IRS Issues Guidance on HSA-Related OBBBA Changes

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IRS Notice 2026-05 (Dec. 9, 2025)

Available at ***https://www.irs.gov/pub/irs-drop/n-26-05.pdf***

The IRS has issued guidance addressing common questions regarding the HSA-related changes made by legislation enacted in July 2025 (referred to in the guidance as the One Big Beautiful Bill Act or OBBBA). As background, the OBBBA made permanent the safe harbor allowing high-deductible health plans (HDHPs) to cover telehealth and other remote care services before the minimum deductible is satisfied without losing their HDHP status. These services are also considered disregarded coverage on a permanent basis and thus will not cause a loss of HSA eligibility. OBBBA also provides that bronze and catastrophic plans available as individual coverage through an Exchange will be treated as HDHPs. In addition, direct primary care service arrangements (DPCSAs) will not adversely affect HSA eligibility if certain requirements are met regarding fees charged and services provided; fees for these arrangements are qualified medical expenses for HSA purposes. Here are highlights of the guidance:

- *Telehealth/Remote Care.* Otherwise eligible individuals may contribute to HSAs for 2025 if they were enrolled in health plans that provided pre-deductible coverage for telehealth or other remote care services before the OBBBA's July 4, 2025, enactment date but otherwise satisfied HDHP requirements, whether contributions are made before or after the OBBBA's enactment. IRS will treat benefits as telehealth and other remote care services for this purpose if they appear on HHS's annually published list of telehealth services payable by Medicare; instructions are provided for analyzing services not on the list. In-person services, medical equipment, or drugs furnished in connection with telehealth and other remote care services may not be provided pre-deductible unless they would otherwise be treated as telehealth services under the guidance.
- *Bronze/Catastrophic Plans.* For months beginning after 2025, bronze or catastrophic plans will be treated as HDHPs if they are available as individual coverage through an Exchange, even if they do not satisfy the HDHP minimum annual deductible or out-of-pocket maximum requirements. Furthermore, employer-sponsored ICHRAs can be used to purchase the coverage. The guidance also addresses bronze or catastrophic plans that are not purchased through an Exchange or are offered as SHOP coverage and modifies earlier guidance regarding HSA eligibility within three months of receiving medical care from the Indian Health Services for certain individuals who enroll in a bronze plan variant.
- *DPCSAs and HSA Eligibility.* Under the OBBBA, the aggregate fees for all DPCSAs for the individual for a month may not exceed $150 (or $300 if the arrangement covers more than one individual), as adjusted annually for inflation for taxable years after 2026. The sole compensation for care provided under a DPCSA must be the fixed periodic fee and DPCSAs may not provide items and services to individuals who are members in the arrangement and have paid a fixed periodic fee while billing separately for those items and services (through insurance or otherwise). However, DPCSAs may offer certain items and services outside of the arrangement regardless of membership, and separately bill members and non-members for those items and services. DPCSA fees may be billed for periods of more than a month (but no more than a year) if the aggregate fees are fixed, periodic, and do not exceed the monthly limit (on an annualized basis). If an arrangement provides services other than permitted primary care services,

members in the arrangement may not decline to use those services and treat the arrangement as a DPCSA, nor may an HDHP offer primary care benefits other than those allowed under the HSA rules (e.g., telehealth and preventive care) through a DPCSA on a pre-deductible basis. And an HDHP may not count an individual's DPCSA fees toward the HDHP's annual deductible and out-of-pocket maximum.

- *Reimbursing DPCSA Fees.* For its fees to qualify for reimbursement from an HSA, the DPCSA must be an arrangement under which an individual is provided with Code § 213(d) medical care consisting solely of primary care services provided by primary care practitioners (as further defined in the guidance), if the sole compensation for the care is a fixed periodic fee, and the care does not include certain prohibited services and items. There is no specific limit on the fee's amount for HSA reimbursement purposes, but DPCSA fees in excess of the monthly dollar limit that applies for HSA eligibility purposes will disqualify the individual from eligibility for making HSA contributions while the individual is enrolled. The guidance explains when HSAs may treat DPCSA expenses as incurred (and therefore reimbursable), and that HSAs may not reimburse DPCSA fees that were paid by an individual's employer, including through cafeteria plan salary reductions.

EBIA Comment: Employers, administrators, and advisors who work with HSAs and HDHPs should familiarize themselves with the guidance and determine whether changes may be needed or advisable to programs and offerings. Public comments on the guidance are invited and should be submitted on or before March 6, 2026. For more information, see EBIA's Consumer-Driven Health Care manual at Sections X.I ("Telehealth and Other Remote Care Services"), X.L ("Bronze and Catastrophic Plans Treated as HDHPs Beginning in 2026"), XI.B.3 ("Direct Primary Care Service Arrangements"), XI.G.8 ("Certain Coverage for Telehealth and Other Remote Care Will Not Prevent HSA Eligibility"), and XV.C.2 ("With Some Exceptions, Insurance Premiums and Coverage Contributions Are Not HSA-Qualified Medical Expenses").

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