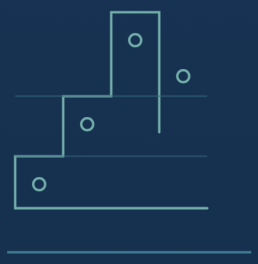
A TAX-EFFICIENT RESPONSE FOR EMPLOYERS AND EMPLOYEES

SOLVING ESCALATING HEALTHCARE COSTS

How a fully insured fixed indemnity benefit, Optiv Advantage, funded through a Section 125 election, helps employers recover payroll-tax cost and helps employees close the co-pay, deductible, and co-insurance gaps behind a $195B medical-debt crisis.



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WHITE PAPER NO. 02 · THE SHORT VERSION

EXECUTIVE SUMMARY

Employer-sponsored premiums are projected to rise about 9.5 percent in 2026, among the steepest increases in fifteen years, driven by high-cost GLP-1 drugs, advanced cancer therapies, and surging mental-health utilization. These pressures are prompting a majority of employers to adopt cost-cutting measures. This paper examines Optiv Advantage, a fully insured fixed indemnity benefit funded through a Section 125 election, as a response.[1]

Optiv Advantage addresses the co-pay, deductible, and co-insurance gaps that fuel a roughly $195B medical-debt crisis affecting about 41 percent of adults. Its features include zero cost-share telemedicine for primary and urgent care, a chronic-disease prescription formulary covering 350-plus medications across 50-plus conditions, and fixed indemnity cash benefits for hospital and other acute medical events.

The structure works on two sides. On the funding side, the premium is paid through a Section 125 election, which lowers the employee's taxable wages and reduces the employer's matching payroll tax. On the benefit side, the fixed indemnity payment reimburses Section 213(d) medical expense and is excluded from income under Section 105(b) to that extent, with any excess includable under the rule of Rev. Rul. 69-154.[2]

The figures in this paper are illustrative and tied to stated assumptions. Used that way, the employer payroll-tax recovery is a forecastable line item rather than a promise, and the employee value depends on each person's own elections and expenses.[3]

HOW TO READ THIS

An important note before the analysis.

WHAT IT IS

An educational analysis of a benefit structure and the tax authorities that govern it.

WHAT IT IS NOT

Not legal, tax, or accounting advice, and not an offer to sell insurance. Consult your own counsel.

1 **KFF 2024 and 2025 Employer Health Benefits Surveys**
2026 premium-trend and cost-driver data.

2 **IRC §§125, 105(b), 213(d); Rev. Rul. 69-154**
Pre-tax funding election; reimbursement exclusion; excess-benefit rule.

3 **Illustrative model, this paper**
Every dollar figure is tied to a stated assumption, not a guaranteed result.

The Optiv Group commissioned and published this paper and has a commercial interest in the benefit discussed, so it may not represent an unbiased view. The carrier is an A-rated, state-licensed insurance carrier and is not named. The benefit is a limited-benefit supplement, not ACA-qualified major-medical coverage.

WHERE THE PRESSURE COMES FROM

THE COST PROBLEM

The cost pressure on employer plans is structural rather than cyclical. Three figures frame it.

~$17K
Average employer premium per employee, 2025.
KFF, illustrative

+9.5%
Projected 2026 premium rise, among the highest in 15 years.
Industry forecast

~59%
Companies adopting cost-cutting measures for 2026.
Survey data

Premiums have outpaced general inflation for years, and a large majority of executives describe current costs as excessive. Among the strategies employers are adopting for 2026, supplemental fixed indemnity is rising fastest. The trend below shows the gap: medical-care prices have risen far faster than prices for all goods and services since 2000.[4]

FIGURE 1 · MEDICAL COST TREND VS. ALL GOODS AND SERVICES

Recreated from KFF analysis of BLS Consumer Price Index data. Indexed cumulative growth from 2000. Illustrative.

Employers are responding by shifting cost somewhere, to deductibles, to supplemental coverage, to renegotiated carrier terms. The question this paper takes up is where the cost finally lands, and who absorbs it.

