Part III - Administrative, Procedural, and Miscellaneous

Expanded Availability of Health Savings Accounts under the One, Big, Beautiful Bill Act (OBBBA)

Notice 2026-5

I. PURPOSE

This notice provides guidance on changes relating to health savings accounts (HSAs) enacted by Pub. L. 119-21, 139 Stat. 72 (July 4, 2025), commonly known as the One, Big, Beautiful Bill Act (OBBBA). These changes generally expand the availability of HSAs under section 223 of the Internal Revenue Code (the Code). This notice provides answers to common questions related to these changes.

II. BACKGROUND

A. Section 223 in general

Section 223 of the Code permits eligible individuals to establish an HSA. HSAs are accounts that can receive tax-favored contributions by or on behalf of eligible individuals. Amounts in an HSA may be used on a tax-free basis to pay or reimburse medical expenses. Among the requirements to qualify as an eligible individual under section 223(c)(1) is that the individual be covered under a high deductible health plan (HDHP) and have no disqualifying health coverage. As defined in section 223(c)(2), an HDHP is a health plan that satisfies certain requirements, including requirements with respect to minimum deductibles and maximum out-of-pocket expenses. Only eligible

individuals under section 223(c)(1) are allowed to make contributions to an HSA or to receive contributions from an employer to their HSA.

Generally, under section 223(c)(2)(A), an HDHP is not permitted to provide benefits for any year until the minimum annual deductible for that year is satisfied and is not permitted to require a payment of an annual deductible plus other annual out-of-pocket expenses (other than premiums) above the out-of-pocket maximum for the year. However, section 223(c)(2)(C) provides a safe harbor for the absence of a deductible for preventive care. Under section 223(c)(2)(C), "[a] plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1861 of the Social Security Act (SSA), except as otherwise provided by the Secretary)."

The statutory minimum annual deductible and out-of-pocket maximum are adjusted annually for inflation. The minimum annual deductible for 2025 is $1,650 for self-only coverage and $3,300 for family coverage, and the out-of-pocket maximum for 2025 is $8,300 for self-only coverage and $16,600 for family coverage.[1]

B. OBBBA changes to section 223

1. Telehealth and Other Remote Care Services.

Section 71306 of the OBBBA makes permanent a safe harbor for the absence of a deductible for telehealth and other remote care services that was initially enacted on a

[1] For calendar year 2026, the annual deduction limit for contributions to HSAs under section 223(b)(2)(A) for an individual with self-only coverage is $4,400 and $8,750 for family coverage. For calendar year 2026, an HDHP is defined under section 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,700 for self-only coverage and $3,400 for family coverage, and for which the annual out-of-pocket expenses (excluding premiums) do not exceed $8,500 for self-only coverage and $17,000 for family coverage (other than bronze and catastrophic plans). Rev. Proc. 2025-19, 2025-18 IRB 1430.

temporary basis as part of the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. 116-136, 134 Stat. 281 (Mar. 27, 2020) (CARES Act). The CARES Act provision was effective March 27, 2020, and applied for plan years beginning on or before December 31, 2021. Subsequent legislation extended the application through taxable years beginning before January 1, 2025. The OBBBA permanent extension applies retroactively for plan years beginning after December 31, 2024.

2. Bronze and Catastrophic Plans Treated as HDHPs

Section 71307 of the OBBBA amended section 223(c)(2) of the Code to provide that the term "high deductible health plan" includes any plan described in subsection (d)(1)(A) or (e) of section 1302 of the Patient Protection and Affordable Care Act (ACA) that is available as individual coverage through an Exchange.

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. 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 under section 1302(c)(1) of the ACA (other than required preventive health care and coverage for at least three primary care visits). In addition, to be a catastrophic plan, enrollment must be restricted to individuals who have not attained the age of 30 before the beginning of the plan year or individuals who are exempt from the requirements of section 5000A because they do not have access to

affordable coverage or are otherwise experiencing a hardship with respect to the capability to obtain coverage under a qualified health plan (QHP).

