THE DEFENSIBLE BENEFIT

BUILT TO WITHSTAND THE AUDIT

How a Section 125 cafeteria plan paired with a fixed indemnity benefit is structured and documented to withstand examination, and what separates a defensible arrangement from one that invites scrutiny.

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EXECUTIVE SUMMARY

Audit defensibility is built, not hoped for. A benefit arrangement survives examination because it was designed around the statute and documented with discipline, and it fails when its design depends on a result the law does not support. That distinction is the subject of this paper.

The framework rests on settled ground. Employer contributions to an accident or health plan are excluded from income under Section 106, a Section 125 election funds them pre-tax, and benefits paid back are excluded under Section 105(b) to the extent they reimburse Section 213(d) medical care. Any amount above the employee's medical expenses is reconciled and reported by the employee. Each link is decades old; Revenue Ruling 69-154 has governed the excess benefit since the 1960s.[1]

What an examiner tests is whether the arrangement actually follows that chain or only appears to. A design that pays only on a documented Section 213(d) medical event, reconciles any excess at the employee level, and keeps the insurance risk with the carrier sits on the defensible side of the line. This paper sets out the examiner's tests, the exclusion chain and the documentary hinge that holds it, the division of risk and records, the recordkeeping a sponsor must keep and is barred from holding, the current posture of the Service, and where the audit risk finally lands.

HOW TO READ THIS

An important note before the framework.

WHAT IT IS

A design-and-documentation framework for a defensible cafeteria-plan and fixed indemnity arrangement.

WHAT IT IS NOT

Not legal or tax advice. Obtain advice from qualified counsel and a tax advisor on your own facts.

1 **IRC §§106, 125, 105(b), 213(d); Rev. Rul. 69-154**
The exclusion chain: contribution, benefit, and the excess-benefit rule.

References reflect federal law as of the publication date and are subject to change. State law is not addressed. The insurance benefit is issued by an A-rated, state-licensed insurance carrier and is not named. A legal position is reported as a 2025 tax opinion on file, an industry position, not adopted as the reader's own.

THE EXAMINER'S VIEW

WHAT AN EXAMINER ACTUALLY TESTS

An examination is a test of substance against form. The examiner is not asking whether the plan has attractive features. The narrower question is whether the payments qualify for the tax treatment the sponsor claimed, and whether the sponsor can show it.

For a fixed indemnity benefit funded through a cafeteria plan, that resolves into three tests. The trigger is where examiners look first, because the trigger reveals what the payment is for. A payment made because an employee completed an activity that cost nothing is not a reimbursement of a medical expense. A payment made because a provider documented a Section 213(d) medical event is a different instrument. Defensibility is decided at the design stage, long before any examiner arrives.[2]

FIGURE 5 · WHAT AN EXAMINER TESTS

TEST 1	**THE CONTRIBUTION** Were the premium contributions properly excluded?	HOLDS WHEN Funded by a §125 election and excluded under §106.
TEST 2	**THE BENEFIT** Was each payment a reimbursement of a §213(d) medical expense?	HOLDS WHEN Payment is conditioned on a documented §213(d) medical event.
TEST 3	**THE EXCESS** Was any benefit above the employee's expenses identified and reported?	HOLDS WHEN The employee reconciles and reports the excess.

IRC §§106, 125, 105(b), 213(d); Rev. Rul. 69-154; 2025 tax opinion on file. Neutral diagnostic tests, not findings.

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2 **IRS C.C.A. 202323006; I.R.C. 6110(k)(3)**
Activity-triggered fact pattern; a chief counsel advice may not be cited as precedent.

3 **Procter & Gamble Co. v. United States**, 733 F. Supp. 2d 857 (S.D. Ohio 2010)
A court set a chief counsel advice aside and construed the statute from its text.

