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An exclusive UBA Partner Firm monthly newsletter, focusing on one of your most important responsibilities — employer compliance.

March 2026

March ACA Reporting Deadlines for 2025 Calendar Year Plans

Each year, employers subject to Affordable Care Act (ACA) reporting must complete several federal filing requirements early in the calendar year. March is the most critical compliance month for ACA reporting because it includes the primary deadline for furnishing employee statements and the electronic filing deadline with the IRS.

These deadlines apply to Applicable Large Employers (ALEs) and to smaller employers that sponsor self-insured health plans. Understanding which forms apply, based on employer size and plan funding, is essential to avoid reporting errors and potential penalties.

Key ACA Reporting Deadlines

For the 2025 calendar year coverage reported in 2026, the following federal deadlines apply.

Deadline	Requirement	Who Must Comply
March 2, 2026	Furnish Forms 1095-C or 1095-B to employees or covered individuals	ALEs and self-insured employers
March 31, 2026	Electronically file ACA forms with the IRS	Most employers (electronic filing required for 10+ returns)

The March 2 deadline reflects the permanent 30-day extension from the original January 31 due date, now built into ACA reporting regulations.

ACA Reporting Responsibilities

ACA reporting requirements vary based on employer size (ALE vs. non-ALE) and funding arrangement (fully insured vs. self-funded).

Applicable Large Employers (50+ full-time employees)

Plan Type	Forms Filed by Employer	Additional Reporting
Fully Insured	Forms 1094-C and 1095-C	Insurance carrier provides 1095-B reporting coverage
Self-insured or Level-funded	Forms 1094-C and 1095-C (including coverage details in Part III)	Employer reports coverage for enrolled individuals

ALE reporting fulfills the employer mandate reporting requirements under Internal Revenue Code §6056, while self-insured ALEs also satisfy §6055 coverage reporting through the same forms.

Non-ALE Employers (fewer than 50 full-time employees)

Plan Type	Reporting Requirement
Fully Insured	No ACA reporting required by employer (carrier handles coverage reporting)
Self-insured or Level-funded	Employer files Forms 1094-B and 1095-B

Alternative Method for Furnishing Forms

Recent legislative changes allow employers to avoid mailing Form 1095-C or 1095-B to all individuals if the employer:

- Posts a clear, conspicuous notice on its website that is reasonably accessible to all responsible individuals by March 2, 2026, stating the form is available upon request.
- Provides the form as required under IRS guidance (generally within 30 days of request and no later than January 31 of the following year).
- Keeps the notice available through October 15, 2026.

This option is intended to reduce administrative burden while still ensuring employees can access the information needed for tax purposes.

Penalty Exposure for Late or Incorrect Filings

Employers that fail to file accurate ACA reports or miss deadlines may face information return penalties:

- $60 to $340 per return depending on how late the filing occurs
- Up to $680 per return for intentional disregard
- Separate penalties may apply for failure to furnish statements to individuals and failure to file with the IRS

In addition, ALEs remain subject to employer shared responsibility penalties under IRC §4980H if coverage was not offered properly or reported incorrectly.

Employer Action Items

- Confirm which reporting forms are required.
  - ALE with fully insured plan: 1094-C and 1095-C
  - ALE with self-insured or level-funded plan: 1094-C and 1095-C (including covered individuals)
  - Small employer with self-insured plan: 1094-B and 1095-B
  - Small employer with fully insured plan: no employer reporting
- Verify electronic filing requirements.

  Employers filing 10 or more information returns must file electronically via the IRS AIR system or through a reporting vendor. This count includes W-2s, 1099s, and ACA forms combined.

  Employers with 10 or fewer employees may file via paper.
- Coordinate data across payroll and benefits systems.

  HR teams should confirm that payroll, HRIS, and benefits administration systems contain consistent data on employee eligibility and hours worked, coverage offers and affordability calculations, enrollment and coverage periods, and any controlled group information before final submission.

- Decide whether to use the alternative method for providing forms to employees or distribute forms directly to employees.
- Retain documentation for potential IRS inquiries.