Before the OBBBA was enacted, many bronze plans did not qualify as HDHPs because the plans' out-of-pocket maximum exceeded the statutory limits for HDHPs or because they provided benefits that were not preventive care without a deductible. Similarly, catastrophic plans could not be HDHPs because they were required to provide three primary care visits before the minimum deductible was satisfied and to have an out-of-pocket maximum that exceeded the statutory limits for HDHPs.

This provision amending the definition of an HDHP applies for months beginning after December 31, 2025.

3. Direct Primary Care Service Arrangements

An individual who is covered under an HDHP is eligible to contribute to an HSA, provided that the individual is not covered under any disqualifying coverage while the individual is covered under the HDHP. An HSA may be used to pay for medical care under section 213(d) of the Code; however, an HSA generally may not be used to pay for insurance, with certain exceptions.

The Treasury Department and the Internal Revenue Service (IRS) understand that direct primary care service arrangements (DPCSAs) typically charge a fixed periodic fee and provide 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. For the purposes of eligibility to contribute to an HSA, this type of DPCSA generally would constitute a health plan that provides coverage before the minimum annual deductible is satisfied and that is not

disregarded coverage or preventive care. Therefore, prior to the effective date of section 223(c)(1)(E) (as added by OBBBA), an individual generally was not eligible to contribute to an HSA if the individual was enrolled in a DPCSA.

Section 71308(a) of the OBBBA amended section 223(c)(1) of the Code to provide that a DPCSA as defined in section 223(c)(1)(E)(ii) is not “treated as a health plan for purposes of [section 223(c)(1)](A)(ii)”, which generally limits eligible individuals to individuals who are enrolled in an HDHP and are not covered under any other health plan. Thus, enrollment in such a DPCSA will not cause an individual to fail to be an eligible individual for that reason. For purposes of this rule, the term "direct primary care service arrangement" means, with respect to any individual, an arrangement under which such individual is provided medical care (as defined in section 213(d)) consisting solely of primary care services provided by primary care practitioners (as defined in section 1833(x)(2)(A) of the SSA, determined without regard to clause (ii) thereof), if the sole compensation for such care is a fixed periodic fee. “Primary care practitioner” is defined in section 1833(x)(2)(A) of the SSA to mean 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. For purposes of section 223(c)(1)(E) of the Code, the term “primary care services” does not include (1) procedures that require the use of general anesthesia, (2) prescription drugs other than vaccines (therefore, vaccines are permitted primary care services), and (3) laboratory services not typically administered in an ambulatory primary care setting.

The term "direct primary care service arrangement" does not include any arrangement if, with respect to an individual for a month, the aggregate fees for all DPCSAs for the individual for a month exceed $150 (or $300 for any such arrangement that covers more than one individual). The aggregate limit is adjusted annually for inflation for taxable years after 2026.

Section 71308 of the OBBBA also amended section 223(d)(2)(C) of the Code to provide that any expense for coverage under “any direct primary care service arrangement” is not subject to the general restriction that prohibits an HSA from being used to pay for insurance.

The provision relating to DPCSAs applies to months beginning after December 31, 2025.

III. QUESTIONS AND ANSWERS

A. Telehealth and Remote Care Services

Q-1. May an otherwise eligible individual contribute to an HSA for 2025 if, before the OBBBA was enacted on July 4, 2025, the individual was enrolled in a health plan that provided coverage for telehealth or other remote care services before the minimum deductible was satisfied, but the health plan otherwise satisfied the requirements to be treated as an HDHP?

A-1. Yes, an otherwise eligible individual may contribute to an HSA for 2025 if, before the OBBBA was enacted on July 4, 2025, the individual was enrolled in a health plan that provided coverage for telehealth or other remote care services before the minimum deductible was satisfied, if the health plan otherwise satisfied the

requirements to be treated as an HDHP. This is true regardless of whether the contribution is made before or after July 4, 2025.

Q-2. Which benefits will the IRS treat as telehealth and other remote care services that may be offered by an HDHP without a deductible?

A-2. A plan will not fail to be an HDHP solely because it offers telehealth benefits without a deductible for a service that is included on the list of telehealth services payable by Medicare that is published annually by the Department of Health and Human Services (HHS) under section 1834(m)(4)(F) of the SSA.[2] For services that are not included on the HHS list, taxpayers should apply the principles of section 1834(m) of the SSA, its implementing regulations at 42 CFR 410.78, and other guidance issued by HHS defining "telehealth services" and related terms.

