

Affordable Care Act: 2027 Compliance Checklist

ellingson group

The Affordable Care Act (ACA) made widespread reforms to health plan coverage when it was enacted in 2010. Since then, changes have been made to various ACA requirements for employer-sponsored health coverage. These changes include annual cost-of-living increases to certain ACA dollar limits, adjustments to ACA reporting requirements and updates to preventive care coverage guidelines.

Changes to some ACA requirements will take effect in 2027 for employers sponsoring group health plans. For example, the affordability percentage under the ACA's employer mandate rules for applicable large employers (ALEs) will increase for plan years beginning in 2027, potentially providing ALEs with more flexibility in setting their employee contribution rates.

To prepare for 2027, employers can use this checklist to review these ACA requirements and develop a compliance strategy. Employers should ensure that their health plan documents, including the Summary of Benefits and Coverage (SBC), are updated to reflect any new plan limits. Employers should also ensure that up-to-date information is communicated to employees at enrollment time. Any changes to a health plan's benefits for the 2027 plan year should be communicated to plan participants through an updated Summary Plan Description (SPD) or a Summary of Material Modifications.

Links and Resources

- IRS Rev. Proc. 2026-26 indexed the ACA's affordability percentage for plan years beginning in 2027.
- IRS Rev. Proc. 2026-22 modified the penalty amounts under the ACA's employer mandate for 2027.
- Guidance from the U.S. Department of Health and Human Services established the cost-sharing limits for 2027 plan years.

PLAN DESIGN CHANGES	
Overall Cost-sharing Limits	**Complete or N/A**
Confirm that your plan's out-of-pocket limit for essential health benefits (EHB) does not exceed the ACA's limit for the plan year beginning in 2027. Effective for plan years beginning on or after Jan. 1, 2027, a health plan's out-of-pocket limit for EHB may not exceed **$12,000 for self-only coverage and $24,000 for family coverage.** This limit applies to all non-grandfathered group health plans, including fully insured and self-funded plans. Any out-of-pocket expenses required by or on behalf of an enrollee with respect to EHB must count toward the cost-sharing limit. This includes deductibles, copayments, coinsurance and similar charges but excludes premiums and spending on noncovered services. Also, plans that use provider networks are not required to count an enrollee's expenses for out-of-network benefits toward the ACA's cost-sharing limit. If you have a health savings account (HSA)-compatible high deductible health plan (HDHP), keep in mind that the plan's out-of-pocket maximum must be lower than the ACA's limit. For 2027, the out-of-pocket maximum for HDHPs is **$8,700 for self-only coverage and $17,400 for family coverage**.	☐
Health Flexible Spending Account (FSA) Limits	**Complete or N/A**
If you have a health FSA, confirm that its dollar limit on employees' salary reduction contributions will not exceed the adjusted limit for the plan year beginning in 2027. The ACA imposes a dollar limit on employees' pre-tax contributions to a health FSA. This limit is indexed each year for cost-of-living adjustments. An employer may set their own dollar limit on employees' contributions to a health FSA as long as the employer's limit does not exceed the ACA's maximum limit in effect for the plan year. For plan years beginning in 2026, the health FSA contribution limit is $3,400. **The health FSA limit for plan years beginning in 2027 has not yet been released.**	☐
If you have a health FSA that allows carryovers of unused amounts, confirm that the maximum unused amount from a plan year beginning in 2027 that is allowed to be carried over to the immediately following plan year beginning in 2028 does not exceed the adjusted limit. For plan years beginning in 2026, the health FSA carryover limit is $680. **The carryover limit for plan years beginning in 2027 has not yet been released.**	☐
First-dollar Preventive Care Coverage	**Complete or N/A**
Confirm that your health plan covers the latest recommended preventive care services without imposing any cost sharing. Non-grandfathered health plans must cover certain preventive health services without imposing cost-sharing requirements (i.e., deductibles, copayments or coinsurance) when the services are provided by in-network health care providers. These preventive health services include, for example, many cancer screenings, blood pressure, diabetes and cholesterol tests, vaccinations against diseases, and counseling on topics such as quitting smoking and losing weight. This coverage mandate also includes preventive health services for women, such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives. The ACA's preventive care guidelines are periodically updated based on new medical research and recommendations. In general, coverage must be provided for a newly recommended preventive health service or item for plan years beginning on or after the one-year anniversary of when the	☐

