WHAT RECENT IRS GUIDANCE SIGNALS FOR FIXED INDEMNITY DESIGN

READING THE ROOM

The chief counsel advice record draws a line rather than condemns a category. This paper reads it accurately: what the Service actually said, what triggered its concern, and how a benefit should be triggered to stay on the defensible side.

optivhealth.us · (833) MY-OPTIV

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WHITE PAPER · REGULATORY OUTLOOK

EXECUTIVE SUMMARY

The largest question a sponsor asks about a fixed indemnity benefit is not how it works but whether the Internal Revenue Service will respect it. The question is fair, and the honest answer is more reassuring than the rumor that prompts it, but only for a sponsor who reads the record accurately.

The Service has issued a series of chief counsel advice memoranda addressing arrangements that pay a benefit on participation in an activity rather than on a documented medical expense. Those memoranda are the source of most of the unease in the category. Read carefully, they draw a line rather than condemn a category. The arrangements the Service questioned share a specific feature: they paid without regard to any incurred medical cost, on activity participation rather than on a substantiated medical event. That feature, not the fixed indemnity form itself, is what drew scrutiny.[1]

This paper sets out what the Service has actually said, what specifically triggered its concern, the line its own reasoning draws between a defensible design and one that recharacterizes wages, how a benefit should be triggered to stay on the defensible side, and where the sponsor's real exposure lies. One question at the edge remains genuinely open, and this paper states it as open rather than papering over it. The thesis is that the line is real and knowable, and a sponsor who understands it can build with confidence.

HOW TO READ THIS

An important note before the analysis.

WHAT IT IS

A reading of the current IRS posture toward fixed indemnity design, drawn from the authorities.

WHAT IT IS NOT

Not legal or tax advice, and not a representation about how any plan will be taxed. Consult your own advisors.

1 **IRS C.C.A. 202323006 (May 9, 2023)**
Activity-participation fact pattern; the trigger, not the category, drew scrutiny.

The Optiv Group has a commercial interest in the structures discussed and publishes this paper; the analysis may not be independent. Where a benefit is insured, the carrier is an A-rated, state-licensed carrier and is not named. Any legal opinion referenced is a 2025 tax opinion on file, an industry position not relied upon by any reader. Current-year tax figures were verified against IRS guidance at the time of writing.

SECTION 1 · THE RECORD

WHAT THE IRS HAS ACTUALLY SAID

A sponsor evaluating category risk needs to separate what the Service has issued from what that guidance means, because the two are routinely conflated. What the Service has issued is a series of chief counsel advice memoranda, most recently C.C.A. 202323006 in 2023, with predecessors reaching back to 2016.[2]

FIGURE 1 · THE CHIEF COUNSEL ADVICE CHAIN

IRS C.C.A. 202323006 and predecessor memoranda; Chief Counsel Directives Manual 33.1.2.2.3.5(9); IRC §6110(k)(3). Structural.

A chief counsel advice is not law. It originates when a field agent asks the Office of Chief Counsel about a specific set of facts, and the response reflects one office's interpretation applied to one fact pattern. It is expressly non-precedential and may not be cited as precedent, not even by the Service.[3] A federal court has set one aside and construed the statute from its own text.[4] These memoranda show the Service's reasoning and signal where examination attention may fall, but a benefit is measured against the statute, not against a memorandum.

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2 **IRS C.C.A. 202323006; 201703013; 201719025; 202317020**
The memoranda, 2016 to 2023; all non-precedential.

3 **I.R.M. 33.1.2.2.3.5(9); IRC §6110(k)(3); Skidmore v. Swift, 323 U.S. 134 (1944)**
A CCA may not be cited as precedent; persuasive only by its reasoning.

4 **Procter & Gamble Co. v. United States, 733 F. Supp. 2d 857 (S.D. Ohio 2010)**
A court disregarded a CCA and read the statute from its text.

NOT THE LAW

A memorandum signals where attention may fall. The design is measured against the statute.