Q-3. If in-person services, medical equipment, or drugs are furnished in connection with a telehealth or other remote care service, may they be provided by an HDHP without a deductible under section 223(c)(2)(E) of the Code?

A-3. No, telehealth or other remote care services do not extend to in-person services, medical equipment, or drugs furnished in connection with those services unless they would otherwise be treated as telehealth services under guidance provided in Q&A-2.

B. Bronze and Catastrophic Plans Treated as HDHPs

[2] See https://www.cms.gov/medicare/coverage/telehealth/list-services; see 90 Fed. Reg. 49266, 49317 (Nov. 5, 2025), https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other#p-573.

Q-4. Will a bronze or catastrophic plan that does not satisfy the minimum annual deductible requirement or maximum out-of-pocket expenses requirement under section 223(c)(2)(A)(i) and (ii) be treated as an HDHP?

A-4. Yes, for months beginning after December 31, 2025, a bronze or catastrophic plan will be treated as an HDHP if the plan is available as individual coverage through an Exchange established under section 1311 or 1321 of the ACA even if the plan does not satisfy the minimum annual deductible requirement or maximum out-of-pocket expenses requirement for an HDHP under section 223(c)(2)(A)(i) and (ii) of the Code.

Q-5. Will a bronze or catastrophic plan that is available as individual coverage fail to be treated as an HDHP because an employer-sponsored health reimbursement arrangement (HRA) such as an individual coverage HRA (ICHRA) or a qualified small employer HRA is used to purchase the coverage?

A-5. No, a bronze or catastrophic plan that is available as individual coverage will not fail to be an HDHP because an employer-sponsored ICHRA is used to purchase the coverage.[3] However, generally, an HRA (including an ICHRA) is permitted to reimburse only premiums for the HRA to be a health plan that would not disqualify an employee from being an eligible individual. See Notice 2008-59, 2008-29 IRB 123, Q&A-1.

Q-6. Will a bronze plan or catastrophic plan purchased off-Exchange on the individual market be treated as an HDHP if the same plan is available as individual coverage through an Exchange?

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[3] See 29 CFR 2510.3-1(l) (establishing safe harbor conditions for when an employer payment of premiums for individual health insurance will not cause the individual health insurance coverage to become group health insurance coverage or coverage offered in connection with a group health plan under the Employee Retirement Income Security Act of 1974, Public Law 93-406, 88 Stat. 829, as amended).

A-6. Yes. 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. This includes plans sold exclusively off-Exchange without a cost-sharing reduction load that are otherwise identical to plans sold on-Exchange with a cost sharing reduction load.[4]

Q-7. If the individual enrolls in a bronze or catastrophic plan that is available as individual coverage on the individual market but not on an Exchange, and the individual has no reason to believe the coverage is not available on an Exchange, may the individual contribute to an HSA?

A-7. Yes. In the interest of sound tax administration, because the ability of an individual to determine whether a particular plan is available on an Exchange is limited, the IRS will treat an individual as an eligible individual if the individual enrolls in a bronze or catastrophic plan that is available as individual coverage on the individual market but not on an Exchange, and the individual has no reason to believe that the bronze or catastrophic plan is not available on an Exchange.

Q-8. Will bronze plans offered as Small Business Health Options Program (SHOP) coverage be treated as HDHPs?

A-8. Generally, no. SHOP coverage that may be offered by a small employer is not individual coverage and therefore does not meet the criteria to be treated as an HDHP under section 223(c)(2)(H). However, such a plan can still be an HDHP if it otherwise satisfies the applicable requirements, including the minimum annual

[4] See https://www.cms.gov/files/document/offering-exchange-only-plans-without-csr-loading.pdf.

deductible requirement and maximum out-of-pocket expenses requirement under sections 223(c)(2)(A)(i) and (ii). Note, however, that an employer-sponsored ICHRA may be used to purchase a bronze plan or catastrophic plan that is available as individual coverage. See Q&A-5.

Q-9. If a bronze plan available as individual coverage on an Exchange provides benefits that are greater than the actuarial equivalent to 60 percent of the full actuarial value of the benefits provided under the plan, may it be treated as an HDHP?