  The IRS may issue Letter 226J or other ACA compliance notices years after the filing period, so employers should maintain documentation supporting:

  - Measurement period calculations
  - Affordability safe harbor determinations
  - Full-time employee status
  - Filed ACA forms and XML submissions

2027 ACA Out-of-Pocket Maximums Increase

Federal regulators recently released the 2027 Affordable Care Act (ACA) cost-sharing limits, which establish the maximum amount individuals may pay out-of-pocket for covered essential health benefits during a plan year. These limits apply to non-grandfathered group health plans, including fully insured, self-insured, and level-funded employer plans of any size.

The Department of Health and Human Services (HHS) set the following maximum annual limitation on cost sharing for plan years beginning in 2027.

	2026 Limit	2027 Limit
Self-only Coverage	$10,600	$12,000
Family Coverage	$21,200	$24,000

Limits are indexed based on changes in employer-sponsored insurance premiums. The 2027 limits represent an approximately 13.2% increase from the 2026 limits.

What Counts Toward the ACA Out-of-Pocket Maximum

Under the ACA, the annual out-of-pocket limit applies only to essential health benefits (EHBs) and must include most forms of cost sharing. This includes:

- Deductibles
- Copayments
- Coinsurance
- Similar cost-sharing charges for EHB services

Costs that do not count toward the limit include:

- Monthly premiums
- Non-covered services
- Balance billing amounts
- Out-of-network expenses (unless the plan chooses to include them)

Once an enrollee reaches the annual limit, the plan must cover 100% of additional EHB in-network costs for the remainder of the plan year.

Embedded Individual Limit Requirement

The ACA also requires an embedded individual out-of-pocket maximum for plans offering family coverage, which means that:

- Each individual covered under a family plan cannot exceed the individual maximum ($12,000 in 2027).
- Once an individual reaches that amount, the plan must pay 100% of additional EHB in-network costs for that individual, even if the family limit has not been met.

This requirement applies to both self-insured and fully insured non-grandfathered plans.

Plans Subject to the ACA Cost-Sharing Limits

Non-grandfathered major medical plans, including fully insured, self-insured, level-funded, small group, large group, and individual/exchange coverage plans, must comply with these limits.

Plans generally not subject to the limits include:

- Grandfathered plans
- Excepted benefits (such as standalone dental or vision)
- Health reimbursement arrangements (HRAs) when structured as standalone coverage

Relationship to High Deductible Health Plans (HDHPs)

Many employer plans are designed as health savings account (HSA)-compatible high deductible health plans (HDHPs). HDHPs must comply with separate IRS limits, which are typically lower than ACA maximums.

For this reason:

- Most HDHPs already fall below the ACA out-of-pocket maximum, meaning no design changes are required.
- Employers should still verify compliance each year because HDHP limits and ACA limits are set by different agencies.

Employer Action Items

Employers should evaluate the 2027 cost-sharing limits as part of their upcoming plan design discussions with carriers, third-party administrators, and benefits advisors.

- Review the current plan design to ensure that the 2027 plan design does not exceed the ACA maximum out-of-pocket limits. Pay special attention to HDHP limits as they can be different than the ACA limits.
- Confirm embedded individual maximums. Plans offering family coverage must include an embedded individual limit no higher than the individual maximum. This is a common compliance issue in older plan designs, self-funded plans with legacy plan documents, and certain level-funded plans.
- Coordinate with carriers or TPAs. Fully insured plans are typically updated automatically by the insurer. However, employers should still review final 2027 benefit summaries, the Summary of Benefits and Coverage (SBC), and any plan design assumptions used in renewal proposals.

  Self-insured employers must ensure their third-party administrator (TPA) systems and plan documents are updated accordingly.
- Evaluate employee cost-sharing strategy based on the higher 2027 limits. Because the 2027 limit increased significantly, some employers may choose to:
  - Maintain existing out-of-pocket maximums
  - Increase limits to offset premium costs
  - Adjust deductible and coinsurance structures

  Any changes should be evaluated carefully to balance employee affordability, recruitment goals, and plan cost management.
- Update plan documents and employee communications. When there is a plan design change, employers may need to update plan documents, including the Summary Plan Description (SPD), Summary of Benefits and Coverage (SBC), and open enrollment materials.

  Clear communication helps employees understand how cost sharing may change in the upcoming plan year.

Understanding the Paid Family and Medical Leave Employer Tax Credit

Providing paid family and medical leave can be a valuable benefit for employees, but it also creates direct payroll costs for employers. To encourage employers to offer paid leave programs, federal tax law includes a Paid Family and Medical Leave (PFML) employer tax credit under Internal Revenue Code Section 45S. This credit allows eligible employers to claim a general business tax credit for a percentage of wages paid to employees while they are on qualifying family or medical leave.

