CURRENT HOT TOPICS IN HEALTH AND WELFARE BENEFITS

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I. INTRODUCTION: WHY HEALTH AND WELFARE BENEFITS MATTER TO TAX ADVISORS

A. How Benefits and Taxes Connect

1. Employee benefits are the largest type of non-cash pay and involve many tax rules in the Internal Revenue Code.

2. Key tax code sections that CPAs and tax professionals should know:

   a. Tax-free income rules: Sections 105, 106, 125, 129, and 132.

   b. Deduction and contribution rules: Sections 162, 213, and 223.

   c. Penalty taxes: Sections 4980B (COBRA violations), 4980D (health plan rule violations), and 4980H (employer coverage requirements).

   d. Information reporting: Sections 6055 and 6056; Forms 1094-C, 1095-C, and W-2.

   e. Tax-advantaged accounts: Section 223 (HSAs), Section 125 (cafeteria plans), and Section 105(b)/(h).

B. The Rules You Need to Know

1. Tax law works together with other federal laws: ERISA, COBRA, HIPAA, ACA, Mental Health Parity, GINA, ADA, and FMLA.

2. Rules come from three agencies: Treasury/IRS, Department of Labor, and HHS.

3. State laws add more requirements (e.g., state health insurance mandates, paid leave taxes, privacy laws).

C. Why This Matters for Your Practice

1. Payroll tax issues: pre-tax elections, Social Security/Medicare tax treatment of benefits, state tax differences.

2. Client service opportunities: year-end planning, merger and acquisition reviews, penalty relief, plan design improvements.

3. Watch out for: IRS Letter 226J penalty notices, penalty taxes, reporting fines, liability for related companies.

4. Working with benefits lawyers: knowing when to refer clients and what questions to ask.

II. ACA EMPLOYER PENALTIES AND REPORTING REQUIREMENTS

A. Understanding ACA Employer Penalties (Code Section 4980H)

1. Section 4980H(a) penalty: applies when an employer fails to offer health coverage to at least 95% of full-time employees.

2. Section 4980H(b) penalty: applies when coverage is offered but is too expensive or doesn't cover enough ("minimum value").

3. Who is a large employer (ALE): companies with 50+ full-time equivalent employees, counting related companies together.

4. Counting full-time employees: monthly method vs. look-back method.

B. Affordability Rules

1. The IRS sets the affordability percentage each year; for 2026, the maximum an employee can be charged for coverage is 9.96% of pay.

2. Safe harbors (easier ways to prove affordability): W-2 wages, rate of pay, federal poverty line.

3. Practical tip: choose the safe harbor that works best for your client's workforce.

C. ACA Reporting: Forms 1094-C and 1095-C

1. Filing deadlines and extension procedures.

2. How to fill out the forms: Line 14 (offer codes), Line 15 (employee's cost for cheapest option), Line 16 (safe harbor/relief codes).

3. Common mistakes and how to fix them.

4. Electronic filing requirements and how to get a Transmitter Control Code (TCC).

D. IRS Letter 226J: When the IRS Thinks Your Client Owes Penalties

1. Letter 226J: The IRS sends this when its records show an employer may owe ACA penalties (based on comparing Form 1094-C/1095-C data with employees who claimed premium tax credits).

2. How to respond and deadlines.

3. Common defenses: reporting errors, corrected filings, transition relief, documentation of measurement periods.

4. Appealing to the IRS Office of Appeals.

E. State Health Insurance Mandates and Reporting

1. Some states require their own 1095-type reporting (e.g., California, New Jersey, Rhode Island, Massachusetts, District of Columbia).

2. Each state has different deadlines, formats, and penalties.

3. How to coordinate state and federal reporting.

F. Related Companies and Payroll Issues

1. Related companies must be counted together for ALE status (Code Sections 414(b), (c), (m), and (o)).

2. Payroll challenges: variable-hour employees, seasonal workers, rehires, and employees on leave.

3. Companies with multiple EINs and how to report.

III. ACA PREVENTIVE CARE AND FIRST-DOLLAR COVERAGE

A. Required Preventive Care Coverage (ACA Section 2713)

1. Non-grandfathered health plans must cover certain preventive services with no out-of-pocket cost to employees.

2. What's covered: recommended screenings (USPSTF A/B), vaccinations (ACIP), women's and children's health services (HRSA guidelines).