WON IN CONSTRUCTION

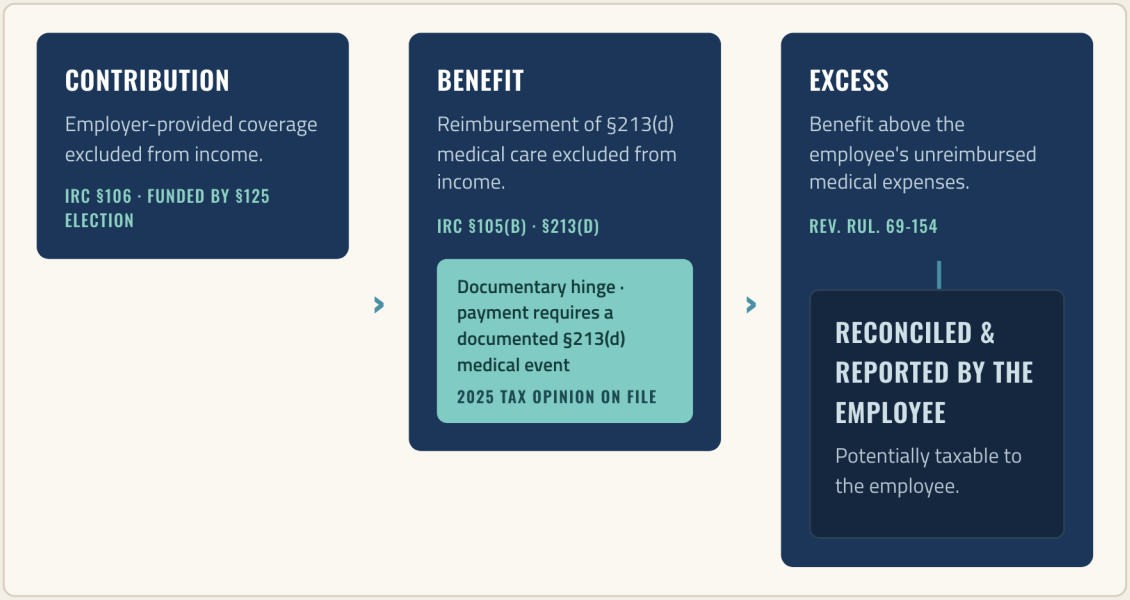
The examination is won or lost in the plan's construction, not in examination tactics.

THE EXCLUSION CHAIN

WHERE THE TAX TREATMENT HOLDS

The favorable treatment of a fixed indemnity benefit is not a single rule. It is a sequence of exclusions, each governed by its own Code section, and the arrangement is defensible only where every link holds.

FIGURE 1 · THE EXCLUSION CHAIN



IRC §§106, 125, 105(b), 213(d); Rev. Rul. 69-154; 2025 tax opinion on file. Structural, not numeric.

The first link is settled and not meaningfully disputed: Section 106 excludes employer-provided coverage, and a Section 125 election funds it pre-tax, reducing taxable income and the payroll-tax wage base.[4] The second link, Section 105(b), excludes amounts that reimburse Section 213(d) medical care, but it does not reach an amount the employee would receive whether or not any expense was incurred.[5]

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4 **IRC §106(a); §125(a), (d)**
Exclusion of employer-provided coverage; pre-tax funding by election.

5 **IRC §105(a), (b); §213(d)(1)(A); Treas. Reg. §1.105-2**
Benefit exclusion limited to reimbursement of incurred Section 213(d) care.

6 **Rev. Rul. 69-154, 1969-1 C.B. 46**
The excess-benefit rule: reduce total expense by total indemnity; include any surplus.

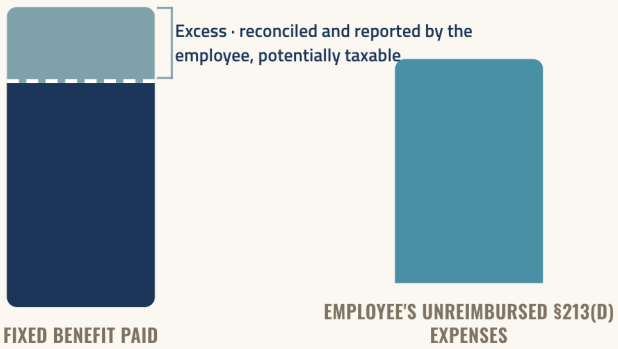
THE HINGE THAT HOLDS IT

DOCUMENTATION OF THE MEDICAL EVENT

A fixed indemnity benefit is defensible under Section 105(b) only if each payment corresponds to a Section 213(d) medical expense, and the arrangement must be able to show that correspondence.

