AMERICAN BENEFITS COUNCIL

March 6, 2026

Submitted electronically via www.regulations.gov

Internal Revenue Service
CC:PA:01:PR (Notice 2026-5)
Room 5503
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Comments on Notice 2026-5

Dear Sir or Madam,

We write on behalf of the American Benefits Council ("the Council") to provide comments in connection with Notice 2026-5, "Expanded Availability of Health Savings Accounts under the One, Big, Beautiful Bill Act (OBBBA)." Notice 2026-5 provides guidance regarding the OBBBA's health savings account (HSA) provisions.

The Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees, and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

The Council commends the U.S. Treasury Department and the Internal Revenue Service (IRS) for developing timely guidance to support implementation of the OBBBA and appreciates the opportunity to comment. We are very appreciative that employers now have increased flexibility to enhance health coverage offered to millions of Americans and believe Notice 2026-5 provides helpful clarification with respect to several aspects of the OBBBA's HSA-related provisions.

At the same time, we respectfully ask the IRS to provide additional clarification to reduce uncertainty and support long-term compliance. We outline our specific requests for clarification in the following pages.

TELEHEALTH AND REMOTE CARE SERVICES

Under the OBBBA, an otherwise HSA-eligible individual may contribute to an HSA if they have coverage for "telehealth and other remote care services" before the minimum statutory deductible is met. As context for our more specific comments, we begin by noting that the Council has long supported providing employers and health plans permanent flexibility to offer telehealth services pre-deductible, and we worked for years to advocate for extensions and permanency of this policy. Employers see virtual health care as essential to improving health care quality and efficiency, and our members saw many positive outcomes due to this provision over the years, including in the context of tele-mental health care. As such, we strongly support the flexibility to offer these services pre-deductible.

As to our more specific comments, we note that the OBBBA does not define the term "telehealth and other remote care services" or specify which services qualify, leaving uncertainty about what types of services are included.

Notice 2026-5 provides guidance on this issue by stating "telehealth and other remote care services" include services included on the list of telehealth services payable by Medicare published annually by the U.S. Department of Health and Human Services (HHS) under Social Security Act (SSA) Section 1834(m)(4)(F). For services not included on the HHS list, Notice 2026-5 states the taxpayer should "apply the principles of [SSA] Section 1834(m), its implementing regulations at 42 CFR 410.78, and other guidance issued by HHS defining 'telehealth services' and related terms." Notice 2026-5 also clarifies that "telehealth and other remote care services" does not include in-person services, medical equipment or drugs furnished in connection with those services unless they would otherwise be treated as telehealth services under the definitions above.

While we acknowledge and appreciate the IRS's efforts in providing clarity, we request additional guidance because the referenced HHS list, as well as the expected analysis for services not enumerated on that list, will be difficult for many of our members, who are not medical practitioners, to interpret and apply in practice. This is because the HHS list contains a list of 285 "Healthcare Common Procedure Coding System" (HCPCS) codes and 42 CFR 410.78 contains many Medicare-specific terms that are not easily understood by a non-medical layperson. Our members would like to better understand what types of services will be treated as qualifying telehealth or other remote care services, particularly for products and services that go beyond the enumerated HHS list of permitted services: For example, CPT codes that plans have covered as permitted telehealth under the prior HSA relief that are not on the HHS list.

It would be helpful if the IRS would issue specific guidelines with clear criteria that is not specific to Medicare to determine whether a service is a qualifying telehealth or other remote care service that aligns with Congress' intentions to ensure HSA-eligible

individuals can access meaningful benefits on a pre-deductible basis. Or, the IRS could clarify that employers and HSA accountholders may make determinations using a reasonable, good faith interpretation of the law and it will not take enforcement actions against employers and HSA accountholders that have no reason to believe particular services are not qualifying telehealth or remote care.

DIRECT PRIMARY CARE SERVICE ARRANGEMENTS

We applaud the inclusion of provisions in the OBBBA expanding the use of direct primary care service arrangements (DPCSAs) as a meaningful option for employees and employers. These are changes the Council has long supported and advocated for, as part of our members' emphasis on prioritizing primary care as a way to lower health care costs and improve health outcomes.[1] We also appreciate the IRS's efforts to clarify the OBBBA's DPCSA provisions.