recommendation was issued. For example, for plan years beginning in 2027, there are updated guidelines for cervical cancer screening.		
Excepted Benefit Health Reimbursement Arrangement (HRA)	**Complete or N/A**	
If you offer an excepted benefit HRA, confirm that its maximum benefit for the plan year beginning in 2027 does not exceed $2,250. Employers with traditional group health plans may offer a limited benefit HRA that is exempt from the ACA's market reforms. This HRA, called an excepted benefit HRA, can be used to reimburse employees' eligible medical care expenses, up to $1,800 each year, as adjusted by the IRS for inflation. For 2027 plan years, the maximum benefit for excepted benefit HRAs is **$2,250**.	☐	
Grandfathered Plan Status	**Complete or N/A**	
If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2027 plan year. Grandfathered plans are exempt from some of the ACA's mandates. A grandfathered plan's status will affect its compliance obligations from year to year. Here are some additional points to keep in mind: • If a plan will lose its grandfathered status for 2027, confirm that the plan has all the additional patient rights and benefits required by the ACA for non-grandfathered plans (e.g., coverage of preventive care without cost-sharing requirements); and • If a plan will keep its grandfathered status, continue to provide the Notice of Grandfathered Status in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan (such as the plan's SPD and open enrollment materials). A model notice is available from the U.S. Department of Labor (DOL).	☐	
EMPLOYER MANDATE RULES		
ALE Status for 2027	**Yes**	**No**
Will you be an ALE for 2027? The ACA's employer mandate rules apply only to ALEs. ALEs are employers with **50 or more full-time employees (including full-time equivalent employees)** on business days during the preceding calendar year. Employers determine each year, based on their current number of employees, whether they will be considered an ALE for the following year. Under the ACA's employer mandate rules, ALEs are required to offer affordable, minimum-value (MV) health coverage to their full-time employees (and dependent children) or pay a penalty. An ALE may be subject to penalties if one or more full-time employees receive a subsidy for purchasing health coverage through an Exchange. An individual may be eligible for an Exchange subsidy because the ALE does not offer health coverage to that individual or offers health coverage that is unaffordable or does not provide MV. *If you answered "No," you can stop completing this section of the checklist. Because your company is not an ALE for 2027, the ACA's employer mandate rules do not apply.*	☐	☐
Offer of Health Plan Coverage	**Yes**	**No**
Do you offer health coverage to your full-time employees? To correctly offer coverage to full-time employees, ALEs must determine which employees are full-time employees under the ACA's definition. A full-time employee is an employee who is employed, on average, at **least 30 hours of service per week (or 130 hours of service in a calendar month).**	☐	☐