A design that conditions payment on a provider's Current Procedural Terminology code, so that a claim pays only when the code indicates a Section 213(d) service was furnished, builds the documentary hinge into the claim itself. The code is the evidence that the trigger was a medical event and not an activity that carried no expense. This single feature is what allows the second link to hold under examination, and it is the feature most often absent from the arrangements the Service has questioned.[7]

FIGURE 2 · THE EXCESS BENEFIT, RECONCILED



Actual medical expenses commonly exceed the fixed benefit, in which case there is no excess. Relationship shown for illustration; amounts vary by individual.

Illustrative. Shows the reconciliation relationship only. No amounts are implied, and individual results vary. Rev. Rul. 69-154; mechanism per the 2025 tax opinion on file.

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7 **2025 tax opinion on file (industry position)**
Claim payment conditioned on a provider's CPT code indicating a Section 213(d) service.

NEVER DESCRIBED AS FREE OF TAX

The benefit is excludable to the extent it reimburses §213(d) care; the excess is potentially taxable to the employee.

RISK AND RECORDS

WHO BEARS THE RISK, AND WHO HOLDS THE RECORDS

Whether an arrangement is insurance, and who stands behind it, is not a labeling question. It determines the tax analysis and it determines what the employer can know.

For federal tax purposes, an arrangement is insurance only if it shifts and distributes risk. A fully insured benefit satisfies both elements: the employer pays a premium and has no further exposure, while the carrier bears the risk, pools it across many insureds, and pays claims from the pool. That allocation of risk produces an allocation of knowledge. The Optiv arrangement is always administered by a licensed third-party administrator, so the claim and the supporting bill go to the carrier and its licensed administrator, not the employer. The employer holds no medical records, and one that never receives the claim cannot be charged with knowing the benefit's character.[8]

FIGURE 3 · FULLY INSURED VERSUS SELF-FUNDED

DIMENSION	FULLY INSURED	SELF-FUNDED
Risk of loss	The carrier. No employer exposure regardless of claims.	The employer. Pays claims from its own account.
Receives claim & bill	The carrier and its licensed administrator. Employer holds no medical records.	The employer.
What the employer knows	Nothing. Does not see the claim.	Direct knowledge of every claim.
Insurance for tax purposes	Yes. Risk is shifted and distributed.	Not treated as insurance for this purpose.
Employer's role in payment	Paying agent only. Remits as the carrier directs.	Principal. Funds and pays the claim.

Helvering v. LeGierse, 312 U.S. 531 (1941); Amerco, 96 T.C. 18 (1991); Harper Group, 96 T.C. 45 (1991); 2025 tax opinion on file. Categorical, drawn from the authorities.

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8 **Helvering v. LeGierse**, 312 U.S. 531 (1941)
Insurance shifts and distributes the risk of economic loss from a fortuitous event.

9 **Amerco**, 96 T.C. 18 (1991); **Harper Group**, 96 T.C. 45 (1991)
Risk distribution is the pooling of many insureds so one loss is borne across the group.

The carrier funds the benefit; the medical event triggers it; the employer only remits it. Routing payment through payroll does not convert the carrier's benefit into the employer's wage.

THE RECORD

WHAT THE SPONSOR MUST KEEP, AND CANNOT HOLD

A sponsor's recordkeeping obligation is real and specific, and so is the limit on what the sponsor is permitted to hold. Defensibility requires getting both right.

