f any township officer or employee is denied coverage under a health care plan … or if any township officer or employee elects not to participate in the township's health care plan, the township may reimburse the officer or employee for each out-of-pocket premium that the officer or employee incurs for insurance policies described in [R.C. 505.60 (A)] that the officer or employee otherwise obtains[.]

Sub. H.B. 458 reordered the provisions of R.C. 505.60 by moving the language of then division (C) to a new division (D). Further, Sub. H.B. 458 amended the language of new division (D) to state, in pertinent part, that "the township may reimburse the officer or employee for each out-of-pocket premium attributable to the coverage provided for the officer or employee for insurance benefits described in [R.C. 505.60 (A)] that the officer or employee otherwise obtains[.]" The bill removed the term "incurs" from new division (D).

spouse's employer-provided health plan. A literal reading of the phrase "that the officer or employee incurs" was rejected by the Attorney General because the officer or employee would never be the individual incurring the liability when his spouse's employer provided the health coverage that he obtained. Rather, only his spouse would be liable to the employer. As noted in your request, the opinion reasoned that

> [b]y authorizing townships to reimburse their officers and employees for out-of-pocket expenses for health care coverage obtained other than through the township, the General Assembly clearly intended to increase the options available to township officers and employees to obtain health care coverage in the most cost-effective manner to both the townships and township personnel.

2005 Op. Att'y Gen. No. 2005-038, at 2-401. "[I]f possible, statutes must be construed so that some operative effect is given to every word written in them. However, if a literal construction of the wording of a statute leads to gross absurdity, manifestly contradictory to common reasoning, the court may interpret the statute so as to arrive at a logical conclusion." *State v. Gordon*, 161 Ohio Misc. 2d 1, 3, 940 N.E.2d 1042 (C.P. Lake County 2010). The ambiguity of "incurs" concerned the out-of-pocket premiums attributable to the health care coverage otherwise obtained by the township officer or employee. These premiums were indirectly incurred as an expense of the family, but failed to qualify for reimbursement because the spouse's employer-provided health care premiums were not directly incurred by the township officer or employer. A plain language reading of "incurs" would have thwarted the General Assembly's intent to provide flexibility in the options available and be cost-effective to the township and its personnel in its provision of a health care plan. The application of a literal meaning of the word "incurs" would not have permitted a township officer or employee to be reimbursed for a spouse's out-of-pocket premiums attributable to the spouse's employer-provided health care plan as the township officer or employee did not personally, or directly, incur the out-of-pocket premiums. This would be an unreasonable result and contrary to the intent of the General Assembly, as the officer or employer would be foreclosed from the option to participate in a health care plan provided by his spouse's employer.

R.C. 505.60(D) identifies two alternative conditions precedent that determine whether a township officer or employee may be reimbursed for out-of-pocket premiums attributable to health care coverage of an officer or employee's immediate dependents: the township's health care plan denies coverage to the officer or employee, or the officer or employee elects not to participate in the township's health care plan. Either of the two conditions precedent must be present before an officer or employee may be reimbursed for out-of-pocket premiums attributable to health care coverage he otherwise obtains for his immediate dependents. The election of single coverage under a township health care plan by a township officer or employee forecloses his eligibility for reimbursement of premiums attributable to health care coverage he otherwise obtains for his immediate dependents. Thus, the plain language renders a result feasible of implementation. *See* R.C. 1.47 (B), (D) (in enacting statutes, it is presumed that the legislature means for the entire statute to be effective and that a result capable of execution is intended). Because a feasible result may be executed within the plain language of the statute, no ambiguity exists. Accordingly, an analysis relying on the intent of the

General Assembly is unnecessary. *See In re Kyle*, 510 B.R. 804, 811 (Bankr. S.D. Ohio 2014) ("[i]f the statutory language is clear, the inquiry ends and the court must apply the plain language").

