

## OBBBA UPDATES FOR TELEHEALTH, HDHPS AND DIRECT PRIMARY CARE

Written By Alston & Bird LLP Health Benefits Practice

**T**he One Big Beautiful Bill Act (OBBBA), enacted July 4, 2025, made big changes related to health savings accounts (HSAs), including permanent telehealth relief for high-deductible health plans (“HDHPs”) and an expansion to the HSA compatibility rules for direct primary care and bronze/catastrophic plan coverage. The IRS published Notice 2026-5 in December 2025 (the “Notice”), which offered interpretative guidance and helpful clarification but still left some questions unanswered. In this update to our prior coverage on the OBBBA, we walk through the questions that were answered and some that remain.

### TELEHEALTH AND OTHER REMOTE CARE SERVICES

The OBBBA permanently allows high-deductible health plans (HDHPs) to provide telehealth and other remote care services before the deductible is met. This rule applies whether the telehealth benefit is offered through the HDHP or outside the HDHP, and it applies retroactively to plan years beginning after December 31, 2024. The Notice confirms that individuals who otherwise qualified for HSA contributions did not lose eligibility in 2025 merely because their plan covered telehealth services on a predeductible basis earlier in the year (assuming the plan otherwise satisfied the HDHP requirements). [Notice Section III.A.Q/A-1] deductible basis earlier in the year (assuming the plan otherwise satisfied the HDHP requirements). [Notice Section III.A.Q/A-1]

## WHAT ARE "TELEHEALTH AND OTHER REMOTE CARE SERVICES"?

Although the telehealth exception is now permanent, the IRS has not adopted a formal definition of "telehealth and other remote care." Instead, the IRS points plan sponsors to the Medicare telehealth services list as a practical benchmark. If a service appears on that list (published annually and available through this page), offering it on a predeductible basis will not, by itself, cause a plan to lose HDHP status. For services that do not appear on the Medicare list, the IRS directs plans to rely on Medicare telehealth rules and related federal guidance issued by HHS. [Notice Section III.A.Q/A-2] deductible basis will not, by itself, cause a plan to lose HDHP status. For services that do not appear on the Medicare list, the IRS directs plans to rely on Medicare telehealth rules and related federal guidance issued by HHS. [Notice Section III.A.Q/A-2]

While the Medicare list provides helpful guidance, it uses service codes and brief descriptions that may not be easy for the average plan sponsor to interpret with confidence. This can make it challenging for plan sponsors to assess whether newer or nontraditional virtual services fall within the exception. As a practical matter, plan sponsors should confirm with telehealth vendors whether covered services align with Medicare-listed telehealth services, particularly where offerings

extend beyond standard virtual visits. Ask your telehealth partner to confirm which covered services match the Medicare list and flag any "nontraditional" offerings for review. traditional virtual services fall within the exception. As a practical matter, plan sponsors should confirm with telehealth vendors whether covered services align with Medicare-listed telehealth services, particularly where offerings extend beyond standard virtual visits. Ask your telehealth partner to confirm which covered services match the Medicare list and flag any "nontraditional" offerings for review.

## IN-PERSON SERVICES, EQUIPMENT, AND DRUGS

The statute also refers to "other remote care," a term that raised questions about how far the telehealth exception might extend. In particular, plan sponsors questioned whether the exception could apply to items such as medical equipment or prescription drugs associated with or prescribed in connection with telehealth services. The IRS makes clear that it does not. The telehealth exception does not extend to in-person services, medical equipment, or prescription drugs furnished in connection with telehealth (unless those items independently qualify under existing telehealth guidance). [Notice Section III.A.Q/A-3] person services, medical equipment, or prescription

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## BRONZE AND CATASTROPHIC PLANS AS INDIVIDUAL COVERAGE

As of January 1, 2026, bronze and catastrophic Exchange plans available as individual coverage now qualify as HSA-compatible HDHPs. This is true regardless of whether the minimum annual deductible requirement or maximum out-of-pocket expenses satisfy standard HDHP thresholds. [Notice Section III.B.Q/A-4]

HDHP treatment is also extended to:





- Any off-exchange bronze or catastrophic coverage on the individual market that is identical to the Exchange plans. [Notice Section III.B.Q/A-6]
- Any bronze or catastrophic coverage purchased off-Exchange on the individual market, even if the bronze or catastrophic plan is not available on the Exchange, as long as the enrollee has no reason to believe the same plan is not available on an Exchange. The Notice makes this allowance “in the interest of sound tax administration” and, as a practical matter, because consumers can’t always verify Exchange equivalence with certainty. [Notice Section III.B.Q/A-7]



