

Law and Policy Group

**GRIST**

# IRS addresses HSA-compatible telehealth, primary care, bronze plans

*By Cheryl Hughes and Jennifer Wiseman  
Dec. 22, 2025*

## In this article

[Telehealth relief for HDHPs](#) | [HSA-compatible DPCSA](#)s | [Bronze and catastrophic plans as HDHPs](#) | [Next steps](#) | [Related resources](#)

In [Notice 2026-5](#), IRS and the Treasury Department provide key details about health savings account (HSA) enhancements passed as part of the One Big Beautiful Bill Act (OBBBA) ([Pub. L. No. 119-21](#)), clearing the way for employers to continue offering telehealth and to begin offering direct primary care service arrangements (DPCSA)s to otherwise HSA-eligible employees.

Effective for the 2025 plan year, OBBBA reinstated and made permanent COVID-19-era telehealth relief allowing HSA-compatible high-deductible health plans (HDHPs) to cover telehealth and other remote care services before the statutory minimum deductible is satisfied. Beginning Jan. 1, 2026, OBBBA also allows individuals enrolled in DPCSA)s to remain eligible to make or receive HSA contributions and treats certain bronze and catastrophic plans as HDHPs.

This article summarizes the Notice 2026-5 question-and-answer guidance, addressing significant topics such as which services the IRS will treat as “telehealth and other remote care services;” whether a DPCSA can separately bill for primary care services or offer services beyond primary care; and whether a bronze or catastrophic plan can be an HDHP if purchased using an employer-sponsored individual coverage health reimbursement account (ICHRA). Comments about the guidance are due March 6, 2026.

## Telehealth relief for HDHPs

An individual must have HDHP coverage to make or receive HSA contributions. Among the applicable statutory requirements, an HDHP generally can’t pay for covered benefits other than preventive care before the statutory HDHP minimum annual deductible is met (\$1,700 for self-only and \$3,400 for family coverage in 2026). OBBBA allows HDHPs to cover telehealth and other remote care services on a pre-deductible or no-deductible basis, similar to preventive care. Additionally, OBBBA permits HSA-eligible

individuals to receive this coverage from standalone vendors outside the HDHP without jeopardizing their eligibility to make or receive HSA contributions.

This telehealth relief was initially established by the 2020 Coronavirus Aid, Relief and Economic Security (CARES) Act for plan years through Dec. 31, 2021, was renewed in the 2022 Consolidated Appropriations Act (CAA) for April 1 through Dec. 31, 2022, and extended by the 2023 CAA for plan years starting after Dec. 31, 2022, and before Jan. 1, 2025. The COVID-era telehealth relief expired on Dec. 31, 2024, for calendar year plans. When OBBBA was enacted on July 4, 2025, the relief was permanently and retroactively reinstated for plan years beginning after Dec. 31, 2024.

## Guidelines for “telehealth and other remote care services”

Neither OBBBA, nor earlier iterations of the telehealth relief, define “telehealth and other remote care services.” The guidance does not provide an exhaustive list of all telehealth services that an HDHP may cover on a pre-deductible basis. Instead, the guidance provides a safe harbor for items and services that Medicare includes on its annual telehealth services list, with some flexibility for telehealth services not on the list. The guidance generally excludes certain items or services from “telehealth and other remote care services” that might be ancillary to a telehealth visit (such as prescription drugs), with some notable exceptions.

### Safe harbor based on Medicare’s telehealth services list

The guidance states that a plan will not fail to be an HDHP solely by offering pre-deductible telehealth benefits for a service included on [Medicare’s telehealth services list](#), essentially creating a safe harbor for listed services.

Medicare’s telehealth services list classifies services by Current Procedural Terminology (CPT) code, with more than 250 CPT codes currently listed. Based on HHS’s [telehealth best practice guides](#), CPT codes for many types of telehealth care employers commonly cover are on the list, such as [primary care](#), [chronic conditions](#) (with a separate guide listing additional codes for telehealth services for [diabetes](#)) and [behavioral health care](#) (with a specific guide for [substance use disorder](#)). It may be challenging for employers to confirm whether particular telehealth services are on the list — both because mapping a plan’s covered telehealth services to CPT codes requires specialized expertise, and because Medicare’s list is subject to annual revision. Employers should ask their vendors whether they intend to administer their benefits program to satisfy the safe harbor (i.e., covering pre-deductible telehealth services only for CPT codes on the Medicare telehealth services list).