SECTION 2 · THE FACT PATTERN

WHAT ACTUALLY TRIGGERED SCRUTINY

The memoranda are most useful read for their facts. In the arrangement the Service examined, an employee made a large pre-tax election and then received a fixed payment for completing a wellness activity, made without regard to whether any medical expense was incurred. The benefit was triggered by participation, not by a documented medical event.[5]

Because the payment bore no relationship to any incurred medical cost, the Service reasoned that the Section 105(b) exclusion, which reaches amounts that reimburse Section 213(d) medical care, did not apply to it. On those facts, that conclusion follows from the statute. The scrutiny attached to the trigger. It did not attach to fixed indemnity as a category, and it did not attach to the use of a Section 125 election as the funding mechanism.[6]

FIGURE 2 · WHAT TRIGGERS THE PAYMENT

THE ARRANGEMENT THE SERVICE QUESTIONED ACTIVITY-PARTICIPATION TRIGGER	THE DEFENSIBLE DESIGN DOCUMENTED MEDICAL-EVENT TRIGGER
■ Pays on completing an activity, a step count, a screening, a questionnaire.	■ Pays on a documented Section 213(d) medical event.
■ Paid without regard to any incurred medical expense.	■ Evidenced by a provider record and an associated procedure code.
■ No reimbursement of Section 213(d) medical care behind the payment.	■ Excluded under Section 105(b) to the extent it reimburses Section 213(d) care.
■ The pattern the Service addressed in non-precedential guidance.	■ Any excess reconciled and included under the excess-benefit rule.

The scrutiny attached to the trigger, not to the category. A single question locates any design: what triggers the payment.

IRS C.C.A. 202323006; IRC §§105(b), 213(d); Rev. Rul. 69-154. Both designs shown at equal weight; the left is the other side of a line, not a warning.

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5 **IRS C.C.A. 202323006 (May 9, 2023)**
A fixed payment for completing a wellness activity, paid without regard to expense.

6 **IRC §105(b); §213(d)(1)**
The exclusion reaches amounts that reimburse Section 213(d) medical care.

ONE QUESTION

A sponsor can locate any design on the correct side of the line by asking what triggers the payment.

SECTION 3 · THE DISTINCTION

THE LINE THE IRS DREW

The Service's own reasoning, followed to its source, rests on settled ground: the distinction between two things the Code treats separately, what is included in gross income, and what is treated as wages.

Gross income, under Section 61(a), is income from whatever source derived. Wages are narrower. For income-tax withholding, Section 3401(a) defines wages as remuneration for services performed, and the parallel FICA and FUTA definitions carry the same core meaning. The two are not interchangeable: an amount can be includable in gross income without being wages, because wages require that the payment be remuneration for services performed.[7]

This distinction governs the fixed indemnity question. When a benefit pays an amount that exceeds the employee's unreimbursed medical expenses, the excess is includable in gross income. That result is settled, and has been for decades under the excess-benefit rule of Revenue Ruling 69-154, which holds that where indemnity benefits exceed the medical expenses actually incurred, the excess is included in income while the portion reimbursing Section 213(d) care remains excluded.[8]

THE LINE, IN ONE SENTENCE

On one side is a benefit paid on a documented medical event, excluded under Section 105(b) to the extent it reimburses Section 213(d) care, with any excess reconciled under Rev. Rul. 69-154. On the other is a benefit paid on activity participation, with no medical expense behind it, which the exclusion does not reach. The first is the structure the excess-benefit rule has governed for half a century; the second is the arrangement the memoranda questioned.

The distinction is not subtle, and a sponsor can locate any design on the correct side of it by asking a single question: what triggers the payment.

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7 **IRC §61(a); §3401(a); §§3121(a), 3306(b)**
Gross income defined broadly; wages defined as remuneration for services.

8 **Rev. Rul. 69-154, 1969-1 C.B. 46**
The excess-benefit rule: the surplus over incurred expense is includable.

TWO DEFINITIONS

An amount can be gross income without being wages. Wages require remuneration for services performed.

SECTION 4 · THE DESIGN ANSWER

HOW A BENEFIT SHOULD BE TRIGGERED

The line converts directly into a design rule. A benefit that pays on a documented Section 213(d) medical event sits on the defensible side; a benefit that pays on activity participation does not. Everything else follows from honoring that trigger.

Documented trigger

Payment conditioned on a documented Section 213(d) medical event, evidenced by a provider record and code, not on a completed activity.

SETTLED

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Carrier-borne risk

Fully insured, with risk shifted and distributed to the carrier, the test of Helvering v. LeGierse, not retained by the employer.

SETTLED

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Excepted-benefit independence

Coverage operates independently of and uncoordinated with the major medical plan, consistent with excepted-benefit status.