Section 6001 requires records sufficient to establish liability, and employment tax records are retained at least four years. The licensed third-party administrator that Optiv provides generates and maintains the claims and benefit-payment records that underlie much of this file and supplies them to the sponsor, so the sponsor holds and produces a record the administered structure already creates rather than assembling it alone. The employer cannot maintain records of an employee's actual medical expenses, and it should not try to: it holds no medical records under this arrangement, because the claim and the medical information are received and held by the carrier and its licensed administrator, away from the employer. The limited record is a designed result, not a gap.[10]

FIGURE 4 · THE SPONSOR'S RECORD

WHAT THE SPONSOR KEEPS	WHAT THE EMPLOYER CANNOT HOLD
■ Written cafeteria plan document, stated plan year and election rules IRC §125(D); NOTICE 2005-42 ■ Section 125 election records IRC §125 ■ Automatic-enrollment opt-out notices COMPLIANCE REFERENCE ON FILE ■ Payroll records showing pre-tax elections IRC §6001; TREAS. REG. §1.6001-1 ■ Records of benefit amounts remitted and reported, generated and supplied by the licensed TPA TREAS. REG. §31.6001-1 *Optiv always provides a licensed TPA that generates, maintains, and supplies these claims and benefit-payment records to the sponsor. Retention: at least four years for employment tax records, and as long as the contents remain material.*	◆ The employee's full set of actual medical expenses ◆ Other coverage or other sources of reimbursement ◆ The medical information underlying a claim *The employer holds no medical records under this arrangement. The claim and the medical information are received and held by the carrier and its licensed TPA, away from the employer, and HIPAA restricts use of protected health information. The excess reconciliation is therefore the employee's.* ***2025 TAX OPINION ON FILE***

IRC §6001; Treas. Reg. §§1.6001-1, 31.6001-1; IRC §125(d); Notice 2005-42; 2025 tax opinion on file.

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10 **IRC §6001; Treas. Reg. §1.6001-1(a), (e), §31.6001-1; IRS Topic No. 305**
Records required; employment-tax records retained at least four years.

11 **IRC §125(d)(1); IRS Notice 2005-42**
Written plan, plan year, and election discipline under Section 125.

The employer's reporting role is limited to stating the benefit amount. The excess is includable in the employee's income and is reconciled and reported by the employee, who alone holds the facts and should consult a tax professional on how to report it.

THE SERVICE'S POSTURE

READING THE IRS POSITION IN 2026

A sponsor evaluating an arrangement in 2026 needs an accurate read of where the Service stands, including what it has done and what it has not.

The Service has issued chief counsel advice memoranda on fixed indemnity and wellness-triggered arrangements, most recently CCA 202323006: an employee made a large pre-tax election and received a fixed monthly payment for completing wellness activities that carried no out-of-pocket cost. Because the payment was made without regard to any incurred medical expense, the Service concluded the Section 105(b) exclusion did not reach it.[12] A defensible design is distinguishable on the grounds the Service itself identified: it is fully insured, pays only on a documented Section 213(d) event, is freestanding rather than layered on a group health plan, and pays nothing for completing an activity that carries no medical expense.[13]

The law here is open and not resolved. The question is whether the Service's reasoning in a non-precedential memorandum, directed at activity-triggered arrangements, could be extended to reach a benefit triggered by a documented Section 213(d) medical event with employee-level reconciliation of any excess. The stronger reading is that it cannot, grounded in the statutory text: Section 105(b) excludes reimbursement of Section 213(d) care, Revenue Ruling 69-154 governs the excess, and a chief counsel advice is not law and may not be cited as precedent.

For the contrary result to control, a specific chain of events would have to occur, and each link would have to hold against the taxpayer in turn:

1. The proposed amendments to the Section 105(b) regulations, issued in July 2023, would first have to be finalized at all, when proposed tax regulations are frequently narrowed or withdrawn after comment.
2. They would then have to be finalized substantially as proposed, rather than softened in response to the objections those amendments drew.
3. The finalized rule would then have to be applied to a design built around a documented medical-event trigger, a design the proposal was not aimed at and does not describe.
4. A sponsor whose benefit pays only on a documented Section 213(d) event would then have to be examined and assessed under that extended reading.
5. And a court reviewing that assessment would have to adopt the wage theory of the memoranda and extend it beyond the activity-participation facts on which it was reached, and would have to do so after *Loper Bright*, which removed the deference that would once have eased the agency's reading and left the court to determine the best reading of the wage statutes for itself, rather than looking, as a federal court has done before, to the plain text.