For purposes of eligibility to contribute to an HSA, the OBBBA defines "direct primary care service arrangement" as an arrangement under which an individual is provided Code Section 213(d) medical care consisting solely of primary care services provided by primary care practitioners, if the sole compensation for such care is a fixed periodic fee. The OBBBA defines the term "primary care services" exclusively by what it does not include, however, which are procedures that require the use of general anesthesia, prescription drugs other than vaccines, and laboratory services not typically administered in an ambulatory primary care setting. Congress specifically directed Treasury to issue regulations or other guidance, after consultation with HHS, regarding this definition.

Additional, specifying guidance would be helpful to our members and their employees to aid in determining the scope of "primary care services." For example, does this term include all services provided by a primary care practitioner that are not procedures that require the use of general anesthesia, prescription drugs other than vaccines, or laboratory services not typically administered in an ambulatory primary care setting? Notice 2026-5 does not define the term other than to note that it is not defined by reference to the definition at SSA Section 1833(x)(2)(B), which specifies a list of HCPCS codes. We respectfully request the IRS consult with HHS and issue guidance specifying the types of services that are "primary care services" and that the guidance be clarifying and enabling, and not be limited to an exhaustive list. We request that the IRS issue this guidance as soon as possible, as the DPCSA provisions are already in effect. In the alternative, the IRS could clarify that employers and HSA accountholders may make determinations using a reasonable, good faith interpretation of the law.

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[1] American Benefits Council, *DESTINATION 2030: A Roadmap for the Future of Employee Benefits* (February 2025), *see* Recommendation M2

Relatedly, while we understand that both the OBBBA and Notice 2026-5 provide that "primary care services" do not include procedures that require the use of general anesthesia, prescription drugs other than vaccines, and laboratory services not typically administered in an ambulatory primary care setting, we encourage the IRS to provide additional clarifying and enabling guidance regarding what these exclusions mean. For instance, it is unclear what the term "laboratory services not typically administered in an ambulatory primary care setting" means because laboratory services can vary widely from primary care provider to primary care provider, depending on the individual's health status and the primary care provider's practice.

Additionally, we acknowledge and appreciate that the IRS provided guidance on whether a provider participating in a DPCSA can offer and separately bill certain health care items and services outside of the DPCSA to individuals. However, our members continue to have ongoing questions regarding the services provided at an employer's on-site clinic. We understand that, under Notice 2026-5, it may be possible for an employer to structure its on-site clinic so a portion of the clinic offering is a DPCSA, and the clinic provider could offer items and services outside of the arrangement to employees, regardless of DPCSA membership, as long as the providers bill separately. However, we would appreciate confirmation from the IRS that this is a permissible arrangement and note that illustrative examples catered to on-site clinics would be beneficial.

The IRS also stated that a DPCSA must be provided outside the high-deductible health plan (HDHP) to be provided pre-deductible. As noted in our October 2025 letter,[2] our view is that the OBBBA is not clear on this point and, from a policy standpoint, it should not matter whether the individual is covered by a DPCSA outside the HDHP or inside the HDHP. Either way, the coverage is the same. Requiring that a DPCSA be provided outside of the HDHP would introduce unnecessary administrative complexity and discourage broader employer adoption of DPCSAs, contrary to the intent of the statute. Accordingly, to ensure continued HSA eligibility for HDHP enrollees, we ask the IRS to reconsider this rule and adopt a rule similar to the telehealth rule and allow an HDHP to cover a qualifying DPCSA on a pre-deductible basis.

If, however, IRS retains the guidance in Notice 2026-5, we ask the IRS to further clarify what it means for a DPCSA to be provided outside of the HDHP. We recommend the IRS conclude that a DPCSA can be offered under the same ERISA plan as an HDHP while still being treated as outside the HDHP.