B. Legal Challenges

1. Lawsuits challenging the preventive care requirements (*Braidwood Management* litigation).

2. Uncertainty for employers and insurers about what they must cover while lawsuits are pending.

C. High-Deductible Health Plans (HDHPs) and HSAs

1. IRS allows preventive care to be covered before the deductible without affecting HSA eligibility (Notice 2004-23).

2. IRS has expanded what counts as preventive care for HDHPs (e.g., Notice 2019-45 for chronic conditions like diabetes).

3. Important: make sure covering new preventive services before the deductible doesn't accidentally disqualify employees from HSA contributions.

IV. HSA AND HIGH-DEDUCTIBLE HEALTH PLAN UPDATES

A. Annual Limits (Adjusted Each Year)

1. HSA contribution limits (individual and family coverage):

- Self-only coverage: **$4,400**
- Family coverage: **$8,750**

2. HDHP minimum deductible and maximum out-of-pocket limits:

HDHP Minimum Deductible:

- Self-only coverage: **$1,700**
- Family coverage: **$3,400**

HDHP Maximum Out-of-Pocket (OOP):

- Self-only coverage: **$8,500**
- Family coverage: **$17,000**

3. Extra contribution for people 55 and older ($1,000, not adjusted for inflation).

B. Common Problems That Disqualify HSA Eligibility

1. Medicare enrollment (including automatic Part A enrollment when applying for Social Security at age 65+).

2. Spouse has a general-purpose FSA or HRA (this disqualifies the employee from HSA contributions).

3. TRICARE and VA benefits.

4. Having other health coverage that isn't an HDHP (including a spouse's employer plan).

5. On-site clinics and employee assistance programs (EAPs) that may provide too much coverage to allow HSA contributions.

6. Direct primary care arrangements and their effect on HSA eligibility.

C. Telehealth and Pre-Deductible Coverage

1. COVID-era relief: telehealth can be covered before the deductible without disqualifying HSA eligibility.

2. The temporary HSA-compatible telehealth safe harbor was made permanent by the One Big Beautiful Bill Act (OBBBA), enacted July 4, 2025.

D. Tax Reporting for HSAs

1. Form W-2 Box 12 Code W (employer and employee HSA contributions).

2. Form 8889 (individual HSA deduction and reporting).

3. Forms 1099-SA and 5498-SA (distributions and contributions).

4. Penalty tax for excess contributions (Section 4973).

V. TELEHEALTH, MENTAL HEALTH, AND VIRTUAL CARE

A. Telehealth After COVID

1. Virtual care is now a standard part of employer-sponsored health plans.
2. Important distinction: telehealth as part of the group health plan vs. standalone employer-paid telehealth programs.

B. Plan Document Requirements

1. Summary Plan Description (SPD) and plan document updates for telehealth services.
2. COBRA rules for telehealth-only coverage options.
3. Making sure wrap documents match vendor contracts.

C. Tax Issues for Standalone Telehealth Programs

1. If telehealth is not part of a group health plan, it may be taxable income to employees.
2. Could trigger penalty taxes under Section 4980D if structured as an "employer payment plan."
3. If it is considered a group health plan, it must follow ACA rules.

D. Mental Health Apps and Vendor Arrangements

1. Mental health apps and digital therapy tools as part of plan design.
2. Vendor contracts and employer responsibilities.
3. Privacy and HIPAA issues.

VI. MENTAL HEALTH PARITY RULES (MHPAEA)

A. Background and Current Focus

1. MHPAEA requires health plans to cover mental health and substance abuse treatment on equal terms with medical/surgical benefits.

2. Two types of limits: numerical limits (like visit caps) and non-numerical limits (like prior authorization requirements).