Each of those conditions is independent, and a break in any one of them stops the adverse result. Two facts cut the other way and belong in the record. When the Service finalized a related rule in April 2024, addressing short-term limited-duration insurance and a consumer notice for fixed indemnity coverage, it did not finalize the Section 105(b) tax-treatment changes, and Treasury stated that the decision not to finalize them should not be read as approval of the arrangements it had questioned.[14] And the Service has returned to this subject across several memoranda over several years, which signals sustained attention rather than a closed file.

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12 **IRS C.C.A. 202323006 (May 9, 2023)**
Payment without regard to incurred expense is not excludable on those facts.

13 **2025 tax opinion on file (industry position)**
Distinguishes a compliant design: full insurance, documented trigger, freestanding, no activity payment.

14 **Prop. Treas. Reg. §1.105-2, 88 Fed. Reg. 44596 (Jul. 12, 2023); Final rule, 89 Fed. Reg. 23338 (Apr. 3, 2024)**
§105(b) tax-treatment changes proposed, then not finalized; not approval.

\+ **Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024)**
Courts determine the best reading of a statute without deferring to the agency.

THE LIABILITY

WHO BEARS THE AUDIT RISK

For a finance leader, the decisive question is not whether the arrangement is attractive but who is exposed if the Service disagrees. The answer is specific, and it cannot be shifted by contract.

The duty to withhold runs to the employer. Section 3402(a) requires every employer that pays wages to withhold the tax due, and wages are all remuneration for services performed. The analysis turns on whether the indemnity benefit is remuneration for services. It is not: the benefit is funded by the carrier and triggered by a covered medical event, it bears no relation to services rendered, and the obligation continues even after employment ends, when there are no services at all.[15]

The Code reinforces the point through its carve-outs, which address payments the employer makes that might otherwise look like compensation. The indemnity benefit does not need them, because it is the carrier's payment and was never remuneration for services to begin with.[16]

The protection is an administered structure, not a transfer of liability.

The licensed third-party administrator that Optiv provides runs claims adjudication, holds the claim and medical information away from the employer, and generates the documented record an examiner tests; the carrier bears the insurance risk and funds the benefit. What remains with the employer is the narrow duty to withhold and report, which cannot be contracted to a vendor. The administered structure produces the record that makes the benefit defensible, while the legal duty stays where the statute puts it.

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15 **IRC §3402(a); §3401(a); §3121(a); §3306(b)**
Employer withholding duty; wages defined as remuneration for services performed.

16 **IRC §3401(a)(20), (a)(21); §3121(a)(2)(B); §3306(b)(2)(B)**
Wage carve-outs for certain employer health-plan payments.

THE ADMINISTERED STRUCTURE

A licensed TPA runs claims and generates the record an examiner tests; the narrow withholding duty stays with the employer.

CONCLUSION

DEFENSIBILITY IS A PRACTICE

An arrangement withstands examination because it was built to. The exclusion chain holds where every link is sound: the contribution excluded under Section 106 and funded by a Section 125 election, the benefit excluded under Section 105(b) to the extent it reimburses Section 213(d) care, and the excess reconciled and reported by the employee under Revenue Ruling 69-154.

The benefit qualifies because it is triggered by a documented medical event and funded by a carrier that bears the risk. The records that answer an examiner are kept, and the records the employer must not hold are kept by no one but the employee who alone holds the facts. The arrangements the Service has questioned failed on identifiable grounds, and a design that avoids those grounds is not the instrument the Service questioned.

