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Compliance Directions

Health Savings Account Access Expands as 2026 Dawns

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On December 9, the IRS issued Notice 2026-05, which contains guidance on the health savings account (HSA) provisions in the One Big Beautiful Bill Act (OBBBA). The OBBBA broadened the ability to contribute to HSAs by permitting free telehealth services prior to meeting the annual high deductible health plan (HDHP) statutory deductible, retaining eligibility to contribute to an HSA during participation in direct primary care service arrangements (DPCSAs), and allowing HSA contributions when an individual is enrolled in a bronze or catastrophic plan.

Telehealth and Other Remote Care Services

Under the OBBBA, if an HSA-eligible individual is covered by a health plan providing "telehealth and other remote care services," they may make HSA contributions before the HDHP statutory minimum deductible is satisfied. HSA contributions may be made regardless of whether the telehealth and other remote care services are provided outside the HDHP or within it. The telehealth provision applies for plan years beginning on or after January 1, 2025, regardless of whether the HSA contributions were covered by the arrangement prior to the OBBBA's passage on July 4, 2025.

"Telehealth and other remote care services" is not defined in the OBBBA nor concretely in Notice 2026-05. But the Notice suggests that remote services limited to Medicare's list of payable telehealth services will be considered a telehealth benefit that will not cause HSA disruption under this guidance. For that purpose, the Notice links to two federal websites (one and two) to find the annually published Medicare Telehealth Services List. Telehealth services do not include any in-person services, medical equipment, or drugs furnished because of the telehealth services unless they would otherwise be found as "telehealth or remote care services."

Note that plan sponsors of HDHPs and telehealth benefits should discuss this guidance with their telehealth vendor and consider requiring the vendor to meet the Medicare standards through contractual language to ensure that these vendors services are limited to those available under Medicare. As the available telehealth services under Medicare change year to year, the vendor should ensure the program continues to meet those parameters.

DPCSAs and Onsite Clinic Implications

An individual seeking to contribute to an HSA, among other qualifiers, must be covered by a qualifying HDHP and must not be covered by any other health plan. Under the OBBBA, certain DPCSAs are disregarded as a health plan for purposes of determining HSA contribution eligibility.

To avoid disruption to HSA contribution ability, the DPCSA:

- Must only provide section 213(d) medical care involving "primary care services,"
- The care must be provided by primary care practitioners, and
- The sole compensation must be limited to a fixed periodic (e.g. monthly) fee, limited to an annually indexed amount of $150/month ($300/month if the DPC arrangement covers more than one person). The DPC may bill the fixed periodic fee for periods more than monthly, but not more than annually. The Notice gives the example that for 2026, the fee for a single individual could be $1,800 for a year; $900 for six months; or $450 for three months.

Primary Care Services

OBBBA defines "primary care services" broadly, excluding procedures requiring general anesthesia, prescription drugs (other than vaccines), and laboratory services not typically provided in a primary care setting. The Notice does not define "primary care services" more specifically. It is anticipated that the Treasury will issue further guidance on the definition.

Arrangements that provide services in addition to primary care services are not DPCSAs (whether through insurance or otherwise), even if an individual declines to use the services outside the DPCSA. But providers participating in the arrangement may separately choose to offer those items and services outside the DPCSA to all individuals, whether members or not, and separately bill members and non-members for those items and services.

Sponsored DPCSAs

An employer that wants to sponsor a DPCSA may not provide membership into it (or pay the associated fees) before the statutory minimum deductible has been satisfied, thereby requiring any DPCSA to be offered separately from an HDHP (i.e., it cannot be a component of a HDHP group health plan but could be offered as a separate benefit). In addition, the sponsor may not count DPCSA fees toward the HDHP deductible or out-of-pocket maximum, if an individual is enrolled in both benefits.

HSA Reimbursement

DPCSA fees are reimbursable from HSAs and not subject to the limit noted above. However, if an employer pays the DPCSA membership fees on behalf of the employee or permits the fees to be taken pretax through the cafeteria plan, the fees are not reimbursable by an HSA.

An HSA may treat a DPCSA fee as an expense incurred on the first day of each month of coverage on a pro rata basis, the first day of the coverage period, or the date the fees are paid. The Notice gives the example that an HSA may immediately reimburse a DPCSA fee beginning on January 1 of the current enrollment year, even if the enrolled individuals paid the fee prior to the first day of the current enrollment year.

Although there is a fee limit for DPCSAs to be considered a disregarded health plan, there is no reimbursement limit for the fixed periodic fee. Therefore, DPCSA fees that do not satisfy the monthly dollar limit will be treated as HSA-reimbursable medical expenses, but they will also prevent the individual from making eligible HSA contributions while the individual is enrolled in the DPCSA.

Bronze and Catastrophic Plans Treated as HDHPs

The OBBBA also provides that bronze or catastrophic plans will be treated as HDHPs if:

- The plan is available through the Marketplace, and
- If the plan is obtained outside the Marketplace that mirrors a Marketplace plan.
- The IRS will also treat a non-mirrored plan obtained outside the Marketplace as an HDHP if the individual had no reason to believe it would not be available in the Marketplace.

Small Business Health Options Program (SHOP) coverage offered by a small employer is not individual coverage, thus it does not meet the HDHP criteria.

Employer-sponsored ICHRAs may be used to purchase individual bronze or catastrophic plans. But, if the ICHRA also reimburses medical care other than individual health coverage premiums before the deductible is met, that ICHRA could constitute other coverage disqualifying the individual from HSA contribution. Plan sponsors of ICHRAs should consider communicating this potential HSA disruption to their participants if the ICHRA reimburses medical care expenses that are not premiums or design the ICHRA to avoid such reimbursements prior to the individual meeting the deductible.

Bronze plans designed to provide a level of coverage with benefits actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan are considered HDHPs.

Prior to OBBBA under Notice 2012-14, HSA eligibility was restricted to those who had not received medical services at an Indian Health Services (IHS) facility during the previous three months. But the current Notice clarifies that Notice 2012-14 does not apply to individuals who receive IHS medical services and enroll in a bronze plan variant with cost-sharing reductions offered to American Indians and Alaska Natives. Therefore, an individual is not disqualified from HSA contributions, even if they have received medical services at an IHS facility during the previous three months.

Employer Action Steps

While the Notice links to two websites containing qualifying telehealth services lists, the information listed is quite dense and may be difficult for employers to wade through. Employers may need to work with their telehealth provider to determine whether their services are "consistent with the principles of" Social Security Act section 1834(m). And, as these lists change, the vendor should continue to ensure compliance with those standards.

Be cautious when designing onsite clinics as DPCSAs. It is theoretically possible for an employer to structure an onsite clinic offering DPCSA membership with items and services provided outside the DPCSA, available to employees who are not DPCSA members, and billed separately. But the distinctions outlined in the Notice lack certain definitions for these terms. If a DPCSA arrangement does not meet the Notice requirements, it provides medical care and would be considered disqualifying insurance preventing HSA eligibility. Further, an onsite clinic that provides more than insignificant medical care (e.g., first aid, workplace injury) will ruin HSA eligibility unless the onsite clinic charges at least fair market value (FMV) for non-preventive services until an HDHP participant meets the statutory minimum deductible. How that would work in conjunction with the new DCPSA rules is not yet clear. Analyzing a particular employer's arrangement design with counsel is imperative.

The intent of this article is to provide general information on employee benefit issues. It should not be construed as legal advice and, as with any interpretation of law, plan sponsors should seek proper legal advice for application of these rules to their plans.