The IRS provides two methods for determining full-time employee status for purposes of offering coverage: the monthly measurement method and the look-back measurement method. *If you answered "No," your company may be subject to penalties if one or more of your full-time employees receive a subsidy to purchase health coverage through an Exchange.*		
Is your health coverage affordable? Health coverage is considered affordable if the employee's required contribution does not exceed 9.5% of the employee's household income for the taxable year (as adjusted each year). The affordability test applies only to the portion of the annual premiums for self-only coverage and does not include any additional cost for family coverage. Also, if an employer offers multiple health coverage options, the affordability test applies to the lowest-cost option that provides MV. Because an employer generally will not know an employee's household income, the IRS has provided three optional safe harbors that ALEs may use to determine affordability based on information that is available to them: the Form W-2 safe harbor, the rate of pay safe harbor and the federal poverty level (FPL) safe harbor. For plan years beginning in 2027, the adjusted affordability percentage is **10.22%.** This is an increase from the affordability contribution percentage for 2026 (9.96%) and the highest the affordability percentage has ever been. This increase potentially allows employers to charge a higher amount for health coverage while still avoiding penalties. For example, the maximum monthly contribution for ALEs with calendar-year plans that use the FPL safe harbor is approximately $135.93 for 2027 (up from $129.90 for 2026). *If you answered "No," your company may be subject to penalties if one or more of your full-time employees receive a subsidy to purchase health coverage through an Exchange.*	☐	☐
Does your health plan coverage provide MV? A health plan provides MV if the plan's share of the total allowed costs of benefits provided under the plan is **at least 60%** of those costs. Three approaches may be used to determine MV: an MV calculator, design-based safe harbor checklists or actuarial certification. In addition, any plan in the small group market that meets any of the "metal levels" of coverage (i.e., bronze, silver, gold or platinum) provides MV. In addition, health plans provide substantial coverage of inpatient hospitalization and physician services to provide MV. *If you answered "No," your company may be subject to penalties if one or more of your full-time employees receive a subsidy to purchase health coverage through an Exchange.*	☐	☐
Possible Penalty Amounts	**Complete or N/A**	
If your company may be liable for an ACA penalty, calculate the possible penalty amount. Depending on the circumstances, 1 of 2 penalties may apply under the ACA's employer mandate rules: the 4980H(a) penalty or the 4980H(b) penalty. Here's an overview of these penalties: • Under Section 4980H(a), an ALE will be subject to a penalty if it does not offer coverage to "substantially all" full-time employees (and dependents) and any one of its full-time employees receives an Exchange subsidy. **For 2027, the 4980H(a) monthly penalty is equal to the ALE's number of full-time employees (minus 30) multiplied by one-twelfth of $3,780 for any applicable month**; and • Under Section 4980H(b), an ALE offering coverage to "substantially all" full-time employees (and dependents) may still be subject to penalties if at least one full-time employee obtains an Exchange subsidy because the employer's coverage is unaffordable or does not provide MV, or the ALE did not offer coverage to all full-time employees. **For 2027, the 4980H(b) monthly penalty assessed on an ALE for each full-time employee**	☐	

who receives a subsidy is one-twelfth of $5,670 for any applicable month. However, the total penalty for an ALE is limited to the amount under 4980H(a).		
REPORTING OF COVERAGE (CODE SECTIONS 6055 AND 6056)		
Affected Employers	**Yes**	**No**
Is your company subject to ACA reporting under Code Sections 6055 or 6056? The following employers are subject to ACA reporting under Internal Revenue Code (Code) Sections 6055 and 6056: • Employers with self-funded health plans (Section 6055 reporting); and • ALEs with either fully insured or self-funded health plans (Section 6056 reporting). Employers who are not ALEs and have fully insured health plans are not subject to these ACA reporting requirements. Employers subject to this reporting must file certain forms with the IRS each year and provide statements upon request to individuals who are covered under the health plan (under Section 6055) and each of the ALE's full-time employees (under Section 6056). Note that ALEs with self-funded plans are required to comply with both reporting obligations. However, to simplify the reporting process, the IRS allows ALEs with self-funded plans to use a single combined form to report the information required under both Sections 6055 and 6056. *If you answered "No," you can stop completing this section of the checklist, as your company is not subject to ACA reporting under Sections 6055 or 6056.*	☐	☐
File Electronic Returns by Deadline	**Complete**	
For the 2026 calendar year, file electronic returns with the IRS by March 31, 2027. Under Code Section 6055, non-ALEs with self-funded health plans file Forms 1094-B (a transmittal) and 1095-B (an information return). Under Code Section 6056, ALEs with fully insured health plans file Forms 1094-C (a transmittal) and 1095-C (an information return). Employers reporting under both Sections 6055 and 6056 (i.e., ALEs with self-funded plans) use a combined reporting method by filing Forms 1094-C and 1095-C. The normal deadline for electronic ACA reporting is **March 31** each year. Reporting entities may receive an automatic 30-day extension to file with the IRS by completing and filing Form 8809 ("Application for Extension of Time to File Information Returns") by the due date of the returns. Virtually all employers subject to ACA reporting are required to file their returns electronically. Paper filing is only available to very small employers (i.e., those who file fewer than 10 information returns during the year). Paper forms must be filed each year by Feb. 28. However, because the paper filing deadline falls on a weekend in 2027, it is extended to the next business day, which is March 1, 2027.	☐	
Provide Statements to Individuals Upon Request	**Complete**	
Notify employees about the availability of individual statements by March 2, 2027, and provide them upon request. Under the ACA's original reporting rules, employers were required to provide written statements to each covered individual (under Section 6055) and each of the ALE's full-time employees (under Section 6056) using Forms 1095-B and 1095-C. These statements were required to be provided to individuals within 30 days of Jan. 31. However, employers are no longer required to send Forms 1095-B and 1095-C to covered individuals unless a form is requested. For this relief to apply, an employer must:	☐	