Medicare has other restrictions on telehealth reimbursement, such as restrictions based on provider type or the patient’s location. Presumably, such restrictions are not relevant to whether the safe harbor applies, but confirmation from the regulators would be helpful.

Importantly, an HDHP is not limited to covering telehealth services on Medicare’s list on a pre-deductible basis. IRS Notice 2026-5 offers flexibility for an HDHP to remain HSA-qualified even if it covers telehealth beyond the safe harbor, subject to a determination process based on “principles” from the Medicare statute (specifically [42 USC 1395m](#)), its implementing [regulation](#) and other HHS guidance

defining “telehealth services” and related terms. Clarification from the regulators on how a plan sponsor would conduct such an analysis to ensure that their HDHP remains HSA-qualified would be helpful.

### Ancillary services furnished in connection with a telehealth visit

IRS Notice 2026-5 clarifies that “telehealth and other remote care services” that are allowed on a pre-deductible basis in an HDHP generally does not extend to in-person services, medical equipment or drugs furnished in connection with a telehealth visit. However, the Q&As state that such ancillary services *could* be covered by an HDHP before the statutory minimum deductible is met if they appear on the Medicare telehealth services list (or for services not on the list, if coverage is warranted under the “principles” described above). Because this appears to be a broad exception to the general rule, examples from regulators of when to permit ancillary services to be covered before the HDHP deductible is met would be helpful (i.e., when is an ancillary in-person service allowed to be covered pre-deductible under an HDHP because it is on the Medicare telehealth services list or is warranted under applicable principles). In the meantime, consult with legal counsel to determine whether a particular service ancillary to telehealth is within the scope of “telehealth and other remote care services.”

### Preventive care safe harbor

An HDHP has always been permitted to cover preventive care expenses before the statutory minimum deductible is satisfied. Over the years, IRS has refined the definition of preventive care that an HDHP may provide pre-deductible in IRS Notices [2004-23](#), [2004-50](#), [2018-12](#) and [2024-75](#) — even expanding that definition to certain chronic conditions in IRS Notice [2019-45](#). Additionally, IRS confirmed in [Notice 2013-57](#) that pre-deductible preventive care allowed in an HDHP includes any such care required free of cost sharing under the Affordable Care Act (ACA). Some services related to a telehealth visit that don’t qualify as “telehealth and other remote care services” may be covered on a pre- or no-deductible basis under the longstanding safe harbor for preventive care.

*Example:* For calendar year 2026, Ellen elects self-only coverage under an HDHP sponsored by her employer. The deductible for the plan is set at the annual minimum statutory deductible — \$1,700. Ellen has a telehealth visit with her doctor on Jan. 5, 2026, and the doctor renews her insulin prescription. Although Ellen has not satisfied the plan’s \$1,700 deductible as of Jan. 5, 2026, OBBBA telehealth relief permits the HDHP to cover the telehealth visit without jeopardizing Ellen’s ability to make or receive HSA contributions. The insulin prescribed at her telehealth visit probably wouldn’t qualify as “telehealth and other remote care services” according to Notice 2026-5, but Q-5 in IRS Notice [2024-75](#) permits an HDHP to cover insulin products and devices used to administer insulin on a pre-deductible basis. Ellen will need to review her coverage terms to see if her HDHP pays for telehealth and/or preventive services pre-deductible.

Some services related to a telehealth visit may be preventive services under the ACA — in which case a nongrandfathered group health plan would be *required* to provide first-dollar, in-network coverage.

*Example:* Marvin is covered by his employer’s nongrandfathered HDHP. During a telehealth visit, Marvin is prescribed a statin for the prevention of cardiovascular disease. Although Notice 2026-5 doesn’t permit a drug prescribed during a telehealth visit to be covered pre-deductible as part of

“telehealth and other remote care services,” the ACA *requires* that Marvin’s plan cover the statin without cost sharing (provided that Marvin meets certain clinical criteria). That coverage will not cause the plan to fail to be an HDHP.