You explain that in the present circumstance the spouses of two officers of a township are each eligible for insurance coverage under Medicare. In each instance, the cost to the township of providing reimbursement to the officer for the Medicare premiums for the spouse as an immediate dependent is less than the cost of providing family health care coverage under the township health care plan that includes the township officer's spouse. To disallow a reimbursement in this situation when the officer elects single coverage would in effect incentivize the officer to elect family coverage, thereby increasing the total cost incurred by the township. While the overall cost of health care coverage that includes coverage of a township officer or employee's immediate dependents may be higher than single coverage for the township officer or employee, the township may limit the amount that the township is willing to pay for each township officer or employee. *See* R.C. 505.60(A) ("the board of township trustees of any township may procure and pay all or *any part of 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" (emphasis added)); 1990 Op. Att'y Gen. No. 90-064, at 2-272 (if the board does procure uniform health insurance coverage to all officers and employees and their immediate dependents, the board is not required to pay the entire costs of providing uniform health insurance coverage, but may limit payment on behalf of each officer or employees to a fixed amount); *see also* 2004 Op. Att'y Gen. No. 2004-004, at 2-37 ("[i]t appears to be common practice for public employers that provide their employees health care coverage to charge such employees one sum for individual coverage and a greater sum for family coverage, because, as a general rule, the cost of obtaining family coverage exceeds the cost of single coverage").

In 2012 Op. Att'y Gen. No. 2012-027, the Attorney General addressed the eligibility of a township officer or employee to be reimbursed for out-of-pocket premiums attributable to health care coverage that he otherwise obtained for his immediate dependents. A plain language analysis was utilized that focused on the absence of the phrase "and their immediate dependents." The opinion recognized that this phrase, "and their immediate dependents" was not included in R.C. 505.60(D). The phrase, "and their immediate dependents," however, had been included in R.C. 505.60(A), R.C. 505.60(B), and R.C. 505.601. The Attorney General reiterated that prior opinions consistently concluded that R.C. 505.60 allowed a board of township trustees to provide insurance for its officers and employees only in the manner specified in the statute. 2012 Op. Att'y Gen. No. 2012-027, at 2-236; s*ee, e.g.,* 1990 Op. Att'y Gen. No. 90-064 (syllabus) ("[p]ursuant to R.C. 505.60(A), the board of township trustees may procure health insurance benefits which offer uniform coverage to township officers and full-time employees and their immediate dependents, while paying only that portion of the insurance premium attributable to the officer or employee"); 1989 Op. Att'y Gen. No. 89-009, at 2-35 (overruled, in part, on other grounds by 2008 Op. Att'y Gen. No. 2008-018) ("[t]he conspicuous absence of such a statement [that township trustees may make payments to township officers and employees as reimbursement for deductible payments] in R.C. 505.60(A) suggests that such authority on the part of a board of township trustees may not be implied").

2012 Op. Att'y Gen. No. 2012-027 concluded that no language in R.C. 505.60(D) expressly authorized reimbursement for out-of-pocket premiums attributable to the coverage otherwise obtained for an officer or employee's immediate dependents. Thus, in the absence of the phrase "and their immediate dependents," a township officer or employee was not to be reimbursed for out-of-pocket health care premiums for coverage otherwise obtained for the officer or employee's immediate dependents. Following the issuance of 2012 Op. Att'y Gen. No. 2012-027, the General Assembly amended R.C. 505.60(D) to insert the language "and their immediate dependents" so that out-of-pocket premiums attributable to health care coverage for the officer or employee's immediate dependents could be reimbursed under certain conditions. *See* Sub. H.B. 347, 129th Gen. A. (2012) (eff. Mar. 22, 2013). While we agree that the 2012 amendment of R.C. 505.60(D) was intended to allow reimbursement for an officer or employee out-of-pocket premiums for health care coverage otherwise obtained for his immediate dependents, we do not agree that the amendment evidences an intent that the reimbursement occur when the officer or employee elects to participate for himself, but not for his immediate dependents. Again, the plain language of R.C. 505.60(D) is "elects not to participate in the health care plan."

The facts and circumstances of your inquiry revolve around the specific language of R.C. 505.60(D), rather than the absence of a specific word or phrase. When alternative express conditions precedent are stated in plain language, as is the case with R.C. 505.60(D), we are constrained to apply that plain language. If a different result is desired, the remedy may be attained by seeking an amendment of the statute by the General Assembly. *Cf. State ex rel. Nimberger v. Bushnell*, 95 Ohio St. 203, 116 N.E. 464 (1917) (syllabus, paragraph four) ("[w]hen the meaning of the language employed in a statute is clear, the fact that its application works an inconvenience or accomplishes a result not anticipated or desired should be taken cognizance of by the legislative body, for such consequence can be avoided only by a change of the law itself, which must be made by legislative enactment").