PROOF RAIL

Sources for this page.

4 **KFF analysis of BLS CPI data**
Medical-care price trend vs. all goods and services since 2000.

5 **Aon, WTW, PwC, and Mercer cost-trend surveys**
2026 premium outlook; specialty and GLP-1 pharmacy trend.

Figures are illustrations from third-party data and should be verified independently. Adoption percentages are survey estimates.

WHERE THE COST LANDS

THE CO-PAY, DEDUCTIBLE, AND CO-INSURANCE GAP

Cost-sharing has outrun household capacity to absorb it. The result is a debt problem that lands on the same employees an employer is trying to retain.

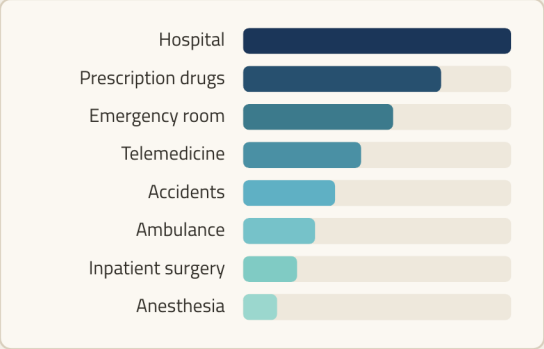
~$195B
Estimated nationwide medical-debt burden.
Aggregated estimate

~41%
Of adults carry unpaid medical bills.
Commonwealth Fund

~25%
Postpone care over cost concerns.
KFF

COST ITEM	TYPICAL AMOUNT
Individual deductible	~$1,644
Office-visit co-pay	~$31
Specialist co-pay	~$42
ER co-pay	$300 to $500
Co-insurance, post-deductible	20 to 30%
Rx co-pay, brand	$50 to $150

FIGURE 2 · OUT-OF-POCKET COST CATEGORIES



Relative shares, descending. CMS NHE and CHCF data. Illustrative; not exact percentages.

High-deductible plans now cover a majority of enrolled workers, and deductibles above $5,000 convert manageable conditions into catastrophic bills. Roughly one in four patients ration prescribed medication. Optiv Advantage is designed to put cash against exactly these gaps, before they become debt.[6]

PROOF RAIL

Sources for this page.

6 **Commonwealth Fund; KFF; Roosevelt Institute**
Medical-debt aggregate, unpaid-bill prevalence, and care-postponement rate.

7 **CMS NHE; CHCF Health Spending Almanac; KFF 2024 EHBS**
Out-of-pocket cost-category distribution and co-pay baselines.

Out-of-pocket figures are typical ranges from third-party surveys; individual exposure varies by plan.

WHAT THE BENEFIT IS

FEATURES OF OPTIV ADVANTAGE

Three layers work together: everyday care with zero cost-share, fixed cash for acute medical events, and monthly cash the employee directs toward qualified Section 213(d) expense.

01 · PROVIDER BENEFITS

Zero cost-share telemedicine for primary and urgent care, and a prescription formulary of 350-plus medications across 50-plus chronic conditions, including 8 of the top 10. Insulin, GLP-1, and specialty cancer drugs default to the major-medical plan.

02 · SPECIALIZED INDEMNITY

Fixed cash on acute events: about $1,000 per day hospital to 30 days, $500 per day ER, $1,000 inpatient surgery, $400 anesthesia, $2,500 critical illness or accident, $500 ambulance. Covers a large share of co-pay categories with provider benefits.

03 · GENERAL INDEMNITY

Monthly cash on a documented medical event, which the employee directs toward any Section 213(d) expense: dental, vision, transportation, lodging, rehabilitation, and more. The excess-benefit calculation governs any taxable portion.

HOW THE THREE LAYERS WORK TOGETHER

Provider benefits handle everyday care with no cost-sharing. Specialized indemnity pays cash for acute events above co-pay thresholds. General indemnity provides monthly cash flow the employee directs toward real Section 213(d) costs. The overwhelming majority of indemnity cash offsets actual out-of-pocket expense, not taxable income.