B. 2021 Law Requirements

1. Plans must prepare written analyses comparing mental health limits to medical/surgical limits.

2. The Department of Labor is actively requesting these analyses from employers.

3. Plans must make the analysis available to regulators and employees upon request.

C. New Regulations

1. Proposed rules expanding requirements for comparing mental health and medical coverage.

2. Rules address network size and outcomes-based standards.

D. What Employers Should Do

1. Review plan documents, SPDs, and administrative practices for compliance.

2. Work with plan administrators and insurers to get the required comparison documentation.

3. Make sure vendors properly administer mental health and substance abuse benefits.

VII. TRANSPARENCY, VENDOR FEES, AND EMPLOYER RESPONSIBILITIES

A. Price Transparency Rules

1. Machine-readable files: plans must post pricing data online (in-network rates, out-of-network amounts, drug prices).

2. Price comparison tool: plans must provide an online tool so employees can compare costs.

3. Current enforcement status and practical concerns.

B. Gag Clause Ban and Annual Attestation

1. The 2021 law banned contract terms that prevent employers from accessing provider cost and quality data.

2. Employers must file an annual certification that their contracts comply.

3. Review existing vendor contracts for prohibited terms.

C. Drug Spending Reporting (RxDC)

1. Plans must report data on drug spending, premiums, and rebates.

2. Reporting deadlines and how employers, insurers, and pharmacy benefit managers coordinate.

D. Broker and Consultant Fee Disclosures

1. The 2021 law requires fee disclosures similar to 401(k) service provider rules.

2. Brokers must disclose all pay—both direct and indirect.

3. Employers have a duty to review whether fees are reasonable.

E. Lawsuits Over Health Plan Costs

1. Lawsuits claiming employers breached their duties by paying too much for health plans, pharmacy benefit managers, or hidden fees.

2. Similar to 401(k) excessive fee lawsuits.

3. Best practices: document how you select vendors, compare fees, and make decisions.

VIII. HIPAA PRIVACY, CYBERSECURITY, AND HEALTH PLAN DATA

A. HIPAA Rules for Employer Health Plans

1. Keeping employer and health plan data separate: employers can only see protected health information (PHI) if the plan documents allow it and the employer certifies compliance.

2. Business associate agreements: what they cover, breach notification rules, vendor management.

3. “Minimum necessary” rule: only access the health information actually needed.

B. HIPAA Security and Cybersecurity

1. Required safeguards for electronic health information: administrative, physical, and technical controls.

2. Data breach response: notification deadlines, reporting to HHS.

3. Recent enforcement trends and settlements.

C. Reproductive Health Privacy Rules

1. 2024 HIPAA rule changes addressing reproductive health information.

2. New limits on sharing health information about lawful reproductive care for certain purposes.

3. New attestation requirements.

D. Wellness Programs and Data

1. Data collected through wellness programs, health screenings, and health risk assessments.

2. Multiple laws apply: HIPAA, ADA, and GINA all restrict health data use.

3. Limits on how vendors can use data and rules for removing identifying information.

IX. REPRODUCTIVE HEALTH, TRAVEL, AND FAMILY-BUILDING BENEFITS

A. Employer Response After *Dobbs*

1. Some employers now offer travel benefits so employees can access lawful reproductive health care in other states.

2. Plan design options: coverage within the group health plan vs. separate travel benefit.

B. Tax Treatment of Medical Travel

1. Section 213: transportation expenses are deductible if they're primarily for medical care.

2. Sections 105/106: employer-paid medical travel through a group health plan is tax-free.

3. HSA/HDHP rules: travel for qualifying medical expenses can be paid from HSAs.

4. Limits and documentation: mileage rates, lodging caps.

C. State Law Issues

1. Self-insured plans may be protected from some state laws under federal ERISA rules.

2. Employers may still face state law risks in some situations.

3. Privacy concerns under HIPAA and state privacy laws.

D. Fertility, Surrogacy, and Adoption Benefits

1. IVF and fertility treatment coverage within group health plans.

2. Surrogacy: complicated tax rules—generally NOT deductible as a medical expense for the intended parent.

3. Adoption assistance: tax-free up to an annual limit under Section 137 ($17,670 for 2026), subject to income phase-outs.

4. Important: distinguish between qualifying medical expenses (tax-free) and personal expenses (taxable).

X. CAFETERIA PLANS, FSAS, HRAS, AND OTHER TAX-ADVANTAGED ACCOUNTS

A. Cafeteria Plan Rules (Section 125)

1. Pre-tax election requirements: once employees make elections, they generally can't change them mid-year.

2. When employees CAN change elections mid-year: life events (marriage, baby, divorce), cost changes, marketplace enrollment.

3. COVID-era flexibility for mid-year health plan changes has expired.

B. Health Flexible Spending Accounts (FSAs)

1. Annual contribution limit (set by IRS each year).

2. Plan design choice: carryover vs. grace period (carryover amounts are limited).

3. "Use it or lose it" rule and COBRA requirements for health FSAs.