Conclusion

On the basis of the foregoing, it is my opinion, and you are hereby advised that R.C. 505.60(D) does not authorize a board of township trustees to reimburse a township officer or employee for out-of-pocket premiums attributable to health care coverage otherwise obtained for the officer or employee's immediate dependents when the officer or employee elects to participate in the township's health care plan, but elects not to participate in the township's health care plan for his immediate dependents.

Very respectfully yours,

MICHAEL DEWINE
Ohio Attorney General

adjustment model under the Medicare Advantage program under part C of title XVIII of the Social Security Act, including any revisions to either such model since the previous report. Such report shall include information on how such revisions impact the predictive ratios under either such model for groups of enrollees in Medicare Advantage plans, including very high and very low cost enrollees, and groups defined by the number of chronic conditions of enrollees.

(B) STUDY AND REPORT ON FUNCTIONAL STATUS.—

(i) STUDY.—The Comptroller General of the United States (in this subparagraph referred to as the "Comptroller General") shall conduct a study on how to most accurately measure the functional status of enrollees in Medicare Advantage plans and whether the use of such functional status would improve the accuracy of risk adjustment payments under the Medicare Advantage program under part C of title XVIII of the Social Security Act. Such study shall include an analysis of the challenges in collecting and reporting functional status information for Medicare Advantage plans under such part, providers of services and suppliers under the Medicare program, and the Centers for Medicare & Medicaid Services.

(ii) REPORT.—Not later than June 30, 2018, the Comptroller General shall submit to Congress a report containing the results of the study under clause (i), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 17007. IMPROVEMENTS TO THE ASSIGNMENT OF BENEFICIARIES UNDER THE MEDICARE SHARED SAVINGS PROGRAM.

Section 1899(c) of the Social Security Act (42 U.S.C. 1395jjj(c)) is amended—

(1) by striking "utilization of primary" and inserting "utilization of—

"(1) in the case of performance years beginning on or after April 1, 2012, primary";

(2) in paragraph (1), as added by paragraph (1) of this section, by striking the period at the end and inserting "; and";

(3) by adding at the end the following new paragraph:

"(2) in the case of performance years beginning on or after January 1, 2019, services provided under this title by a Federally qualified health center or rural health clinic (as those terms are defined in section 1861(aa)), as may be determined by the Secretary.".

TITLE XVIII—OTHER PROVISIONS

SEC. 18001. EXCEPTION FROM GROUP HEALTH PLAN REQUIREMENTS FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.

(a) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986 AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.—

(1) IN GENERAL.—Section 9831 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(d) EXCEPTION FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

"(1) IN GENERAL.—For purposes of this title (except as provided in section 4980I(f)(4) and notwithstanding any other provision of this title), the term 'group health plan' shall not include any qualified small employer health reimbursement arrangement.

"(2) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'qualified small employer health reimbursement arrangement' means an arrangement which—

"(i) is described in subparagraph (B), and

"(ii) is provided on the same terms to all eligible employees of the eligible employer.

"(B) ARRANGEMENT DESCRIBED.—An arrangement is described in this subparagraph if—

"(i) such arrangement is funded solely by an eligible employer and no salary reduction contributions may be made under such arrangement,

"(ii) such arrangement provides, after the employee provides proof of coverage, for the payment of, or reimbursement of, an eligible employee for expenses for medical care (as defined in section 213(d)) incurred by the eligible employee or the eligible employee's family members (as determined under the terms of the arrangement), and

"(iii) the amount of payments and reimbursements described in clause (ii) for any year do not exceed $4,950 ($10,000 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee).

"(C) CERTAIN VARIATION PERMITTED.—For purposes of subparagraph (A)(ii), an arrangement shall not fail to be treated as provided on the same terms to each eligible employee merely because the employee's permitted benefit under such arrangement varies in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market based on—

"(i) the age of the eligible employee (and, in the case of an arrangement which covers medical expenses of the eligible employee's family members, the age of such family members), or

"(ii) the number of family members of the eligible employee the medical expenses of which are covered under such arrangement.

The variation permitted under the preceding sentence shall be determined by reference to the same insurance policy with respect to all eligible employees.

"(D) RULES RELATING TO MAXIMUM DOLLAR LIMITATION.—

"(i) AMOUNT PRORATED IN CERTAIN CASES.—In the case of an individual who is not covered by an arrangement for the entire year, the limitation under subparagraph (B)(iii) for such year shall be an amount which bears the same ratio to the amount which would (but for this clause) be in effect for such individual for such year under subparagraph (B)(iii) as the number of months for which such individual is covered by the arrangement for such year bears to 12.