A-9. Yes. Bronze plans described under section 1302(d)(1)(A) of the ACA (that is, a plan providing a level of coverage that is designed to provide benefits that are actuarially equivalent of 60 percent of the full actuarial value of the benefits that are provided under the plan) are treated as HDHPs under section 223(c)(2)(H) of the Code. However, compliance with other provisions of the ACA may affect the real actuarial value of a bronze plan. The Treasury Department and the IRS have consulted with HHS and are aware that some bronze plan variants may have an actuarial value that exceeds 60 percent because of factors such as the de minimis variance provided for under section 1302(d)(3) of the ACA or cost-sharing reductions offered to American Indians and Alaska Natives under section 1402(d) of the ACA. These plans are still considered bronze plans under section 1302(d)(1)(A) of the ACA by HHS and are treated as HDHPs under section 223(c)(2)(H) of the Code.

Q-10. An individual generally is not an eligible individual who may contribute to an HSA if the individual has received medical services at an Indian Health Services (IHS) facility at any time during the previous three months. See Notice 2012-14, 2012-8 IRB 41. Does Notice 2012-14 apply to individuals who receive medical services at an

IHS facility and enroll in a bronze plan variant with cost-sharing reductions offered to American Indians and Alaska Natives under section 1402(d) of the ACA, which may have special coverage requirements related to IHS facilities?

A-10. No. Notice 2012-14 does not apply to individuals who receive medical services at an IHS facility and enroll in a bronze plan variant with cost-sharing reductions offered to American Indians and Alaska Natives under section 1402(d) of the ACA. Thus, such individuals may be eligible individuals even if they have received medical services at an IHS facility during the previous three months.

C. Direct Primary Care Service Arrangements

DPCSA not treated as a health plan

Q-11. Does a DPCSA under section 223(c)(1)(E) of the Code 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-11. No, the sole compensation for care provided under a DPCSA must be the fixed periodic fee. Thus, a DPCSA under section 223(c)(1)(E) 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).

Q-12. Does a DPCSA under section 223(c)(1)(E) of the Code include an arrangement in which providers participating in the arrangement, which otherwise qualifies as a DPCSA, offer certain healthcare items and services outside of the arrangement to individuals regardless of membership in the arrangement and

separately bill both members and non-members for those items and services (through insurance or otherwise)?

A-12. Yes.

Q-13. May a DPCSA under section 223(c)(1)(E) include an arrangement that has fees that are billed for periods of more than a month but no more than a year?

A-13. Yes, a DPCSA under section 223(c)(1)(E) 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). For 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.

Q-14. If an arrangement provides services other than the primary care services described in section 223(c)(1)(E), may an individual who is a member in the arrangement decline to use such services and treat the arrangement as a DPCSA under section 223(c)(1)(E)?

A-14. No. Whether an arrangement qualifies as a DPCSA under section 223(c)(1)(E) depends on the terms of the arrangement, not the services used by an individual.

Q-15. May an HDHP offer primary care benefits other than those allowed under section 223(c)(2)(C)-(G) (for example, telehealth and preventive care) by paying fees for, or providing membership in, a DPCSA without a deductible or before the minimum deductible has been satisfied?

A-15. No. Certain DPCSAs are not treated as a health plan for purposes of section 223(c)(1)(A)(ii), which generally defines eligible individuals who may contribute

to an HSA as individuals who are enrolled in an HDHP and are not covered under any other health plan. However, section 223 does not provide that an HDHP may offer a benefit that consists of paying fees for, or providing membership in, a DPCSA without a deductible or before the deductible has been satisfied.[5]

Q-16. If an individual is enrolled in both a DPCSA and an HDHP, may the HDHP count fees paid by the individual for the individual's membership in the DPCSA toward the annual deductible and out-of-pocket maximum for the HDHP?

A-16. No. In this situation, the fees for membership in a DPCSA paid by the individual would not be amounts paid out-of-pocket for items and services that are covered by the HDHP and therefore would not count toward the minimum annual deductible and out-of-pocket maximum for the HDHP.