WHAT THE BENEFIT IS, AND IS NOT

Optiv Advantage is a fully insured fixed indemnity benefit backed by an A-rated, state-licensed insurance carrier. It is a limited-benefit supplement, **not an ACA-qualified or regulated major-medical product**, and not a replacement for comprehensive coverage.

PRESCRIPTION COVERAGE

CHRONIC-CONDITION FORMULARY AND WORKFORCE PREVALENCE

The formulary concentrates on the maintenance medications that drive a large share of employer plan cost, the chronic conditions most of a workforce actually carries.

FIGURE 4 · FORMULARY AND WORKFORCE PREVALENCE

CONDITION	WORKFORCE PREVALENCE	SAMPLE FORMULARY
Hypertension	~29%	Amlodipine, Lisinopril, Losartan, Metoprolol, HCTZ
Cholesterol	~25%	Atorvastatin, Simvastatin
Arthritis	~20%	Celecoxib, Meloxicam, Naproxen, Allopurinol
Depression / anxiety	~18%	Sertraline, Escitalopram, Bupropion, Duloxetine
Diabetes	~10%	Metformin, Glyburide-Metformin
COPD / asthma	~10%	Montelukast, Levalbuterol, Ipratropium-Albuterol
Heart disease	~6%	Atorvastatin, Clopidogrel, Metoprolol, Warfarin

Prevalence ranges are illustrative, from CDC and NHANES data. The governing formulary controls the medication list; sample drugs are representative, not exhaustive.

EXCLUSIONS

Insulin, GLP-1 drugs, specialty-condition drugs, and cancer-treatment medications are **not covered**. These default to the employer-sponsored major-medical plan.

PROOF RAIL

Sources for this page.

8 **Governing plan formulary schedule**
Medication and formulation counts; condition coverage.

9 **CDC and NHANES chronic-condition prevalence**
Workforce prevalence ranges, illustrative.

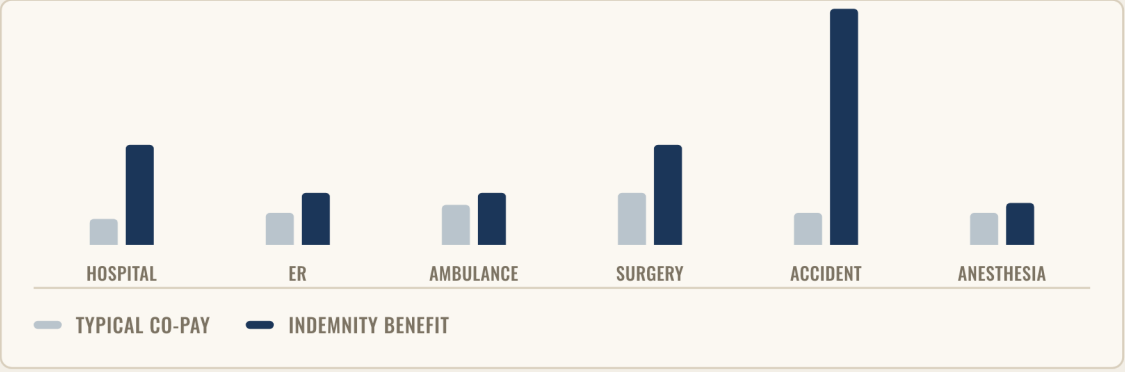
Sample drug lists are representative, not exhaustive; the governing formulary controls.

HOW THE CASH MAPS TO THE GAP

INDEMNITY BENEFITS AND TYPICAL CO-PAY EXPOSURE

Fixed indemnity pays a defined cash amount on a defined event. Where that amount exceeds the associated co-pay or cost-share, the excess reimburses real Section 213(d) costs, such as transportation, lodging, and other event-related out-of-pocket expense.

FIGURE 3 · TYPICAL CO-PAY VS. INDEMNITY BENEFIT, BY EVENT TYPE



KFF 2024 Employer Health Benefits Survey baselines; indemnity per the governing schedule of benefits. All amounts USD. Illustrative.

