National Compliance Update
USI EMPLOYEE BENEFITS

December 11, 2025

Guidance on HSA Provisions in OBBBA

The Internal Revenue Service ("IRS") issued Notice 2026-5 ("the Notice"), providing the first guidance addressing the expansion of health savings accounts ("HSAs") under the One Big Beautiful Bill Act ("OBBBA").

Briefly, OBBBA provides that first-dollar coverage of telehealth and certain direct primary care arrangements will not preclude otherwise eligible individuals enrolled in a high-deductible health plan ("HDHP") from establishing and contributing to an HSA.[1]

Notice 2026-5 addresses these changes under OBBBA and provides helpful guidance in a frequently asked question ("FAQ") format. Briefly:

- *With respect to telehealth and other remote care services*, the guidance:
  - Refers to the list of telehealth services payable by Medicare to establish which items and services will be considered telehealth for purposes of HSA compatibility.
  - Confirms that certain in-person services, medical equipment, and prescription drugs furnished in connection with telehealth cannot be offered for free (or at a reduced cost) under this relief.
- *With respect to direct primary care arrangements*, the guidance:
  - Narrowly defines an HSA-compatible direct primary care arrangement, apparently limiting the relief to those arrangements where the sole compensation is the fixed periodic fee. Arrangements that bill separately for services or extend beyond primary care may not meet this definition.
  - Permits the fee to be billed for periods of more than one month, provided the aggregate fees are fixed, periodic, and do not exceed the monthly limit (on an annualized basis).
  - Describes how the cost for these arrangements may be reimbursable on a tax-favored basis through an HSA.

[1] See USI's EB Compliance Update, One Big Beautiful Bill Act Signed into Law (July 10, 2025).

In addition, the Notice addresses the expanded definition of an HDHP to include certain bronze level and catastrophic plans that are available in the individual market.

The IRS is also requesting comments on all aspects of this guidance. Comments should be submitted on or before March 5, 2026. Instructions for submitting comments are included in the Notice.

The following provides a high-level summary of the guidance and additional details.

TELEHEALTH AND OTHER REMOTE CARE SERVICES

Background

Generally, telehealth or other remote care services provided for free (or at a reduced cost) before the minimum deductible in an HDHP[2] is satisfied is disqualifying coverage for purposes of contributing to an HSA. A temporary safe harbor permitted first dollar coverage for telehealth and other remote care services, but it expired for plan years beginning on or after January 1, 2025.[3]

However, effective July 4, 2025, OBBBA made the safe harbor permanent and retroactive to plan years beginning on or after January 1, 2025.

While the temporary relief was in effect, the IRS provided limited implementation guidance. However, as the safe harbor is now permanent, the IRS is taking this opportunity to provide some helpful clarification.

> ***USI Note***. The relief is optional; employers are not required to offer free or reduced cost telehealth or other remote care services as part of an HDHP's plan design.

FAQs

The FAQs confirm:

- An otherwise eligible individual may contribute to an HSA for 2025 if, before OBBBA was enacted, the individual was enrolled in a health plan that provided coverage for telehealth or other remote care services before the minimum deductible is satisfied.
- The IRS will treat as telehealth, and other remote care services, benefits that are included on the list of telehealth services payable by Medicare that is published annually by the Department of Health and Human Services ("HHS"). For a list of these services see List of Telehealth Services | CMS.[4]
- In-person services, medical equipment, and drugs furnished in connection with a telehealth or other remote care service may not be offered before the minimum deductible is met unless they would otherwise be treated as telehealth (as described above).

  > ***USI Note***. This is an important clarification. Telehealth that also provides free (or reduced cost) in-person follow-up care, medical equipment, or prescription drugs does

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[2] For calendar year 2026, the minimum deductible for an HDHP is $1,700 for self-only coverage and $3,400 for family coverage. The maximum out-of-pocket is $8,500 for self-only coverage and $17,000 for family coverage (other than bronze or catastrophic plans).

[3] During the COVID-19 pandemic, the federal government enacted a series of laws to encourage the use of telehealth and other remote care services and extended the relief several times.

[4] For services that are not included on the HHS list, taxpayers should apply the principles of section 1834(m) of the Social Security Administration ("SSA"), its implementing regulations at 42 CFR 410.78, and other guidance issued by HHS defining "telehealth services" and related terms.

not meet this definition. Some vendors may have relied on the lack of guidance to treat more benefits as telehealth than what is provided for under the Notice.

DIRECT PRIMARY CARE ARRANGEMENTS

Background

Typically, a direct primary care arrangement charges a fixed periodic fee and provides for an array of primary care services and items, such as physical examinations, vaccinations, urgent care, laboratory testing, and the diagnosis and treatment of some sicknesses and injuries.

Before OBBBA, this type of arrangement would be disqualifying coverage for purposes of contributing to an HSA because it provides coverage for non-preventive care services before the minimum HDHP deductible is satisfied.

However, beginning January 1, 2026, certain direct primary care service arrangements ("DPCSAs") will not be considered disqualifying coverage. For this purpose, a DPCSA means an arrangement where the individual is:

- provided medical care consisting solely of *primary care services* provided by *primary care practitioners;* and
- the sole compensation for the care is a fixed periodic fee.

A DPCSA does not include any arrangement if the aggregate fees for all DPCSAs for the individual for a month exceed $150/month (or $300 for any arrangement that covers more than one individual).

For this purpose:

- A *primary care practitioner* means an individual who is a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine, or who is a nurse practitioner, clinical nurse specialist, or physician assistant.[5]
- Primary care services do not include:
  - procedures that require the use of general anesthesia;
  - prescription drugs other than vaccines (therefore, vaccines are permitted primary care services); and
  - laboratory services not typically administered in an ambulatory primary care setting.