Overview of the Paid Family Leave Tax Credit

The Section 45S employer credit was originally introduced as part of the Tax Cuts and Jobs Act of 2017 to incentivize employers to voluntarily provide paid family and medical leave. Under this provision, eligible employers may claim a credit equal to 12.5% to 25% of wages paid to qualifying employees during periods of family or medical leave.

The credit is calculated based on wages paid during qualifying leave for up to 12 weeks per employee each year. The minimum percentage is 12.5% and is increased by 0.25% for each percentage point by which the amount paid to a qualifying employee exceeds 50% of the employee's wages, with a maximum of 25%.

Employer Eligibility

To claim the credit, employers must meet several statutory requirements.

1. Employers must maintain a written leave policy that:
    - Provides at least two weeks of paid family and medical leave annually for full-time employees
    - Provides proportionate leave for part-time employees
    - Guarantees that employees will not face retaliation for taking leave
2. The leave policy must provide at least 50% of the employee's normal wages during leave. Higher wage replacement rates generate larger tax credits.

The credit applies only to qualifying employees, generally defined as workers who:

- Have been employed for at least one year (or shorter if permitted under updated rules)
- Earn below a specified compensation threshold in the prior year

Types of Leave That Qualify

Qualifying leave generally mirrors leave covered under the Family and Medical Leave Act (FMLA) and includes

- The birth of a child
- Adoption or foster placement
- The employee's serious health condition
- Caring for a spouse, parent, or child with a serious health condition
- Certain military-related family leave situations

Employers can design policies that align with these categories while maintaining flexibility in the way the benefit is administered.

Claiming the Credit

Employers claim the paid family leave tax credit as part of their annual federal business tax return. The typical filing process includes:

- Calculating qualifying wages paid during leave
- Applying the applicable credit percentage

- Filing IRS Form 8994 (Employer Credit for Paid Family and Medical Leave)
- Reporting the credit through Form 3800 (General Business Credit)

Employers must also reduce their deduction for employee compensation by the amount of the credit claimed.

Interaction With State Paid Leave Programs

Many states now operate mandatory paid family leave programs funded through payroll contributions or employer taxes. Federal tax rules treat these programs differently. State-required leave can count toward meeting the minimum leave requirement, but wages required by state law generally cannot be included when calculating the federal credit amount. As a result, employers in states with mandatory programs may only be able to claim the credit for leave benefits exceeding state requirements.

Employer Action Items

Employers considering a paid leave program or evaluating an existing one should carefully review the Section 45S credit.

- Evaluate current leave policies.

  Many employers already offer some form of paid parental or medical leave. HR teams should review whether current policies meet the requirements for the federal credit, particularly for minimum wage replacement, eligibility rules, and written policy requirements. Small policy adjustments may allow employers to qualify for the credit.

- Understand the interaction with state leave laws.

  Employers operating in states with mandatory paid family leave programs should confirm:

  - What portion of leave is required by state law
  - Whether additional voluntary benefits are offered
  - Which wages may be eligible for the federal credit

  Coordination between federal tax rules and state programs is essential.

- Maintain documentation to be prepared if the IRS requests verification. This includes:

  - The written paid leave policy
  - Employees who took qualifying leave
  - Wages paid during leave
  - Payroll and benefit calculations used to determine the credit

- Coordinate with tax advisors.

  The credit affects both tax filings and payroll accounting, so employers should work with tax advisors or accounting teams to confirm eligibility requirements, credit calculations, and proper filing. This is particularly important for employers claiming multiple business tax credits.

- Consider the role of paid leave in benefits strategy. Beyond tax considerations, paid family leave policies may also support employee recruitment and retention, and well-being during major life events. For some employers, the tax credit may partially offset costs while supporting broader workforce strategies.

Department of Labor Shifts Enforcement Priorities in 2026

The U.S. Department of Labor's Employee Benefits Security Administration (EBSA) recently announced a significant update to its national enforcement projects for fiscal year 2026. These projects signal where the agency will focus investigations and compliance efforts under the Employee Retirement Income Security Act (ERISA) and related federal laws.

EBSA oversees more than 2.6 million health plans and 800,000 private retirement plans covering over 156 million Americans, making enforcement priorities an important indicator of regulatory risk for employers, plan sponsors, fiduciaries, and service providers.