EVENT TYPE	BENEFIT AMOUNT	DURATION	ANNUAL MAX
Hospital inpatient	~$1,000 / day	Up to 30 days	~$30,000
Emergency room	~$500 / day	Up to 3 days	~$1,500
Ambulance transport	~$500 / trip	Up to 3 trips	~$1,500
Inpatient surgery	~$1,000 / event	1 day	~$1,000
Critical illness / accident	~$2,500 / event	1 day	~$2,500
Anesthesia	~$400 / event	1 day	~$400

PROOF RAIL

Sources for this page.

10 **KFF 2024 EHBS; governing schedule of benefits**
Co-pay baselines and indemnity amounts used in the comparison.

11 **IRC §213(d)**
Defines the qualified medical expense the indemnity excess reimburses.

THE EXCESS IS NOT WASTE

Under Section 213(d) it reimburses associated real-world costs, which keeps most of the cash out of gross income.

WHERE THE EXCLUSION STOPS

THE EXCESS-BENEFIT BOUNDARY

The Section 105(b) exclusion is not unlimited. It reaches the portion of a benefit that reimburses actual Section 213(d) medical expense. Where a fixed benefit exceeds the expense actually incurred, the excess is includable in gross income. That has been the rule for fixed indemnity benefits for decades.[12]

The arrangement is built around that rule rather than hiding it. The excess is determined by the employee, who alone holds the medical-expense information, through a calculation that subtracts qualified Section 213(d) expense from total indemnity received.

EXCESS-BENEFIT CALCULATION · ILLUSTRATIVE

LINE	ILLUSTRATIVE AMOUNT
Total indemnity received, annual	~$14,400
Less: Section 213(d) qualified out-of-pocket expense	(~$14,000)
Excess benefit, gross income, not wages	~$400
Reported on Form 1040, Schedule 1, Line z	~$400

Illustrative only, tied to the stated assumption. Most participants have qualifying expenses that substantially offset the indemnity. The taxable excess depends on each employee's actual Section 213(d) expense, which only the employee can determine. Not a promise of any outcome.

Insurance carriers typically do not issue a 1099 on these payments, and the amounts do not appear as wages on the W-2. The employee assembles the total indemnity received, subtracts qualified Section 213(d) expense, and reports any excess as other income.

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Authority for this page.

12 **IRC §105(b); §213(d); §61(a); Rev. Rul. 69-154**
Reimbursement excluded; the excess over actual expense is gross income under the excess-benefit rule.

The excess is determined by the employee, who alone holds the medical-expense information. The arrangement is built around the rule, not against it.

THE EMPLOYER SIDE

HOW EMPLOYERS RECOVER COST

Two effects work together: a payroll-tax reduction on the pre-tax premium, and a benefit offset where Optiv Advantage absorbs costs the major-medical plan would otherwise carry. Any administration fee is disclosed and netted in the figures below.[13]

FIGURE 5 · FICA REDUCTION, ILLUSTRATIVE MONTHLY MATH PER PARTICIPANT

Illustrative, tied to a $1,500 monthly pre-tax premium and a $35 monthly administration fee. Not a guaranteed dollar amount.

Pre-tax Section 125 salary reductions are excluded from the wage base under IRC §§ 3121(a)(5)(G) and 3306(b)(5)(G), so the employer's 7.65 percent match is calculated on a smaller number. On the assumption above, that is about $1,377 per participant per year gross, and about $957 per participant per year after a $35 monthly administration fee.

~$957
Illustrative net FICA recovery per participant per year, after fee.

~$3,455
Illustrative combined recovery per participant, benefit offset plus tax.

varies
Aggregate recovery scales with participation and the wage base.

STATE THIS CAREFULLY

The employer recovery is a reduction in the payroll-tax base, modeled from a census. It is not a guaranteed dollar amount and not employer profit. Every figure here is an illustration tied to a stated assumption, and the administration fee is netted in each recovery figure. **No figure is presented as a guaranteed outcome.**

PROOF RAIL

Authority and assumptions.

