Newsflash! The Affordable Care Act’s (ACA) employer mandate is complicated—often horrifyingly so. But perhaps the most challenging aspect of the mandate is demonstrating to federal authorities—when need be—that the employer made an offer of coverage to a full-time employee, and did so at the appropriate time and price point.

Employers everywhere are asking, “How do I do this? Do I need to get written refusals of coverage? What if I can’t get an employee to reply?”

Unfortunately, to date the authorities have had nothing to say on this point.

Why—and When—the Employer Must Prove a Coverage Offer

To understand why an employer might need to prove a coverage offer requires an understanding of at least two things:

1. The fundamentals of the ACA’s employer mandate.
2. How the online public health insurance exchanges, or marketplaces, are supposed to work.
The employer mandate requires larger employers to offer, at least once per year, “minimum value” and “affordable” coverage to full-time employees or risk penalties.

**Full-time employees** are those who average at least 30 hours per week, although employers may use 130 hours per month as the benchmark. Most employees aren’t considered full-time for employer-mandate purposes right away. Employees hired to work full-time hours need a coverage offer by the first day of their fourth full calendar month of employment. Employees hired to work part-time or variable hours might not be considered full time for quite some time, if at all. Employers are permitted to average these employees’ hours over a measurement period of up to a year to see if they average sufficient hours to be considered full time.

**Minimum value** health coverage is coverage designed to pay at least 60 percent of the employee’s anticipated medical expenses. This equates, generally, with what the online health insurance marketplaces refer to as bronze-level coverage.

Coverage is considered **affordable** if the employee-only tier of coverage does not cost the employee more than 9.56 percent (for 2018) of his or her household income. The IRS offers employers several affordability “safe harbors” under which the employer will be deemed to have offered affordable coverage if the monthly charge for employee-only coverage doesn’t cost the employee more than 9.5 percent of W-2 pay, the mainland federal poverty level, or the employee’s hourly rate of pay multiplied by 130.

If the employer offers multiple coverage options to the full-time employee, only one has to be minimum value and affordable for the employer to dodge penalties.

**Only Full-Time Employees Who Waive or Opt Out of the Employer’s Coverage Offer Pose the “Prove the Coverage Offer” Issue**

As a practical matter, proving a coverage offer is relevant only with respect to full-time employees who decline to enroll in coverage offered by the employer. The employer has no duty to offer coverage to **non-full-time employees** (although if the employer doesn’t offer coverage to them, the employer might have to later prove they were not full time).
Of course, for employees who actually enroll in coverage, proving that coverage was offered is easy: the employer will have a record of the employees’ actual enrollment and a paper or electronic trail of payroll withholding of premiums.

The same holds true, happily, for employees who are automatically, or passively, enrolled or reenrolled, even if the employee opts out. An automatic enrollment might occur when an employee becomes newly eligible for coverage. The employer simply automatically enrolls the employee, typically after advance notice to the employee and an opportunity to opt out. A passive (also known as evergreen) enrollment occurs when an employee is already enrolled, and the employer unilaterally reenrolls the employee at open enrollment unless the employee opts out.

A passive enrollment counts as a coverage offer. Of course, evidence of the employee’s opt-out election—which should be captured somewhere as part of the employer’s benefits administration system or process—would be proof of that offer. Similarly, automatically enrolling an employee in coverage is considered an offer as long as (i) the employee has a chance to opt out, or (ii) the coverage is minimum value and the employee-only tier meets the poverty level affordability safe harbor. Here, too, a record of the employee’s opt out would be proof of the offer of coverage.

The Public Health Insurance Exchanges (Marketplaces)

How is it, then, that full-time employees who decline an offer of coverage actually become an issue? The answer lies in how the public marketplaces operate. The marketplaces offer subsidized, individual health insurance policies to employees who don’t have access to minimum value and affordable coverage from an employer.

*Lockton Comment:* Interestingly, subsidies are not available to employees enrolled in employment-based coverage—whether through the employee’s own employer or another employer, like a spouse’s or domestic partner’s employer—even if it’s not minimum value and affordable, as long as it’s more robust than, say, a dental, vision or health flexible spending account program.