4. Combining with HSAs: must use limited-purpose or post-deductible FSA designs.

C. Dependent Care Accounts (Section 129)

1. Annual limit: $7,500 ($3,750 if married filing separately) under the CAA 2026; prior limit was $5,000 ($2,500 if married filing separately).

2. Nondiscrimination testing: plans must pass tests to ensure benefits aren't tilted toward owners and highly paid employees.

3. IRS proposed regulations under Sections 128 and 129: significantly ease the nondiscrimination testing rules for dependent care FSAs.

4. 55% average benefits test: the average benefits provided to non-highly compensated employees must be at least 55% of the average benefits provided to highly compensated employees.

5. Key rule change: when running the 55% average benefits test, the average is now calculated using only employees who receive more than $0 in benefits during the plan year (whether through salary reduction or otherwise).

6. Reliance regulations: employers may rely on the proposed regulations beginning in 2026.

7. Practical impact: this change allows most employers to pass the 55% average benefits test far more easily and to take full advantage of the increased $7,500 dependent care FSA limit under the CAA 2026.

8. Coordination with the dependent care tax credit.

D. Types of HRAs

1. Individual Coverage HRA (ICHRA): lets employers fund individual market insurance; affects ACA penalty calculations.

2. Excepted Benefit HRA (EBHRA): limited annual amount, supplements group coverage.

3. Qualified Small Employer HRA (QSEHRA): for employers with fewer than 50 employees who don't offer group health coverage.

4. COBRA rules vary for each HRA type.

E. ICHRA Affordability for ACA Purposes

1. How ICHRA affordability affects ACA employer penalties.

2. To be "affordable," ICHRA must cover enough of the cheapest Silver plan after the employee's contribution.

3. Reporting requirements for ICHRAs.

XI. COBRA, SEVERANCE, AND MERGER/ACQUISITION ISSUES

A. COBRA Basics and Common Mistakes

1. Events that trigger COBRA: job loss, reduced hours, divorce, Medicare enrollment, dependent aging out of coverage.

2. Required notices: initial notice, qualifying event notice, election notice, early termination notice.

3. Election periods, premium payment deadlines, and how long coverage lasts.

B. COBRA Penalty Tax (Section 4980B)

1. $100 per day penalty for each affected person ($200/day if more than one family member).

2. Minimum penalty per plan: $2,500 ($15,000 for more than minor violations).

3. IRS Form 8928 reporting.

4. How to fix problems and request penalty relief.

C. Lessons from COBRA Premium Assistance Programs

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1. The 2021 COBRA subsidy program: compliance lessons for future similar programs.