13 **IRC §§3121(a)(5)(G), 3306(b)(5)(G)**
Pre-tax Section 125 reductions excluded from the FICA and FUTA wage base.

\+ **Illustrative model**
$1,500 monthly pre-tax premium; $35 monthly administration fee; recovery before each employee's position relative to the Social Security wage base.

FEE DISCLOSURE

The $35 per-month administration fee is netted in every recovery figure in this paper.

THE EMPLOYEE SIDE

VALUE FOR EMPLOYEES

For the employee, value comes from three places: a pre-tax premium reduction that lowers taxable wages, no-deductible prescriptions and telemedicine, and indemnity cash that is gross income only to the extent it exceeds documented Section 213(d) expense.[14]

FIGURE 6 · EMPLOYEE PRE-TAX FLOW, ILLUSTRATIVE

Illustrative. The figure depends entirely on the employee's own elections and expenses and is not a promised outcome.

Because the premium is paid pre-tax, it reduces the employee's federal taxable income and FICA, and in many states the state taxable income as well. The indemnity offset matters because, without it, an employee deducting medical expense must both itemize and clear the Section 213(d) threshold of 7.5 percent of adjusted gross income. Most employees do neither.

The indemnity structure lets qualified Section 213(d) expense offset the benefit directly, which is what keeps most of the cash out of gross income. On an illustrative $1,500 monthly pre-tax premium producing a $1,200 monthly indemnity, a participant in the stated example sees a net annual take-home increase. The figure depends entirely on the employee's own elections and expenses and is not a promised outcome.

PROOF RAIL

Authority for this page.

14 **IRC §105(b); §213(d); §61(a)**
Reimbursement excluded; the 7.5% AGI itemized-deduction threshold the indemnity offset avoids.

The taxable excess depends on each employee's actual Section 213(d) expense, which only the employee can determine. Never assumed to be zero.

THE LEGAL FRAMEWORK

THE COMPLIANCE FRAMEWORK

The tax posture rests on a chain of settled authority, with one question on the benefit side that remains open and is stated as open rather than papered over.[15]

§125 · §106
Pre-tax election excludes premium from income and the wage base.
SETTLED

›

§105(b)
Reimbursement of §213(d) expense excluded.
SETTLED

›

§61(a)
Excess over actual expense is gross income.
SETTLED

›

§§3401 / 3121 / 3306
Wage treatment of the excess.
OPEN

RISK-SHIFTING	A material transfer of insurance risk satisfies the insurance-characterization test of *Helvering v. Le Gierse*, 312 U.S. 531 (1941), and Rev. Rul. 2002-89, supporting treatment as genuine insurance rather than disguised compensation.
EXCEPTED BENEFIT	Non-coordination with the major-medical plan supports treatment as an excepted benefit under 45 C.F.R. §148.220(b)(4), ERISA §733(c)(2), and IRC §9832(c)(2).
NON-PRECEDENTIAL GUIDANCE	The Service has scrutinized arrangements that pay on activity participation. The Chief Counsel Advice addressing such an arrangement is non-precedential and is distinguishable from a benefit that pays only on a documented Section 213(d) event.

A 2025 TAX OPINION ON FILE

A 2025 tax opinion on file reaches the not-wages conclusion. It was prepared on its own facts, is referenced here as an industry position, may not be relied upon by any reader, and is not a representation about how any specific employer's plan will be taxed.

PROOF RAIL

Authority for this page.

15 **Helvering v. Le Gierse**, 312 U.S. 531 (1941); **Rev. Rul. 2002-89** *Insurance-risk characterization test.*

16 **45 C.F.R. §148.220(b)(4); ERISA §733(c)(2); IRC §9832(c)(2)** *Excepted-benefit and non-coordination provisions.*

17 **I.R.S. Chief Counsel Advice 202323006** *Activity-triggered arrangement; non-precedential and distinguishable.*

THE WAGE TREATMENT OF THE EXCESS

WHAT IS SETTLED, AND WHAT REMAINS OPEN

That a properly operated election reduces the wage base, and that the benefit reimbursing Section 213(d) expense is excluded under Section 105(b), is settled. One question on the benefit side is not.