"(ii) INFLATION ADJUSTMENT.—In the case of any year beginning after 2016, each of the dollar amounts in subparagraph (B)(iii) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If any dollar amount increased under the preceding sentence is not a multiple of $50, such dollar amount shall be rounded to the next lowest multiple of $50.

"(3) OTHER DEFINITIONS.—For purposes of this subsection—

"(A) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means any employee of an eligible employer, except that the terms of the arrangement may exclude from consideration employees described in any clause of section 105(h)(3)(B) (applied by substituting '90 days' for '3 years' in clause (i) thereof).

"(B) ELIGIBLE EMPLOYER.—The term 'eligible employer' means an employer that—

"(i) is not an applicable large employer as defined in section 4980H(c)(2), and

"(ii) does not offer a group health plan to any of its employees.

"(C) PERMITTED BENEFIT.—The term 'permitted benefit' means, with respect to any eligible employee, the maximum dollar amount of payments and reimbursements which may be made under the terms of the qualified small employer health reimbursement arrangement for the year with respect to such employee.

"(4) NOTICE.—

"(A) IN GENERAL.—An employer funding a qualified small employer health reimbursement arrangement for any year shall, not later than 90 days before the beginning of such year (or, in the case of an employee who is not eligible to participate in the arrangement as of the beginning of such year, the date on which such employee is first so eligible), provide a written notice to each eligible employee which includes the information described in subparagraph (B).

"(B) CONTENTS OF NOTICE.—The notice required under subparagraph (A) shall include each of the following:

"(i) A statement of the amount which would be such eligible employee's permitted benefit under the arrangement for the year.

"(ii) A statement that the eligible employee should provide the information described in clause (i) to any health insurance exchange to which the employee applies for advance payment of the premium assistance tax credit.

"(iii) A statement that if the employee is not covered under minimum essential coverage for any month the employee may be subject to tax under section 5000A for such month and reimbursements under the arrangement may be includible in gross income.".

(2) LIMITATION ON EXCLUSION FROM GROSS INCOME.—Section 106 of such Code is amended by adding at the end the following:

"(g) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this section and section 105, payments or reimbursements from a qualified small employer health reimbursement arrangement (as defined in section 9831(d)) of an individual for medical care (as defined in section 213(d)) shall not be treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan if for the month in which such medical care is provided the individual does not have minimum essential coverage (within the meaning of section 5000A(f)).".

(3) COORDINATION WITH HEALTH INSURANCE PREMIUM CREDIT.—Section 36B(c) of such Code is amended by adding at the end the following new paragraph:

"(4) SPECIAL RULES FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

"(A) IN GENERAL.—The term 'coverage month' shall not include any month with respect to an employee (or any spouse or dependent of such employee) if for such month the employee is provided a qualified small employer health reimbursement arrangement which constitutes affordable coverage.

"(B) DENIAL OF DOUBLE BENEFIT.—In the case of any employee who is provided a qualified small employer health reimbursement arrangement for any coverage month (determined without regard to subparagraph (A)), the credit otherwise allowable under subsection (a) to the taxpayer for such month shall be reduced (but not below zero) by the amount described in subparagraph (C)(i)(II) for such month.

"(C) AFFORDABLE COVERAGE.—For purposes of subparagraph (A), a qualified small employer health reimbursement arrangement shall be treated as constituting affordable coverage for a month if—

"(i) the excess of—

"(I) the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant individual health insurance market, over

"(II) 1/12 of the employee's permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed—

"(ii) 1/12 of 9.5 percent of the employee's household income.

"(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this paragraph, the term 'qualified small employer health reimbursement arrangement' has the meaning given such term by section 9831(d)(2).

"(E) COVERAGE FOR LESS THAN ENTIRE YEAR.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (C)(i)(II) shall be applied by substituting 'the number of months during the year for which such arrangement was provided' for '12'.

"(F) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent amount under subparagraph (C)(ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).".

(4) APPLICATION OF EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.—

(A) IN GENERAL.—Section 4980I(f)(4) of such Code is amended by adding at the end the following: "Section 9831(d)(1) shall not apply for purposes of this section.".