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## ICHRAS AND BRONZE OR CATASTROPHIC PLANS

Employer-sponsored individual coverage health reimbursement arrangements (“ICHRAs”) can reimburse premiums for these individual plans without harming HSA eligibility. However, if the ICHRA reimburses more than the bronze or catastrophic plan premium on a pre-deductible basis, the employee could lose eligibility to contribute to an HSA. The Notice references prior HRA guidance to clarify that HRAs in general (which includes ICHRAs) must only reimburse premiums so as to avoid disqualifying an employee from being an eligible individual for HSA purposes. [Notice Section III.B.Q/A-5, referencing Notice 2008-59, 2008-29 IRB 123, Q&A-1]

## ACTUARIAL VALUE FOR SOME BRONZE PLANS

When the OBBBA allowed bronze plans to be treated as HDHPs for purposes of HSA compatibility, it did so by reference to a specific provision in the Affordable Care Act (“ACA”) that defines bronze level plans as providing benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan (ACA § 1302(d)(1)(A)). Some bronze variants run a bit richer than 60% actuarial value due to other ACA rules. The IRS and HHS are aware of this and have confirmed that these plans are still considered bronze plans for purposes of HDHP treatment. [Notice Section III.B.Q/A-9]



## SHOP PLANS

SHOP plans—plans offered by small employers as Small Business Health Options Program (“SHOP”) coverage—that are also bronze plans will not be treated as an HDHP under the OBBBA. SHOP coverage is not individual coverage and, consequently, must satisfy the traditional HDHP requirements in order to be compatible with an HSA, including the minimum annual deductible requirement and maximum out-of-pocket expenses requirement. [Notice Section III.B.Q/A-8]

## SERVICES RECEIVED AT IHS FACILITIES MAY NOT DISQUALIFY OTHERWISE ELIGIBLE INDIVIDUALS

As explained in earlier guidance from 2014, some individuals are disqualified from contributing to an HSA because the individual has received medical services at an Indian Health Services (IHS) facility during the previous three months. [See Notice 2012-14] This prior guidance 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 § 1402(d) of the ACA, which may have special coverage requirements related to IHS facilities. Consequently, these individuals may be eligible to make HSA contributions even if they received medical services at an IHS facility during the previous three months. [Notice Section III.B.Q/A-10]

## DIRECT PRIMARY CARE ARRANGEMENTS

The OBBBA lets direct primary care service arrangements (DPCSA) exist alongside an HDHP without destroying HSA eligibility, even though DPCSA services are “pre deductible” within the DPCSA itself. DPCSA that meet certain requirements (referred to in this article as a “compatible DPCSA”) will not disqualify an individual from contributing to an HSA. Compatible DPCSA must provide medical care consisting solely of primary care services delivered by primary care practitioners, and the sole compensation for such care is limited to a fixed periodic fee of no more than \$150/month for individuals, \$300/month for families. Fees for a compatible DPCSA will qualify as an eligible expenditure for HSA purposes. deductible” within the DPCSA itself. DPCSA that meet certain requirements (referred to in this article as a “compatible DPCSA”) will not disqualify an individual from contributing to an HSA. Compatible DPCAs must provide medical care consisting solely of primary care services delivered by primary care practitioners, and the sole compensation for such care is limited to a fixed periodic fee of no more than \$150/month for individuals, \$300/month for families. Fees for a compatible DPCSA will qualify as an eligible expenditure for HSA purposes.

This arrangement raised a number of questions, including whether a DPCSA could be funded by an employer on a pre-tax basis (or by an employee through a 125 plan), whether annual payment could be prorated, whether the DPCSA could be integrated into the employer’s HDHP, and what constitutes “primary care services.” The Notice provides helpful guidance for each of these, though some questions remain on the scope of primary care services.

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## DPCAS AND THE EMPLOYER'S HDHP

Generally, a DPCSA cannot be integrated into the employer's HDHP. The Notice includes a number of Q/As that, when taken together, make such an arrangement impractical:

- Generally, a DPCSA cannot be offered through the HDHP to offer pre-deductible primary care benefits. Because the standard HDHP limitations for pre-deductible services still apply (e.g., preventive care and now telehealth), and to the extent the DPCSA offers pre-deductible benefits outside of current permitted pre-deductible services, the benefits would violate the HDHP rules. The Notice implies that an HDHP could offer the DPCSA membership benefits for a DPCSA that offers only primary care benefits that are also permitted as pre-deductible coverage under the standard rules, or after the HDHP deductible has been satisfied, but, in practice, such an arrangement would raise administrative difficulties. [Notice Section III.C.Q/A-15]
- If an employee enrolled in an HDHP is a DPCSA member, the DPCSA membership fee may not count toward the HDHP's minimum annual deductible or out-of-pocket expense. [Notice Section III.C.Q/A-16]
- The fixed periodic fee is the only compensation allowed under a compatible DPCSA for the primary care services. An arrangement will not qualify as a compatible DPCSA if the participant is billed separately for the primary care services (through insurance or otherwise) in addition to the fixed periodic fee. [Notice Section III.C.Q/A-11]
- Notably, DPCSA fees cannot be reimbursed by an HSA if the fees were paid by the employer, including by salary reduction through a section 125 cafeteria plan. [Notice Section III.C.Q/A-18]

