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OBBBA Changes to Health Savings Accounts

Cross References

- Notice 2026-5

The IRS recently issued guidance on changes relating to health savings accounts (HSAs) made by the One Big Beautiful Bill Act (OBBBA) signed into law on July 4, 2025. IRC section 223 allows individuals to establish HSAs that can receive tax-favored contributions to pay or reimburse medical expenses on a tax-free basis. To qualify, eligible individuals must be covered under a high deductible health plan (HDHP) and have no disqualifying health coverage. In general, an HDHP is not permitted to provide benefits until the minimum annual deductible for that year is satisfied. There is a limit to the minimum annual deductible and annual out-of-pocket expenses (other than premiums). There is an exception to the minimum annual deductible rule for certain preventive care (meaning the plan can cover the cost of preventive care before the annual deductible is met).

OBBBA made the following changes to HSAs.

Telehealth and other remote care services. 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 temporary basis as part of the Coronavirus Aid, Relief, and Economic Security Act (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 tax years beginning before January 1, 2025. The OBBBA permanent extension applies retroactively for plan years beginning after December 31, 2024.

Bronze and catastrophic plans treated as HDHPs. OBBBA law changes provide that the term "high deductible health plan" includes any plan described in section 1302 of the Patient Protection and Affordable Care Act (ACA) that is available as individual coverage through an Exchange. Section 1302 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 also 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 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 minimum essential coverage requirements 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 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.

These OBBBA changes that amend the definition of an HDHP applies for months beginning after December 31, 2025.

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, however, an HSA generally may not be used to pay for insurance, with certain exceptions.

The IRS understands 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 enactment of OBBBA, an individual generally was not eligible to contribute to an HSA if the individual was enrolled in a DPCSA.

OBBBA provides that a DPCSA as defined in IRC section 223(c)(1)(E)(ii) is not treated as a health plan for purposes of IRC 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 consisting solely of primary care services provided by primary care practitioners if the sole compensation for such care is a fixed periodic fee. "Primary care practitioner" is defined 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. 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.

OBBBA also amended IRC section 223(d)(2)(C) 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.

Q&As. Notice 2026-5 provides for a number of questions and answers as guidance to illustrate the changes made by OBBBA.