• Post a clear and conspicuous notice on its website by **March 2, 2027**, stating that covered individuals and full-time employees may receive a copy of their statement upon request. The notice must include an email address, a physical address to which a request may be sent and a telephone number to contact the reporting entity; and • Retain the notice in the same location on its website through **Oct. 15, 2027.** An employer must fulfill any request by Jan. 31, 2027, or by 30 days after the request date, whichever is later.	
PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (PCORI) FEES	
Pay PCORI Fees (Self-funded Plans Only)	**Complete or N/A**
Pay PCORI fees by Aug. 2, 2027, for plan years ending in 2026. Under the ACA, employers with self-funded plans must pay PCORI fees each year. These fees are reported and paid using IRS Form 720 (Quarterly Federal Excise Tax Return). For fully insured plans, the health insurance issuer is responsible for reporting and paying these fees. PCORI fees are due each year by July 31 of the year following the last day of the plan year. Because the deadline falls on a weekend in 2027, it is extended to the next business day, which is **Aug. 2, 2027,** for plan years ending in 2026.	☐
DISCLOSURE REQUIREMENTS	
SBC	**Complete**
Provide an updated SBC in connection with the plan's open enrollment period for 2027. Health plans and issuers must provide an SBC to applicants and enrollees to help them understand their coverage and make coverage decisions. The SBC should be included with the plan's enrollment materials. If coverage automatically renews for current participants, the SBC must generally be provided no later than 30 days before the beginning of the new plan year. The SBC must follow strict formatting requirements. Federal agencies have provided templates and related materials, including instructions and a uniform glossary of coverage terms, for health plans and health insurance issuers to use. It should be updated before the plan's open enrollment period to reflect any changes in coverage for the upcoming plan year. For self-funded plans, the plan administrator is responsible for providing the SBC. For insured plans, both the plan and the issuer are obligated to provide the SBC; however, this obligation is satisfied for both parties if either provides the SBC. Typically, the issuer will prepare the SBC for an insured health plan, although the employer may need to provide it to employees.	☐
Employee Notice of Exchange	**Complete**
Provide all new hires with a written notice about the ACA's health insurance Exchanges. The DOL has provided model Exchange notices for employers to use, which require some customization.	☐
Notice of Patient Protections	**Complete or N/A**
Provide a Notice of Patient Protections if your health plan requires participants to designate a participating primary care provider. Under the ACA, group health plans and issuers requiring the designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Additionally, plans and issuers that provide obstetrical/gynecological care and require the designation of a participating primary care provider may not require preauthorization or referrals for such care.	☐

If a health plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If a plan is subject to this notice requirement, confirm that this notice is included in the plan's open enrollment materials. It may be included in the plan's SPD or benefit description provided by a carrier or third-party administrator. Model language is available from the DOL.	
Grandfathered Plan Notice	**Complete or N/A**
If you have a grandfathered plan, make sure to include information about the plan's grandfathered status in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials. Model language is available from the DOL.	☐

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