2. How the payroll tax credit worked; IRS audits of claims.

D. Severance and Employer-Paid COBRA

1. Employer payment of COBRA premiums as part of severance: plan document requirements.

2. Gross-up vs. direct payment approaches; how it's taxed to the employee.

3. Deferred compensation rules (Section 409A) generally don't apply to standard severance pay within limits.

E. Merger and Acquisition Due Diligence

1. Related company rules: buyer may inherit liability for ACA and COBRA penalties of target's related companies.

2. Asset deals: buyer may take on COBRA obligations from before closing.

3. ACA reporting for mid-year acquisitions: who reports what.

4. Timeline for combining benefits and communicating with employees.

5. Due diligence checklist: plan documents, SPDs, compliance history, audits or lawsuits, retiree health liabilities.

XII. WELLNESS PROGRAMS AND LIFESTYLE SPENDING ACCOUNTS

A. HIPAA Wellness Program Rules

1. Two types: participation-only programs (complete a health survey) vs. health-based programs (achieve health goals).

2. Incentive limits for health-based programs: generally 30% of coverage cost (50% for tobacco cessation).

3. Must offer alternatives for people who can't meet health goals.

B. ADA and GINA Rules for Wellness Programs

1. EEOC rules limit incentives tied to medical questions and genetic testing.

2. Previous rules were challenged in court; current guidance is uncertain.

C. Weight Loss Drugs (GLP-1s) and Health Plan Coverage

1. Covering weight loss drugs like Ozempic/Wegovy under group health plans.

2. Cost control strategies: prior authorization, step therapy, specialty pharmacy.

3. ACA preventive care considerations (USPSTF obesity screening recommendation).

4. Possible mental health parity issues if eating disorders are covered as mental health conditions.

D. Taxable vs. Tax-Free Wellness Benefits

1. Cash rewards and premium discounts: generally taxable unless structured through a cafeteria plan.

2. Small non-cash rewards may qualify as tax-free "de minimis" fringes.

3. Gym memberships and fitness programs: generally taxable (don't qualify as medical care).

E. Lifestyle Spending Accounts (LSAs)

1. Employer-funded accounts for non-traditional wellness (financial planning, fitness, personal development).

2. Tax treatment: generally taxable W-2 income.

3. Must be reported on payroll.

4. Not covered by federal ERISA rules; state laws may apply.

XIII. RETIREE HEALTH, EXECUTIVE HEALTH PLANS, AND NONDISCRIMINATION

A. Retiree Health Benefits

1. Funded vs. unfunded structures.

2. VEBAs (trust funds for retiree benefits under Code Section 501(c)(9)): funding rules, contribution limits, tax on investment income.

3. Retiree-only HRAs and Medicare coordination.

B. Nondiscrimination Rules for Self-Insured Plans (Section 105(h))

1. Applies to self-insured health plans (employer pays claims directly).

2. Two tests: who's eligible (eligibility test) and what benefits they get (benefits test).

3. If the plan discriminates: highly paid employees must pay tax on excess benefits.

4. Testing can be complicated for plans with multiple tiers or executive carve-outs.

C. Nondiscrimination Rules for Insured Plans

1. The ACA extended nondiscrimination rules to insured group health plans (Code Section 9815/PHS Act Section 2716).

2. However, the IRS has delayed enforcement indefinitely; no final rules have been issued.

D. ERISA Reporting and Accounting Rules

1. Form 5500 filing for funded welfare plans; exemptions available for unfunded or fully insured plans with fewer than 100 participants.

2. Accounting rules (ASC 715, formerly FAS 106) for retiree benefits: important for financial statements.

XIV. PAID LEAVE, DISABILITY, AND FRINGE BENEFITS

A. State Paid Family and Medical Leave Programs

1. More and more states require paid leave funded through payroll taxes.

2. Employer and employee contribution rates and wage limits vary by state.

3. Benefits are usually taxable to employees (state rules vary).

4. Multi-state employers face complexity: withholding rules, which state's rules apply, private plan alternatives.

B. Tax Treatment of Disability Coverage

1. If employer pays the premiums: premiums aren't taxable, but benefits ARE taxable to employee.

2. If employee pays premiums (after-tax): benefits are tax-free.

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3. If employee pays premiums pre-tax (through cafeteria plan): treated as employer-paid, so benefits are taxable.

4. W-2 reporting: special rules for third-party sick pay.

C. Other Tax-Free Fringe Benefits (Section 132)

1. Commuter benefits (Section 132(f)): monthly limits for transit passes and parking.

2. Small tax-free perks: occasional meals, snacks, holiday gifts.

3. Work-related benefits and remote work considerations.

4. Employee assistance programs (EAPs): tax treatment depends on what services are covered.

D. Remote Work Tax Issues

1. Home office equipment and internet reimbursements: may qualify as tax-free working condition fringe or accountable plan expense.

2. Multi-state tax withholding and benefits eligibility for remote workers.

3. How remote work affects COBRA, state continuation coverage, and benefits administration.

XV. SECONDARY 125 PLANS – THE CREATIVE SIDE OF BENEFITS?

A. Overview

1. A “Secondary 125 Plan” (also marketed as a “supplemental,” “wellness,” or “SIMRP” plan) is a second cafeteria plan arrangement layered on top of an employer’s existing major medical coverage, usually sold by third-party promoters as a no-cost way to cut payroll taxes.

2. The typical structure pairs a pre-tax salary reduction under Section 125 with a self-insured medical reimbursement plan, fixed indemnity policy, or wellness program that pays cash benefits back to the employee.

3. The arrangement relies on Section 125 to let employees pay "premiums" with pre-tax dollars and on Sections 105 and 106 to exclude the payments made back to them. That combined result is the main thing the IRS disputes.

B. How They Work

1. Employer participation: the employer adopts a plan document and a vendor contract. Promoters often charge a per-employee monthly fee or a share of the claimed FICA savings.

2. Employee participation: employees elect a large pre-tax salary reduction (often several hundred dollars or more per month) to pay the premium for the secondary plan.

3. Benefits offered: telehealth access, health coaching, preventive or wellness services, and fixed cash "indemnity" or "wellness" payments that are triggered by minimal activities (e.g., completing a health survey, watching a video, or attending a coaching call).