USI Note. Nothing requires an employer to offer a DPCSA.

In addition, expenses for coverage under any DPCSA are reimbursable on a tax-favored basis through an HSA.[6]

[5] Primary care practitioners, as defined in section 1833(x)(2)(A) of the SSA, determined without regard to clause (ii) thereof.
[6] While not addressed in this Notice, it does not appear that DPC fees may be reimbursed through other tax-favored accounts like a health reimbursement arrangement ("HRA") or health flexible spending account ("health FSA").

FAQs

DPCSA permitted coverage

- The sole compensation for care provided under the DPCSA must be the fixed periodic fee. A DPCSA does not include an arrangement that provides certain healthcare items and services to individuals on the condition that they are members in the arrangement and have paid a fixed periodic fee, but bills separately for those items and services (through insurance or otherwise).
- A DPCSA may include an arrangement that has fees that are billed for periods of more than a month, but no more than a year, provided the aggregate fees are fixed, periodic, and do not exceed the monthly limit (on an annualized basis).
  - Example: For 2026, the fee for a single individual could be $1,800 for a year; $900 for six months; or $450 for three months.[7]
- Whether an arrangement qualifies as a DPCSA depends on the terms of the arrangement and not the services used by the individual.
  - For example, a DPCSA does not include an arrangement that provides services other than permitted primary care but allows the individual to decline to use those services.
- The HDHP may not offer a benefit that consists of paying fees for, or providing membership in, a DPCSA without a deductible (or before the deductible is satisfied).
- Amounts paid by the individual in fees for membership in the DPCSA may not count toward the annual HDHP deductible or out-of-pocket maximum.

DPCSA fees as an eligible HSA expense

- DPCSA fees paid by an employer are not expenses of the HSA beneficiary that may be reimbursed on a tax-favored basis by the HSA.
- HSAs may treat an expense for a DPCSA as incurred on (1) the first day of each month of coverage on a pro-rata basis, (2) the first day of the coverage period, or (3) the date the fees are paid.
  - Example: An HSA may immediately reimburse a substantiated fee for a DPCSA that begins on January 1 of that enrollment year, even if the enrolled individuals paid the fee prior to the first day of the enrollment year.
- There is no specific limit on the amount of the fixed periodic fee for tax-free reimbursement of otherwise eligible DPCSA fees. Therefore, fees for a DPCSA that do not satisfy the monthly dollar limit ($150/$300) will be treated as a medical expense reimbursable through an HSA. However, such coverage will disqualify the covered individual from making HSA contributions when the individual is enrolled in a DPCSA that has a fixed periodic fee that is more than the $150/$300 monthly limit.

[7] $1,800 ($150 x 12 months); $900 ($150 x 6 months); $450 ($150 x 3 months).

BRONZE LEVEL PLANS AND CATASTROPHIC COVERAGE

The guidance also addresses the amended definition of an HDHP to include bronze level plans[8] and catastrophic coverage[9] in the individual market. While this portion of the guidance pertains to the individual coverage market, there are a few items that employers should be aware of:

- A bronze or catastrophic plan that is available as individual coverage will not fail to be an HDHP because an employer-sponsored individual coverage health reimbursement arrangement ("ICHRA") is used to purchase the coverage. However, an ICHRA is permitted to reimburse only premiums in order for the individual to remain HSA-eligible.
- A bronze plan or catastrophic plan purchased off-Exchange on the individual market will be treated as an HDHP if the same plan is available as individual coverage through an Exchange.
- Bronze plans offered as a Small Business Health Options Program ("SHOP") will not be treated as an HDHP as the coverage is not individual coverage. However, such a plan could still be an HDHP if it otherwise satisfies the applicable requirements.

EMPLOYER NEXT STEPS

The Notice reflects the first guidance on the expansion of HSA-compatible coverage under OBBBA. The IRS may issue future guidance on this topic, particularly in response to comments received by stakeholders in response to publication of this Notice.

Employers considering enhanced telehealth or DPCSA solutions with HDHP/HSA plans should carefully review this Notice and discuss compliance with applicable vendors. The following should be specifically addressed:

Telehealth

- Ensure benefits offered in the telehealth program are consistent with those that are included on the list of telehealth services payable by Medicare.
- Review any services provided by the telehealth provider that may go beyond what is permitted, such as offering free or reduced cost in-person services, medical equipment, and drugs. This will likely cause the individual to lose eligibility to make HSA contributions before the minimum deductible is satisfied.
- Discuss with telehealth vendors whether their program satisfies the requirements outlined in the Notice.

DPCSA

- Ensure the DPCSA meets the requirements outlined in the Notice, including the periodic fee limits.

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[8] Section 1302(d)(1)(A) of the ACA describes a bronze level plan, which is required to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan. https://www.healthcare.gov/glossary/bronze-health-plan/

[9] Section 1302(e) of the ACA describes a catastrophic plan, which is a health plan solely offered in the individual market that does not provide bronze or higher levels of coverage and that generally provides essential health benefits only after an individual has incurred the maximum cost sharing (other than mandated preventive care). In addition, enrollment is restricted to individuals under age 30 or individuals who do not have access to affordable coverage or are otherwise experiencing a hardship with respect to the ability to obtain a qualified health plan. https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans/

- Be aware that offering services more than primary care will pose problems for HSA eligibility, even if the individual can waive the non-primary care services.
- Discuss with direct primary care vendors whether their program satisfies the requirements outlined in the Notice.

RESOURCE

- IRS Notice 2026-5, Expanded Availability of Health Savings Accounts under the One, Big, Beautiful Bill Act (OBBBA)

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