SETTLED

Three features, all drawn from the authorities: a documented Section 213(d) trigger, carrier-borne insurance risk, and genuine excepted-benefit independence.[9]

A design with these features is the structure Optiv Advantage occupies. It pays on documented medical events, it is funded through a Section 125 election described separately as the funding mechanism, and the insurance risk sits with an A-rated, state-licensed carrier. The design does not pay on activity participation, and it does not describe its benefit as fully exempt from tax, because the excess over reimbursed medical care is includable and the design reconciles it.[10] The strength of the position is not a clever reading of the statute. It is that the design honors the same line the Service's own reasoning draws.

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9 **IRC §§105(b), 213(d); Helvering v. LeGierse, 312 U.S. 531 (1941); IRC §9832(c)(2); 45 C.F.R. §148.220(b)(4)**
Documented trigger; risk shifting and distribution; excepted-benefit non-coordination.

10 **Rev. Rul. 69-154; 2025 tax opinion on file**
The excess is includable and reconciled; never described as fully exempt.

DRAWN, NOT ASSERTED

The features are drawn from the authorities rather than asserted over them.

SECTION 5 · THE SETTLED GROUND

WHERE THE EXPOSURE ACTUALLY LIES

A sponsor deserves a precise account of what it is exposed to, separating what is settled from what is genuinely open. Most of the exposure is settled and modest.

The settled exposure is the excess benefit. When a benefit pays more than the employee's unreimbursed medical expenses, the excess is includable in the employee's gross income and is reconciled and reported by the employee, who holds the facts the reconciliation requires. That is the excess-benefit rule, and it is not a defect in the design; it is how the design is supposed to work.[11]

THE RECONCILIATION IS ANNUAL, BY DESIGN

The excess-benefit rule measures total benefits received during the year against total unreimbursed Section 213(d) expense for the year, and only the net excess is includable. A single month read in isolation can look mismatched in either direction without that mismatch being the taxable result. A larger event's unreimbursed expense enters the annual total and absorbs benefit dollars paid in lighter months, and the includable amount, if any, is whatever remains once the full year is netted.[12]

The same mechanism answers the genuinely empty month. If an employee truly incurs no qualifying expense in a month, that amount is not excluded by default; it enters the annual reconciliation like every other benefit dollar. If qualifying expense elsewhere in the year offsets it, nothing is includable on its account; if not, it is part of the includable excess the employee reports. A structure that instead paid every month regardless, and treated those payments as excluded, would be paying amounts the employee is entitled to receive irrespective of whether expenses were incurred, which is precisely what the Section 105(b) regulation places outside the exclusion.[13]

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11 **Rev. Rul. 69-154, 1969-1 C.B. 46**
The excess is includable; reconciliation and reporting belong to the employee.

12 **Rev. Rul. 69-154; Treas. Reg. §1.105-2**
The exclusion is measured against medical expense for the taxable year.

13 **Treas. Reg. §1.105-2**
No exclusion for amounts received irrespective of whether expense was incurred.

ANNUAL, NOT MONTHLY

A benefit can pay consistently and still be measured accurately at year end.

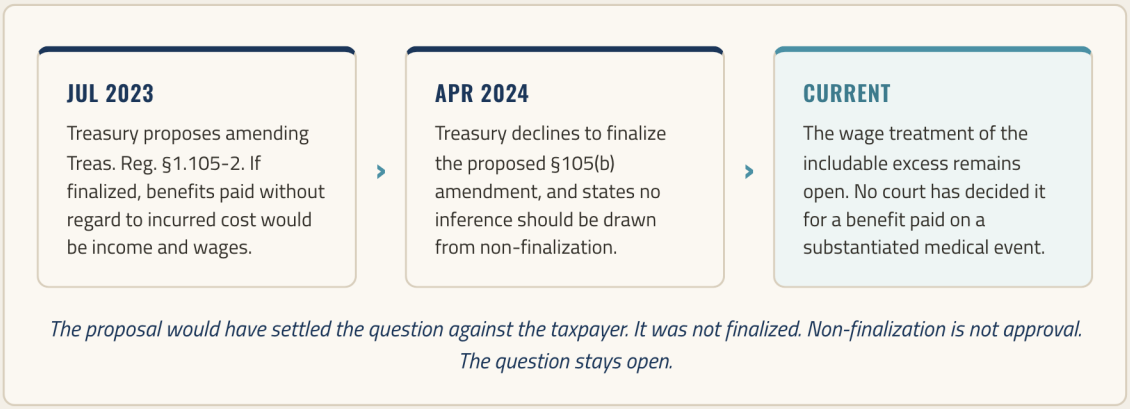
SECTION 5 · THE FRONTIER

THE ONE QUESTION THAT STAYS OPEN

The open question sits one step further out. Whether the includable excess, beyond being gross income, is also wages subject to withholding and to FICA and FUTA is a question no court has decided for an arrangement that pays on a substantiated medical event. The stronger reading of the statute is that it is not: a benefit paid because a medical event occurred is not payment for a service performed.[14]