None of this makes any arrangement immune from examination, and no honest paper would claim it does. Deliberate design and disciplined documentation do not buy immunity. They produce defensibility, a file that answers the examiner's questions because the answers were built into the arrangement from the start. A benefit either survives scrutiny on its records or depends on not being looked at, and which of the two a sponsor has is something the sponsor controls.

> **A benefit either survives scrutiny on its records, or it depends on not being looked at.**

APPLY TO ANY ARRANGEMENT UNDER CONSIDERATION

DEFENSIBILITY CHECKLIST

EACH ITEM CORRESPONDS TO A TEST AN EXAMINER IS LIKELY TO APPLY	TEN TESTS

- ☐ Is the benefit **FULLY INSURED**, with the carrier bearing the entire risk of loss, rather than self-funded?
  HELVERING V. LEGIERSE; 2025 OPINION ON FILE
- ☐ Does each payment require **DOCUMENTATION OF A §213(D) EVENT**, such as a provider code, rather than paying on activity completion?
  IRC §105(B), §213(D)
- ☐ Is the arrangement a **FREESTANDING POLICY** rather than layered on a group health plan?
  2025 OPINION ON FILE
- ☐ Is the excess reconciliation **PERFORMED AND REPORTED BY THE EMPLOYEE**, who holds the facts?
  REV. RUL. 69-154
- ☐ Does the employer remit and report **WITHOUT RECEIVING THE CLAIM FORM** or underlying medical information?
  2025 OPINION ON FILE; HIPAA
- ☐ Is there a **WRITTEN CAFETERIA PLAN DOCUMENT** with a stated plan year and election rules?
  IRC §125(D); NOTICE 2005-42
- ☐ Where automatic enrollment is used, are **OPT-OUT NOTICES** given on hire and before each plan year, and retained?
  COMPLIANCE REFERENCE ON FILE
- ☐ Are **EMPLOYMENT-TAX RECORDS**, plan documents, election records, and notices retained for the required period?
  TREAS. REG. §31.6001-1, §1.6001-1
- ☐ Is the benefit described as what it is, a **FIXED INDEMNITY BENEFIT TIED TO A §213(D) EVENT**, and never as free of tax?
  IRC §105(B); REV. RUL. 69-154
- ☐ Does the sponsor understand the **EMPLOYMENT-TAX LIABILITY IS THE EMPLOYER'S** and cannot be shifted to an administrator?
  IRC §3402(A), §3401(A)

SUPPORTING AUTHORITY

SOURCES AND DISCLOSURES

STATUTE AND REGULATION

IRC §§105(a)-(b), 106(a), 125(a),(d), 213(d)(1)(A), 3401(a) incl. (a)(20)-(a)(21), 3402(a), 3121(a) incl. (a)(2)(B), 3306(b) incl. (b)(2)(B), 6001, 6110(k)(3); Treas. Reg. §§1.105-2, 1.6001-1(a),(e), 31.6001-1.

IRS GUIDANCE AND RULINGS

Rev. Rul. 69-154, 1969-1 C.B. 46; IRS Notice 2005-42, 2005-1 C.B. 1204; IRS C.C.A. 202323006 (May 9, 2023), and C.C.A. 201622031, 201703013, 201719025; IRS Topic No. 305 (Recordkeeping); IRS Publication 15 (Circular E) (2026).

RULEMAKING RECORD AND CASE LAW

Prop. Treas. Reg. §1.105-2, 88 Fed. Reg. 44596 (proposed Jul. 12, 2023); Final rule, Short-Term, Limited-Duration Insurance and fixed indemnity excepted benefits, 89 Fed. Reg. 23338 (Apr. 3, 2024). Helvering v. LeGierse, 312 U.S. 531 (1941); Procter & Gamble Co. v. United States, 733 F. Supp. 2d 857 (S.D. Ohio 2010); Amerco & Subsidiaries v. Commissioner, 96 T.C. 18 (1991), aff'd, 979 F.2d 162 (9th Cir. 1992); Harper Group v. Commissioner, 96 T.C. 45 (1991), aff'd, 979 F.2d 1341 (9th Cir. 1992); Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024).

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