An employer can, however, pay that DPCSA membership fee for a DPCSA that is outside of the HDHP. As long as the DPCSA is outside of the HDHP, an employer can subsidize a DPCSA and treat the amount of the subsidy as compensation excludable from the employee's gross income under Code § 106. The HDHP is still subject to the standard limitations with respect to pre-deductible coverage. As the Notice makes clear, an HDHP cannot 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." [Notice Section III.C.Q/A-15 and 18]



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Also notable is that even though an arrangement will not qualify as a compatible DPCSA if the participant is billed separately for the primary care services (through insurance or otherwise) in addition to the fixed periodic fee, a provider can still separately offer healthcare items and services outside of the DPCSA, as long as membership in the DPCSA is not required to receive those separate offerings. Providers participating in a compatible DPCSA can offer healthcare items and services outside of the arrangement to individuals (regardless of whether they are DPCSA members) and separately bill individuals for those items and services (through insurance or otherwise). [Notice Section III.C.Q/A-12]

## DPCSA FEES CAN BE PRORATED

DPCSA fees can cover more than one month, but no more than one year, so long as the annualized amount does not exceed the monthly limit. The example given in the Notice is a fee for a single individual, which could be \$1,800 per year, \$900 for six months, or \$450 per quarter, each of which does not exceed \$150 per month. [Notice Section III.C.Q/A-13]

DPCSA fees can be prorated, and they can even be reimbursed from an HSA before the coverage period for the arrangement. An HSA can reimburse a substantiated fee for compatible DPCSA coverage that begins on January 1 prior to the date coverage begins. 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. [Notice Section III.C.Q/A-19]

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## WHAT ARE "PRIMARY CARE SERVICES"?

An arrangement that meets the OBBBA's definition of a DPCSA will not be treated as a health plan for purposes of disqualifying an individual from contributing to an HSA. One of the requirements is that an arrangement must be restricted solely to primary care services. The OBBBA did not provide a definition for "primary care services" but did state that such services had to be provided by a primary care practitioner as defined in the Social Security Act ("SSA"). The Notice clarifies that this reference to the SSA did not import the definition of "primary care services" identified in the SSA. Instead of providing additional guidance for the definition of "primary care services," the Notice just reinforces the OBBBA's specific exclusion of the following:

- (1) procedures that require the use of general anesthesia,
- (2) prescription drugs other than vaccines, and
- (3) laboratory services not typically administered in an ambulatory primary care setting. [Notice Section III.C.Q/A-17]

Individuals will need to examine the terms of the DPCSA carefully to ensure that it doesn't offer any disqualifying coverage. If an arrangement offers services that are not primary care services, such as anesthesia, the arrangement cannot be treated as a DPCSA. This is true even if an individual does not use the disqualifying services. An individual cannot simply decline such services and still treat the arrangement as a compatible DPCSA. The actual terms of the arrangement are controlling for determining the arrangement's compatibility with an HSA. [Notice Section III.C.Q/A-14]

## CAN AN HSA REIMBURSE FEES THAT ARE NOT COMPATIBLE DPCSAS?

An individual can still use their HSA to reimburse fees for a direct primary care service arrangement that would otherwise be a compatible DPCSA, but for the fixed periodic fee exceeding the statutory maximum. The limit on the fixed periodic fee applies for purposes of determining whether the arrangement is a health plan that would disqualify an individual from making an HSA contribution. If the fees for an arrangement exceed the maximum, but the arrangement otherwise meets all of the requirements for a compatible



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DPCSA, the fees may be reimbursed from an HSA as qualified medical care. However, because the non-compatible DPCSA would be considered a health plan, the individual would be ineligible to contribute to an HSA, but the individual could still use their HSA dollars to pay the fees. [III.C.Q/A-20]

## KEY TAKEAWAYS

The IRS guidance helps resolve a number of OBBB-related questions related to the compatibility of telehealth, bronze and catastrophic coverage, and direct primary care. Nonetheless, as noted herein, many questions still remain. ■

### *About the Authors*

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