For the contrary result to prevail, the question would have to be litigated; a court would have to adopt the wage treatment the Service has asserted only in non-precedential memoranda; it would have to read the wage statutes against the ordinary meaning of remuneration for services; and it would have to do so after Loper Bright removed the deference that once would have eased the agency's reading.[15]

FIGURE 3 · THE REGULATORY FRONTIER



88 Fed. Reg. 44596 (proposed Jul. 12, 2023); 89 Fed. Reg. 23338 (Apr. 3, 2024); IRC §§3401(a), 3121(a), 3306(b); Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024).

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14 **IRC §3401(a); §§3121(a), 3306(b)**
Wages are remuneration for services performed.

15 **Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024); I.R.M. 33.1.2; Procter & Gamble, 733 F. Supp. 2d 857**
Independent judgment, no deference; CCA non-binding and set aside.

16 **88 Fed. Reg. 44596; 89 Fed. Reg. 23338**
Proposed, then not finalized; non-finalization is not approval.

CONCLUSION

THE HONEST POSITION

The room, read accurately, is calmer than the rumor suggests. The Service has issued a series of non-precedential memoranda addressing a specific kind of arrangement: one that pays on activity participation, without regard to any incurred medical expense. Those memoranda are not law, a federal court has set one aside in favor of the statute, and they draw a line rather than condemn a category.

The line runs between a benefit triggered by a documented medical event and a benefit triggered by activity participation, and the Service's own reasoning, traced to its source, rests on the settled distinction between gross income and wages and on the excess-benefit rule that has governed fixed indemnity plans for half a century. A design that honors that line, a documented Section 213(d) trigger, carrier-borne insurance risk, genuine excepted-benefit independence, and an excess that is reconciled rather than ignored, stays on the defensible side of it.

One question remains open at the regulatory frontier, the wage treatment of the includable excess, and this paper has stated it as open. A sponsor should understand both the settled ground and the open question, should describe its benefit honestly as carrying an includable excess rather than as fully exempt, and should take the analysis to its own counsel on its own facts.

The line the Service drew is real and knowable. A sponsor who understands it can build with confidence.

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SUPPORTING AUTHORITY

SOURCES AND DISCLOSURES

STATUTE AND REGULATION

IRC §§61(a), 105(b), 106, 125, 213(d), 3401(a), 3121(a), 3306(b), 6110(k)(3), 9832(c)(2); ERISA §733(c)(2); 45 C.F.R. §148.220(b)(4); Treas. Reg. §1.105-2.

IRS GUIDANCE AND RULINGS

Rev. Rul. 69-154, 1969-1 C.B. 46; Rev. Rul. 2002-89; IRS Chief Counsel Advice 202323006 (May 9, 2023), and predecessors 201703013 (Dec. 12, 2016), 201719025 (Apr. 24, 2017), 202317020 (Mar. 29, 2023); Internal Revenue Manual, Chief Counsel Directives Manual 33.1.2.2.3.5(9).

RULEMAKING RECORD AND CASE LAW

Proposed Rule, 88 Fed. Reg. 44596 (Jul. 12, 2023); Final Rule, 89 Fed. Reg. 23338 (Apr. 3, 2024) (declining to finalize the proposed §1.105-2 amendments). Helvering v. LeGierse, 312 U.S. 531 (1941); Procter & Gamble Co. v. United States, 733 F. Supp. 2d 857 (S.D. Ohio 2010); Skidmore v. Swift & Co., 323 U.S. 134 (1944); Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024).

The Optiv Group has a commercial interest in the structures discussed and publishes this paper; the analysis may not be independent. References reflect federal law as of the publication date and are subject to change; state law is not addressed. The benefit structures described are offered through an A-rated, state-licensed insurance carrier that is not named. Any legal opinion referenced is a 2025 tax opinion on file, an industry position prepared on its own facts, which may not be relied upon by any reader. Chief Counsel Advice is non-precedential and is identified as such where cited. This paper is informational only and is not legal or tax advice; obtain advice from qualified counsel and a tax advisor on your own facts. Contact: info@optivhealth.us · optivhealth.us · (833) MY-OPTIV.