4. Claimed tax savings: the salary reduction lowers taxable wages, which reduces the employee's income tax and both the employer's and employee's FICA taxes. The cash benefit then returns most of the reduction to the employee and is treated as tax-free, so take-home pay stays roughly the same while payroll taxes go down.

C. The Creative Side

1. Wellness indemnity designs: fixed payments for participating in wellness activities, which are labeled as “medical care” even though they are not tied to any medical expense the employee actually incurred.

2. Self-insured medical reimbursement plans (SIMRPs) funded with pre-tax premiums that pay back nearly the full premium through recurring benefit payments.

3. Premium “refund” or “advance” features that return contributions to employees regardless of claims, and fixed indemnity riders sold as supplements to major medical coverage.

4. Marketing claims to watch for: “zero net cost,” “guaranteed FICA savings,” “IRS-approved,” or legal opinion letters issued by the promoter’s own counsel.

D. Potential for Abuse

1. IRS Chief Counsel guidance: Chief Counsel Advice 201622031 and 201703013 concluded that fixed payments under these wellness arrangements are taxable wages subject to income tax withholding and FICA, because the payments do not reimburse medical expenses the employee actually incurred. CCA 202323006 (2023) reaffirmed that view for fixed indemnity policies that pay benefits regardless of actual medical expenses.

2. Underlying authorities: Section 105(b) excludes only reimbursements of medical expenses that were actually incurred and substantiated (Treas. Reg. §1.105-2). Rev. Rul. 2002-3 treats amounts paid without regard to actual expenses as taxable, and the proposed Section 125 regulations

(2007) prohibit benefits that defer or return compensation outside the plan's qualified benefits.

3. Enforcement posture: the IRS has warned the public about promoters of these wellness and indemnity arrangements and treats unsubstantiated wellness payments as wages. Expect employment tax audits that focus on Forms 941 and W-2 reporting.

4. Employer risks: back FICA and federal income tax withholding, interest, and penalties (including potential personal liability under the trust fund recovery penalty, Section 6672). If the plan's claimed benefits are disallowed, the cafeteria plan itself may be disqualified, which makes every employee's salary reduction taxable. ERISA fiduciary, COBRA, and plan document exposure may also apply.

5. Employee risks: wage income that was underreported, amended returns, and lower Social Security earnings credits from the reduced FICA wages.

6. Practical tip: before implementation, request the plan document, the insurance policy, and the claims data. Confirm that benefits are tied to medical expenses that were actually incurred, treat wellness and indemnity payments as wages unless they are substantiated, and consider unwinding existing arrangements and voluntary correction.

XVI. PRACTICAL CHECKLIST FOR CPAS AND TAX ADVISORS

A. Key Questions to Ask Clients

1. What type of health plan does the client have (fully insured, self-insured, level-funded)?

2. Is the client a large employer (50+ full-time equivalents)? Are there related companies?

3. What tax-advantaged accounts are offered (HSA, health FSA, dependent care, HRA)?

4. Are there special health plans for executives or retirees?

5. How does the client handle COBRA? Any open issues?

6. Are there standalone telehealth, wellness, or lifestyle programs (not part of the group health plan)?

7. Is a merger, acquisition, or reorganization planned?

B. Year-End Payroll and Reporting Checklist

1. Form W-2: verify Box 12 codes (DD for health coverage cost, W for HSA contributions), Box 10 (dependent care), Box 14 (as applicable).

2. ACA reporting: 1094-C/1095-C form codes, affordability safe harbor documentation, state reporting.

3. FSA/HSA contribution limit compliance.

4. PCORI fee calculation and payment (Form 720, due annually by July 31).

5. Taxable fringe benefit and wellness incentive reporting.

C. Merger and Acquisition Coordination

1. Identify all health and welfare benefit plans, policies, and arrangements.

2. Analyze related company and affiliated service group relationships.

3. Check for ACA penalty exposure, COBRA claims, and Department of Labor/IRS audit history.

4. Calculate retiree health and post-retirement benefit liabilities.

5. Work with benefits lawyers on how the deal structure affects benefits.

D. Working with Benefits Lawyers

1. When to refer: complex plan design, employer liability issues, government audit response, benefits lawsuits, M&A benefits integration.

2. Joint opportunities: transaction benefits due diligence, executive pay design, penalty relief.

3. Stay in touch about regulatory changes.