The updated enforcement framework reflects a shift toward issues that have impact on participants, including cybersecurity risks, mental health parity compliance, and protections against surprise medical billing.

Key EBSA Enforcement Priorities for 2026

Cybersecurity for employee benefit plans

Cybersecurity remains one of EBSA's top enforcement areas. Investigations will focus on the way plan sponsors and service providers protect sensitive participant data and plan assets from cyber threats.

EBSA will evaluate:

- Governance and cybersecurity controls
- Vendor oversight and data protection practices
- Fraud prevention measures related to retirement distributions

Cybersecurity enforcement is built on its 2021 guidance and subsequent enforcement activity to help plan fiduciaries mitigate risks associated with data breaches and identity theft.

Mental Health Parity and Substance Use Disorder Benefits

EBSA will intensify enforcement related to the Mental Health Parity and Addiction Equity Act (MHPAEA). Investigations will focus on barriers that prevent participants from accessing mental health or substance use disorder benefits. These may include:

- Restrictive treatment limitations
- Inaccurate provider directories
- Network inadequacy
- Burdensome claims procedures

The agency is particularly interested in compliance with the comparative analysis requirement for non-quantitative treatment limitations (NQTLs) under the Consolidated Appropriations Act, 2021.

Surprise billing and No Surprises Act Compliance

EBSA will continue enforcing the No Surprises Act (NSA) to protect participants from unexpected medical bills. Investigations may examine whether plans:

- Apply the prudent layperson standard for emergency services
- Charge in-network cost-sharing for NSA-protected services

- Provide required disclosures and notices
- Follow proper timelines in claims processing and payment disputes

EBSA may also review third-party administrators if systemic issues appear across multiple plans.

Benefit distribution protection

EBSA will investigate whether participants and beneficiaries are receiving benefits owed to them in a timely and accurate manner. This project addresses issues such as:

- Delayed or denied retirement distributions
- Abandoned plans
- Custodians holding unclaimed assets

The focus is to ensure participants receive benefits even when plan sponsors experience financial distress or fail to properly administer the plan.

Retirement asset management and fiduciary oversight

Investigations will examine whether fiduciaries:

- Prudently select and monitor investment options
- Evaluate fees and performance
- Manage conflicts of interest
- Follow ERISA fiduciary standards in investment oversight

This initiative may also review investment strategies used by underfunded defined benefit plans and decision-making processes in participant-directed plans.

Criminal abuse of contributory benefit plans

EBSA will prioritize investigations involving fraud or misuse of participant contributions, targeting situations where employers improperly use employee payroll deductions intended for benefits, such as:

- Diverting employee contributions for business expenses
- Failing to remit contributions to insurers or plan trust accounts

Additional Enforcement Areas

Although not part of the formal national projects, EBSA will also continue targeting:

- Fraudulent Multiple Employer Welfare Arrangements (MEWAs)
- Criminal schemes involving employee benefit plans

These investigations aim to shut down arrangements that collect premiums but fail to pay claims or remain financially viable.

The agency also shifted resources away from some previous initiatives, including.

- Removing Employee Stock Ownership Plans (ESOPs) from the national enforcement project list
- Reducing focus on missing participant investigations following the launch of the Retirement Savings Lost and Found database.

Employer Action Items

Given EBSA's updated priorities, employers and plan fiduciaries should review compliance in several critical areas.

- Conduct cybersecurity risk assessments for benefit plans.
- Ensure MHPAEA comparative analyses are documented and current.
- Verify No Surprises Act notices and claims processes.
- Review fiduciary governance and investment oversight procedures.
- Confirm participant contributions are timely remitted.

Taking proactive steps can reduce the likelihood of enforcement actions and help ensure plans operate in compliance with federal requirements.

Question of the Month

Dropping Voluntary Elections

Q. Can an employee cancel their voluntary life or voluntary critical illness coverage outside of open enrollment and without a qualifying life event if these benefits are post-tax?

A. If the elections are made post-tax, they do not have to comply with the Qualifying Life Event rules that apply to pre-tax elections. So if the plan allows an employee to drop coverage at any time, and the employer allows this flexibility, there is no concern with employees dropping after-tax coverages without a Qualifying Life Event.

Answers to the Question of the Week are provided by Kutak Rock.