Thus, when an employee applies for marketplace-based coverage and subsidies, the employee is effectively saying, “My employer doesn’t offer me minimum value and affordable coverage, and I’m not enrolled in any employment-based medical coverage.”

For its part, the marketplace wants to verify that this is so, for two reasons. First, it wants to be sure the employee is actually entitled to the subsidies he or she is receiving. Second, it wants to identify the employer that may be shirking its responsibility under the ACA’s employer mandate and refer that employer to the IRS to determine if the employer owes a tax penalty.

*Lockton Comment:* An employer mandate penalty might apply if (i) the employer is subject to the employer mandate, (ii) the employee is considered full time (for employer mandate purposes) for at least a month during the calendar year, and (iii) the employee doesn’t receive an adequate offer of coverage from the employer for the period he or she is considered full time.
How Is the Issue Likely to Arise?

The issue will most often arise like this: A full-time employee who was offered coverage by an employer subject to the employer mandate declines to enroll in the employer’s plan because the employee believes or suspects he or she can get subsidized (and less expensive) coverage through a marketplace.

The employee identifies his or her employer to the marketplace and misrepresents the nature of the employer’s coverage offer.

*Lockton Comment:* In this case, it’s easy to forgive the employee because the marketplace enrollment process—particularly the explanations that accompany it—is less than clear.

Next, the marketplace awards subsidies to the employee. It later notifies the employer that the employee is receiving subsidized marketplace coverage and asks the employer to prove that the employee either is not full time or that the employer in fact offered minimum value and affordable coverage to the employee.

If the employer can’t prove to the marketplace that it made that coverage offer to the employee (or prove the employee was not full time), the marketplace will refer the employer to the IRS for potential assessment of penalties. The employer should then have another opportunity to make its case that the employee was not full time or that the employer offered adequate coverage.

Proving an employee was not full-time is relatively easy; payroll records will suffice. But how can the employer prove it offered minimum value and affordable coverage, when the employee chose not to enroll?

**Proving a Coverage Offer Was Made**

Before we explore ways an employer can attempt to prove it made an offer of coverage, let’s review the text of the employer mandate regulations:

> An . . . employer [subject to the employer mandate] . . . will not be treated as having made an offer of coverage to a full-time employee for a plan year if the employee does not have an effective opportunity to elect to enroll in the coverage at least once with respect to the plan year . . . Whether an employee has an effective opportunity to enroll or to decline to enroll is determined based on all the relevant facts and circumstances, including adequacy of notice of the availability of the offer of coverage, the period of time during which acceptance of the offer of coverage may be made, and any other conditions on the offer.

Clearly, this guidance supplies no hint about how the employer is to prove it made an offer of coverage that gives the employee an “effective opportunity” to enroll or decline to enroll.
What are the possibilities? What are other employers doing?

We know that both paper and electronic enrollment processes are common. The great unknown in all of this, however, is the answer to this question: What will the marketplaces and the IRS accept as adequate proof of a coverage offer? Although we don’t currently know, certain options may be sufficient, as described below.

**Hand deliver the enrollment packet.** Hand delivery works, but the employer might want to have the employee sign an acknowledgment of receipt. Some employers are going a step further, ensuring that someone (for example, an HR representative or an outside vendor) works through the packet with the employee and, if the employee doesn’t want the coverage offered, obtains a written refusal of the coverage offer.

**Mail the enrollment packet to the employee’s last known address.** This may prove adequate, although the best approach might be to send the packet by certified mail/return receipt requested, as this will show the time and date of mailing and the proof of delivery or attempted delivery. Obviously, hassles and costs are associated with this approach.

*Lockton Comment:* Let’s analogize for a moment to the COBRA world, where any means of providing a COBRA notice is acceptable as long as the method used is “reasonably calculated to ensure actual receipt.” Guaranteeing receipt is not the standard. COBRA regulations permit the use of first-, second- or third-class mail, but if the employer or COBRA vendor uses second- or third-class mail, return/forwarding postage must be guaranteed and address correction must be requested. There are several court cases finding that first-class mail meets the COBRA notice obligation but few if any cases reaching the same conclusion about second- or third-class mail.

If an employer sends an enrollment packet by first-class mail, and it is returned undelivered, the employer probably has a duty to inquire as to the employee’s correct home address and try again.