Q-17. Section 223(c)(1)(E) defines "primary care practitioners" by reference to section 1833(x)(2)(A) of the SSA. Does section 223(c)(1)(E) of the Code define "primary care services" by reference to the services identified by the Health Care Procedure Coding System (HCPCS) codes under section 1833(x)(2)(B) of the SSA?

A-17. No. Although section 223(c)(1)(E)(ii)(I) of the Code defines "primary care practitioners" by reference to section 1833(x)(2)(A) of the SSA, it does not define "primary care services" by reference to the definition at section 1833(x)(2)(B) of the SSA. In addition, section 223(c)(1)(E)(iii) of the Code specifically excludes from "primary care services" (1) procedures that require the use of general anesthesia, (2) prescription

[5] Bronze plans are treated as HDHPs under section 223 regardless of which services they cover before the deductible. It is the Treasury Department's and IRS's understanding that ACA section 1301(a)(3) allows QHPs to provide coverage through a direct primary care medical home plan. Nothing in this notice is intended to provide any interpretive guidance with respect to ACA section 1301(a)(3).

drugs other than vaccines, and (3) laboratory services not typically administered in an ambulatory primary care setting.

HSA distributions for the reimbursement of fees for a DPCSA

Q-18. Are DPCSA fees treated as amounts paid for qualified medical expenses under section 223(d)(2) that may be reimbursed by an HSA if they were paid by an individual's employer, including by salary reduction through a section 125 cafeteria plan?

A-18. No. These payments by the employer are not expenses of the HSA beneficiary. The payments are compensation excluded from employees' gross income under section 106.

Q-19. May DPCSA fees be reimbursed from an HSA before the coverage period for the arrangement?

A-19. Generally, yes. An HSA is permitted to 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 period of coverage, or (3) the date the fees are paid. Thus, for 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.

Q-20. What requirements must an arrangement meet in order to qualify as a DPCSA whose fees are treated as amounts paid for qualified medical expenses under section 223(d)(2) that may be reimbursed by an HSA?

A-20. For purposes of section 223(d)(2), a DPCSA is an arrangement under which an individual is provided medical care (as defined in section 213(d)) consisting

solely of primary care services provided by primary care practitioners (as defined in section 1833(x)(2)(A) of the SSA, determined without regard to clause (ii) thereof), if the sole compensation for such care is a fixed periodic fee, and such care does not include (1) procedures that require the use of general anesthesia, (2) prescription drugs other than vaccines, or (3) laboratory services not typically administered in an ambulatory primary care setting. For purposes of section 223(d)(2), there is no specific limit on the amount of the fixed periodic fee as there is for purposes of determining whether a DPCSA is a health plan under section 223(c)(1)(E). Thus, fees for a DPCSA that do not satisfy the monthly dollar limit in section 223(c)(1)(E)(ii)(II) will be treated as medical expenses reimbursable from an HSA in accordance with section 223(d)(2)(C)(v) but will disqualify the covered individual from eligibility for making HSA contributions while the individual is enrolled.

IV. REQUEST FOR COMMENTS

The Treasury Department and the IRS request comments on all aspects of this notice. Written comments should be submitted on or before March 6, 2026. Consideration will be given, however, to any written comment submitted after that date, if such consideration will not delay the issuance of guidance. The subject line for the comments should include a reference to Notice 2026-5. Comments may be submitted electronically via the Federal eRulemaking Portal at *https://www.regulations.gov* (type IRS-2025-0335 in the search field on the regulations.gov homepage to find this notice and submit comments). Alternatively, comments may be submitted by mail to: Internal Revenue Service, CC:PA:01:PR (Notice 2026-5), Room 5503, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. All commenters are strongly encouraged to

submit comments electronically. The Treasury Department and the IRS will publish for public availability any comment submitted electronically, or on paper, to the IRS's public docket on *https://www.regulations.gov*.

V. EFFECT ON OTHER DOCUMENTS

Notice 2012-14 is modified with respect to the guidance regarding eligibility to contribute to an HSA within three months of receiving medical care from the Indian Health Services.

VI. DRAFTING INFORMATION

The principal author of this notice is Alexander Krupnick of the Office of Associate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes), though other Treasury Department and IRS officials participated in its development. For further information on the provisions of this notice, contact Mr. Krupnick at (202) 317-5500 (not a toll-free number).