[2] American Benefits Council, "Request for Guidance Under the One Big Beautiful Bill Act" (October 30, 2025)

Furthermore, while, as we have expressed before, our members are very supportive of the DPCSA provision in the OBBBA and appreciate the IRS's work to implement it, we have also recently heard from several members that there is some tension with the monthly fee limitation, as there are types of DPCSAs employers would like to offer that would exceed that limit. In particular, we have heard about tensions with the limit because the cost of providing primary care services varies meaningfully based on geographic market, provider model, and scope of integrated care management services. Without additional flexibility, employers may be deterred from offering DPCSAs, which would undermine the OBBBA's objective of expanding access to primary care while preserving HSA eligibility.

We appreciate that there are limits to what the IRS can do in response to this issue, but we wanted to notify you of it, as we understand the Administration is supportive of this expansion, and so we respectfully request that you consider whether there is anything the IRS can do in guidance to provide additional flexibility with regard to the monthly fee limitation applicable to DPCSAs. For example, the IRS could clarify that certain separately identifiable administrative, care coordination, or technology access fees are not required to be aggregated with the DPCSA fee for purposes of applying the limit or could permit a reasonable de minimis variation above the limit (for example, by allowing reasonable geographic adjustments reflecting local market cost variation).

Finally, although the IRS provided some helpful initial guidance in Notice 2026-5, our members continue to have additional questions regarding DPCSAs. In particular, clarification would be helpful as to whether a DPCSA may provide services that are not Code Section 213(d) medical care, such as general wellness services. In addition, while we think it is clear that an employer may fully subsidize the cost of a qualifying DPCSA (within the monthly fee limitation) for employees enrolled in an HDHP (including through automatic enrollment mechanisms) we have received questions on this from our members, so guidance confirming the ability to auto-enroll employees would be helpful.

DEPENDENT CARE ASSISTANCE PROGRAMS

While we recognize the IRS did not address the OBBBA's provision on dependent care assistance programs (DCAPs) in Notice 2026-5, we believe it is important to address the issue so more of our members' employees can avail themselves of the increased exclusion limit under the OBBBA. We also understand the IRS may address DCAP nondiscrimination testing in the context of child savings accounts (or "Trump Accounts"), as the OBBBA and Notice 2025-68 provide that rules "similar to" rules under Code Section 129 apply to employer Trump Account contributions under Code Section 128.

For millions of Americans, childcare is unaffordable, and DCAPs can help bring down the cost for these families. This is why the Council has long supported increasing the tax excludable amount under DCAPs.[3] And, while we greatly appreciate that the OBBBA increased the tax-free benefits a DCAP may provide, we are concerned many employers may not be comfortable adopting the increased amount because doing so may increase the risk the DCAP will not pass the 55% average benefits nondiscrimination test under Code Section 129.

Under one interpretation of the test, a significant number of DCAPs currently may have trouble passing the test because many employees do not participate in the DCAP because they do not have eligible dependents. And, under this interpretation, all those employees would therefore be treated as having a $0 contribution. There are other reasonable interpretations of the test, however, such as to only count the contributions of those who elect to participate in the DCAP.

Some employers may be hesitant to adopt the increased limit due to this potential testing issue. We request guidance from the IRS that provides clarity on how to perform the test and to ensure the test does not unduly restrict a DCAP's benefits for employees who have eligible dependents. For example, the IRS could interpret the test to take into account only employees who have elected to participate in the DCAP. This would better capture Congress' intent to ensure the provision of expanded benefits for employees with eligible dependents. This will also align with Congress's intent in tying the Trump Account Code Section 128 nondiscrimination rules to the Code Section 129 nondiscrimination rules. We have provided further detail related to Trump Account contributions in our February 19 letter regarding Notice 2025-68.[4]

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Thank you for the opportunity to comment. We greatly appreciate your attention to these comments among the many other essential matters before you. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

Matt Muma
Senior Counsel, Health Policy

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[3] American Benefits Council, *DESTINATION 2030: A Roadmap for the Future of Employee Benefits* (February 2025), *see* Recommendation S1

[4] American Benefits Council, *Comments on Initial Trump Account Guidance (Notice 2025-68)* (February 19, 2026)