**Mail a packet or postcard to the employee’s last known address, and rely on evidence of a business practice to prove it was mailed.** Courts have accepted this method in the COBRA context. To bolster its argument that the packet or postcard was actually mailed, when there’s no direct proof (like a certified mail receipt) that it was, the prudent employer will:

- Adopt a written policy describing its process for mailing the packet or postcard.
- Keep a copy of the material mailed.
- Ensure there is some record of having mailed the packet or document, if only a log maintained by the employer that reflects a notation that the document or packet was mailed to the employee on a given date.
Ensure someone at the employer or plan sponsor is able to verify, if asked, that the policy was in effect and, to the best of his or her knowledge and belief, was followed on the given date. Of course, people change jobs, so this might include a self-serving affidavit completed by the person mailing the information, which is attached to the log.

But self-serving affidavits alone, or mere proof that the employer/plan sponsor directed a third party to send the packet or postcard, might not be adequate to prove the employer made a coverage offer.

**Use first-class mail to send a postcard to the employee, providing enrollment instructions.** Some employers use this approach, and its efficacy probably hinges on direct or circumstantial proof the postcard was sent (as described above) and on just how effectively, efficiently and timely the employee may begin the enrollment process after receipt of the postcard. For example, if the postcard offers a web address, the efficacy of this approach might hinge on whether the employee can access the web from home.

Typically, the employer will have no proof of the postcard’s delivery and might not have direct proof that any particular postcard was even mailed. Rather, the employer might need to rely on evidence of a business practice or process (as described above) as circumstantial proof that the postcard was sent. The employer may also rely on evidence of how a recipient of the postcard could readily commence the enrollment process.

**Special Issues With Electronic Benefits Administration Systems**

Many employers use a benefits administration system to manage their enrollment processes. Some of these online systems are now prompting employees for affirmative refusals of a coverage offer. In some cases, the enrollment system will request or require the employee to supply a reason for refusing the coverage. In a perfect world, these refusals would reflect the employee’s acknowledgement regarding the minimum value nature of the coverage offered to the employee and the lowest employee-only cost for that coverage.

**Lockton Comment:** For example, an acknowledgment might say something like, “I acknowledge that I was offered health insurance coverage for 2016 under the XYZ PPO coverage option offered by my employer, and that my cost for employee-only coverage under that option would be $xxx per month, subject to change at my employer’s discretion.”
But what if the employee never begins the enrollment process, or never checks the “I decline coverage” box?

Where the employer sends an eligible employee an email, containing an electronic enrollment guide or a link to an electronic enrollment website, some systems are able to demonstrate that the email was sent, that the email was opened, and/or that the employee at least clicked through to the enrollment website.

**Lockton Comment:** We suspect, as more and more employers begin receiving inquiries from HealthCare.gov or state-based online marketplaces asking them to prove coverage offers, these employers will demand that their online benefits administration systems have the capacity to generate reports showing delivery of an email to an employee’s email account, and that the employee opened the email.

For now, we are seeing more employers working to identify which of their employees who were offered coverage declined to enroll. Where these employers did not receive an affirmative electronic or written refusal of coverage, some are directing managers to seek out the employees at issue and obtain a written refusal.

Will all this effort prove necessary? Will federal authorities accept, as proof an offer was made, evidence of a business process that is circumstantial proof a given employee received an offer of coverage? Will authorities require something more definitive?

Clearly, that remains to be seen. We should know in a few short months precisely the sort of evidence federal authorities, particularly, will require of employers to demonstrate the employers made an adequate offer of coverage to their full-time employees.

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**How Long Should You Keep Records of Your Coverage Offers?**

Generally, the IRS has three years, and sometimes up to six years, to challenge whether an employer made an offer of coverage. Accordingly, we generally encourage employers to maintain records for at least six years. Most employers maintain employment and health plan enrollment records for at least this long.

Employers relying on a vendor to help prove an offer (a provider of an electronic enrollment system, for example) might want to ensure the vendor agrees that the enrollment information will be maintained for at least six years, that the employer can access that information upon reasonable notice and that the vendor will turn over enrollment information (or continue to make it available to the employer) after the contract is terminated.
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