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 Section 213(d) medical event. The stronger reading of the statute is that it is not. Wages are defined as remuneration for services performed, and a benefit paid because a medical event occurred is not payment for a service performed.

For the contrary result to prevail, several specific things would each have to happen. The question would first have to be litigated. A court would then have to adopt the wage treatment the Service has asserted only in non-precedential guidance, guidance the agency's own manual treats as non-binding. The court 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 would once have eased the agency's reading.

The contrary result is possible, and the record is not one-sided. Treasury proposed an amendment that would have settled the wage treatment against the taxpayer by treating fixed indemnity amounts paid without regard to actual medical cost as wages. It did not enact the amendment, and it did not finalize it. That the proposal was made shows the question is live. That it was not finalized is not approval of the taxpayer's position. Those facts keep the question open.

IN PLAIN TERMS

THE STRUCTURE IN PLAIN TERMS

Stripped of the mechanics, the structure does three things. It lets an employee pay a benefit premium before tax, which lowers the employee's taxable wages and the employer's matching payroll tax. It pays fixed cash when a documented medical event occurs, which the employee applies to real out-of-pocket cost. And it keeps that cash out of gross income to the extent it reimburses Section 213(d) medical expense, with any excess treated as ordinary income and reported by the employee.

For the employer, the payroll-tax recovery is a forecastable line item that scales with participation, and the benefit works alongside the existing major-medical plan rather than replacing it. For the employee, the value is lower out-of-pocket cost and cash that arrives when a medical event does. For both, the structure depends on a properly operated Section 125 plan and a benefit that pays only on a substantiated medical event, which is what keeps the tax treatment defensible.

Settled where settled, open where open.

The honest position

Optiv Advantage answers a real and rising cost problem from two sides at once. The funding-side recovery follows from the Section 125 wage-base reduction and is forecastable from a census. The benefit-side exclusion follows from Section 105(b) and the Section 213(d) standard and is well settled, with the excess over actual expense includable under a decades-old rule.

One question on the benefit side, the wage treatment of any includable excess, remains open, and this paper has stated it as open. An employer evaluating the structure should understand both the settled ground and the open question, model the recovery from its own census, take the supporting analysis to its own counsel, and confirm that any arrangement it adopts is properly documented and pays only on a substantiated medical event. The figures here are illustrations. The mechanism is what an employer can plan around.

SUPPORTING AUTHORITY

SOURCES AND DISCLOSURES

STATUTE AND REGULATION

Internal Revenue Code §§125, 105(b), 106, 213(d), 61(a), 3401(a), 3121(a) and 3306(b), including the Section 125 exclusions at §§3121(a)(5)(G) and 3306(b)(5)(G); §9832(c)(2); ERISA §733(c)(2); 45 C.F.R. §148.220(b)(4).

IRS GUIDANCE AND RULINGS

Rev. Rul. 69-154, 1969-1 C.B. 46 (excess-benefit rule for fixed indemnity health benefits); Rev. Rul. 2002-89 (insurance-characterization and risk-shifting); I.R.S. Chief Counsel Advice 202323006 (activity-triggered arrangement; non-precedential).

CASE LAW AND RULEMAKING RECORD

Helvering v. Le Gierse, 312 U.S. 531 (1941); Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024). U.S. Department of the Treasury, General Explanations of the Administration's FY 2023 and FY 2024 Revenue Proposals (proposed wage treatment of fixed indemnity amounts; not enacted, not finalized). A 2025 tax opinion on file is referenced as an industry position on its own facts and may not be relied upon by any reader.

DATA SOURCES

KFF Employer Health Benefits Surveys (2024, 2025) and Americans' Challenges with Health Care Costs (2025); Aon, WTW, PwC, and Mercer cost-trend surveys; Commonwealth Fund and Roosevelt Institute medical-debt reports; CMS National Health Expenditure data; CHCF Health Spending Almanac; BLS CPI analysis; CDC and NHANES chronic-condition prevalence. Third-party figures, treated as illustrative; verify independently.

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