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IRS Notice 2026-5: Key HSA Eligibility Updates Under OBBA

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Issued date: 12/19/25

On December 9, 2025, the IRS issued Notice 2026-5 (Notice), providing guidance on Health Savings Account (HSA) changes introduced by the One Big Beautiful Bill Act (OBBA). The IRS is seeking comments on all aspects of this Notice with comments due by March 6, 2026.

HSA Eligibility Generally

Section 223 of the Internal Revenue Code allows eligible individuals to establish HSAs. To qualify, an individual must:

- Be covered under a high-deductible health plan (HDHP).
- Have no disqualifying coverage (coverage that provides cost-sharing before meeting HDHP minimums).

HDHPs must meet minimum deductible and maximum out-of-pocket limits set by the IRS, though preventive care and certain other coverage can be disregarded without affecting HSA eligibility. OBBA expanded these rules to increase access to HSAs, and the Notice addresses these changes, specifically on telehealth services, bronze and catastrophic plans, and direct primary care service arrangements (DPCSA).

Telehealth and Remote Services

Telehealth, or other remote care services, provided for free, or at a reduced cost, before satisfying the minimum deductible in an HDHP are generally disqualifying coverage. OBBA made a permanent safe harbor that permits first dollar coverage for telehealth and other remote care services. The guidance addresses telehealth services that can be reimbursed by an HDHP without affecting HSA eligibility. Services that are reimbursed by the plan are qualified if the services appear in the Health and Human Services annual Medicare telehealth payable list. The list is updated annually. It should be noted that this relief is optional for employers and are not required to offer free or reduced telehealth services.

The Notice also confirms that 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 services in accordance with the Medicare payable list.

Individual Bronze and Catastrophic Plans

Effective January 1, 2026, bronze and catastrophic plans will be treated as HDHPs if available as individual coverage through an ACA Marketplace, whether they meet standard HDHP deductible minimums or out-of-pocket limits or not. This also applies to off-Marketplace plans that are identical to Marketplace versions. However, if an individual has no reason to believe that a plan is not offered on the Marketplace and is enrolling in off-Marketplace coverage, they can still enroll in the plan and be eligible for an HSA.

For employers:

- ICHRAs can be used to purchase coverage without affecting HDHP status. However, it is important to note that reimbursements should be limited to either premiums or post-deductible expenses in order for the individual to retain HSA eligibility.

- Bronze plans offered through SHOP do not qualify under this provision. Thus, employer sponsored plans must continue to comply with HDHP requirements.

Direct Primary Care Service Arrangements

DPCSAs charge a fixed fee and provide 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 OBBA, 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.

The Notice confirms much of what was already in OBBA but provides some additional insights. It reiterates that DPCSAs will not be treated as health plans if they meet strict criteria: primary care services only provided by primary care practitioners, a fixed periodic fee not exceeding the statutory annual limit ($1,800 self-only / $3,600 family for 2026) and there is no separate billing for any items and services provided to the participant.

It also clarifies that for billing purposes, the arrangement can be made for periods more than a month, but the fee must be a fixed amount that does not exceed the annual limit. The following examples were provided for a single individual:

- Option 1: One $1,800 payment for the year

- Option 2: $900 for six months (two payments during the year)

- Option 3: $450 for three months (quarterly payments).

With respect to paying for the fee, the Notice permits reimbursement on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the fees are paid. The HDHP may not pay for the fee without a deductible or before the deductible has been satisfied and the fees paid by the individual for the DPCSA do not count toward the annual HDHP deductible or out-of-pocket maximum.

Finally, fees paid through a Section 125 plan or employer-paid fees cannot be reimbursed by the HSA. And, if fees are higher than the annual limit, the individual will be ineligible to contribute to the HSA, but the fee remains reimbursable.

Employer Action

Employers interested in implementing telehealth or DPCSA solutions with HDHP/HSA plans, or those that already have these in place, should review the guidance and discuss with applicable carriers, TPAs, and vendors to ensure compliance.

Consider the following action items in response to this Notice:

- Review telehealth services that may go beyond what is permitted, to not cause a loss of eligibility.
- Assess DPCAs offered to employees to ensure fees and services meet IRS criteria, including the periodic fee limits.
- Be aware that offering services more than primary care will create problems for HSA eligibility, even if the individual can waive the non-primary care services.
- Update plan communications to explain to employees how these arrangements might affect HSA eligibility.
- SHOP Employers: be prepared to answer questions from employees on whether their bronze plan can be paired with an HSA, if offering SHOP coverage.
- Stay tuned for additional guidance!