(B) DETERMINATION OF COST OF COVERAGE.—Section 4980I(d)(2) of such Code is amended by redesignating subparagraph (D) as subparagraph (E) and by inserting after subparagraph (C) the following new subparagraph:

"(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of applicable employer-sponsored coverage consisting of coverage under any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)), the cost of coverage shall be equal to the amount described in section 6051(a)(15).".

(5) ENFORCEMENT OF NOTICE REQUIREMENT.—Section 6652 of such Code is amended by adding at the end the following new subsection:

"(o) FAILURE TO PROVIDE NOTICES WITH RESPECT TO QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of each failure to provide a written notice as required by section 9831(d)(4), unless it is shown that such failure is due to reasonable cause and not willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such written notice, an amount equal to $50 per employee per incident of failure to provide such notice, but the total amount imposed on such person for all such failures during any calendar year shall not exceed $2,500.".

(6) REPORTING.—

(A) W–2 REPORTING.—Section 6051(a) of such Code is amended by striking "and" at the end of paragraph (13), by striking the period at the end of paragraph (14) and inserting ", and", and by inserting after paragraph (14) the following new paragraph:

"(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee.".

(B) INFORMATION REQUIRED TO BE PROVIDED BY EXCHANGE SUBSIDY APPLICANTS.—Section 1411(b)(3) of the Patient Protection and Affordable Care Act is amended

by redesignating subparagraph (B) as subparagraph (C) and by inserting after subparagraph (A) the following new subparagraph:

"(B) CERTAIN INDIVIDUAL HEALTH INSURANCE POLICIES OBTAINED THROUGH SMALL EMPLOYERS.—The amount of the enrollee's permitted benefit (as defined in section 9831(d)(3)(C) of the Internal Revenue Code of 1986) under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of such Code).".

(7) EFFECTIVE DATES.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the amendments made by this subsection shall apply to years beginning after December 31, 2016.

(B) TRANSITION RELIEF.—The relief under Treasury Notice 2015–17 shall be treated as applying to any plan year beginning on or before December 31, 2016.

(C) COORDINATION WITH HEALTH INSURANCE PREMIUM CREDIT.—The amendments made by paragraph (3) shall apply to taxable years beginning after December 31, 2016.

(D) EMPLOYEE NOTICE.—

(i) IN GENERAL.—The amendments made by paragraph (5) shall apply to notices with respect to years beginning after December 31, 2016.

(ii) TRANSITION RELIEF.—For purposes of section 6652(o) of the Internal Revenue Code of 1986 (as added by this Act), a person shall not be treated as failing to provide a written notice as required by section 9831(d)(4) of such Code if such notice is so provided not later than 90 days after the date of the enactment of this Act.

(E) W–2 REPORTING.—The amendments made by paragraph (6)(A) shall apply to calendar years beginning after December 31, 2016.

(F) INFORMATION PROVIDED BY EXCHANGE SUBSIDY APPLICANTS.—

(i) IN GENERAL.—The amendments made by paragraph (6)(B) shall apply to applications for enrollment made after December 31, 2016.

(ii) VERIFICATION.—Verification under section 1411 of the Patient Protection and Affordable Care Act of information provided under section 1411(b)(3)(B) of such Act shall apply with respect to months beginning after October 2016.

(iii) TRANSITIONAL RELIEF.—In the case of an application for enrollment under section 1411(b) of the Patient Protection and Affordable Care Act made before April 1, 2017, the requirement of section 1411(b)(3)(B) of such Act shall be treated as met if the information described therein is provided not later than 30 days after the date on which the applicant receives the notice described in section 9831(d)(4) of the Internal Revenue Code of 1986.

(8) SUBSTANTIATION REQUIREMENTS.—The Secretary of the Treasury (or his designee) may issue substantiation requirements as necessary to carry out this subsection.

(b) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)) is amended by adding at the end the following: "Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).".

(2) EXCEPTION FROM CONTINUATION COVERAGE REQUIREMENTS, ETC.—Section 607(1) of such Act (29 U.S.C. 1167(1)) is amended by adding at the end the following: "Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2016.

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—

(1) IN GENERAL.—Section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)) is amended by adding at the end the following: "Except for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).".

(2) EXCEPTION FROM CONTINUATION COVERAGE REQUIREMENTS.—Section 2208(1) of the Public Health Service Act (42 U.S.C. 300bb–8(1)) is amended by adding at the end the following: "Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2016.

Speaker of the House of Representatives.

Vice President of the United States and
President of the Senate.