## Retroactivity of telehealth relief for HDHPs

Some HDHPs may have continued to cover telehealth and other remote care services on a pre-deductible basis in early 2025, anticipating that Congress would reinstate the lapsed telehealth relief. Notice 2026-5 clarifies that an otherwise eligible individual enrolled in such an HDHP could contribute to an HSA during 2025. Most decisions about whether an HDHP should cover pre-deductible telehealth services retroactively to Jan. 1, 2025, were likely made long before IRS Notice 2026-5 was issued, but employers whose HDHPs covered pre-deductible telehealth services prior to OBBBA’s enactment on July 4, 2026, will find this confirmation helpful.

## HSA-compatible DPCSAs

Starting next year, participating in a DPCSA won’t jeopardize an otherwise HSA-eligible individual’s ability to make or receive HSA contributions. Additionally, any DPCSA fees paid by an individual can be reimbursed tax free from an HSA as medical expenses. Employers can provide coverage under a DPCSA to employees tax free (including through pretax salary reductions under a cafeteria plan), but the HDHP apparently can’t offer a DPCSA to participants. These new provisions were added by OBBBA, explained further by IRS in Notice 2026-5 and are discussed in more detail below.

## Background on direct primary care

In recent years, direct primary care has become increasingly popular. Typically, a direct primary care arrangement charges a fixed periodic fee for a variety of primary care services and items, like physical exams, vaccines, urgent care, lab work and the diagnosis and treatment of some sicknesses and injuries. Concierge care, which involves paying a fee for improved access to a provider, while submitting claims for medical care to insurance or a group health plan, has also grown in popularity.

Yet coverage under these arrangements raised compliance issues for employers offering HDHPs, as a participant in an HDHP can’t contribute to an HSA if they also have disqualifying coverage. IRS could view direct primary care arrangements as a health plan that provides coverage that is neither expressly permitted nor within the [preventive care safe harbor](#) before the HDHP’s minimum deductible is satisfied. As a result, any participant in a direct primary care arrangement may have been ineligible to contribute to an HSA through the end of 2025.

Separately, HSA accountholders have questioned whether their HSA could be used to pay the fees for a direct primary care arrangement, as HSAs can reimburse or pay for qualified medical expenses under section 213(d) of the Internal Revenue Code (IRC) but generally not for insurance premiums.

## DPCSA changes in OBBBA

OBBBA changed the law so that a DPCSA meeting certain requirements is not considered a health plan that would make someone ineligible to contribute to an HSA. Recent guidance explains those requirements and describes when an HSA can be used to pay or reimburse the periodic fee for a DPCSA and other related expenses.

### What is a “direct primary care service arrangement”?

OBBBA defines a DPCSA as an arrangement for medical care that involves:

- Primary care services only
- Providers who are exclusively “primary care practitioners”
- Compensation for care that is limited to a fixed periodic fee

*Primary care services.* OBBBA does not explicitly define what constitutes primary care services. Instead, the law requires that a DPCSA’s services be provided solely by primary care practitioners and prohibits DPCSAs from offering certain services. Services that cannot be offered are:

- Procedures requiring general anesthesia
- Prescription drugs (other than vaccines)
- Lab services not typically administered in an ambulatory primary care setting

Notice 2026-5 does not propose a definition of primary care services beyond what OBBBA provides (and specifically rejects looking to the Social Security Act for a definition). The agencies include as background information examples of services that they understand to be typically covered, including physical exams, vaccinations, urgent care, lab testing and the diagnosis and treatment of some sicknesses and injuries, but the list appears to be illustrative only.

*Primary care practitioner.* A “primary care practitioner” as defined by section 1833(x)(2)(A) of the [Social Security Act](#) (without regard to clause (ii)) includes:

- Physicians with a primary specialty designation of family medicine, internal medicine, geriatric medicine or pediatric medicine
- Nurse practitioners, clinical nurse specialists or physicians’ assistants

*Periodic fees.* The aggregate fees for a DPCSA cannot exceed \$150 per month per individual member (\$300 for coverage with more than one individual, which appears to allow for dependent coverage). These amounts will be indexed for inflation in future years. Notice 2026-5 clarifies that the periodic fees can be 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 the year, \$900 for six months or \$450 for three months.

If a direct primary care arrangement's fees exceed the statutory limits (as indexed), the arrangement disqualifies a covered individual from making or receiving HSA contributions, but the covered individual's fees could be reimbursed from an HSA on a tax-free basis, as discussed below.

Notice 2026-5 also offers some important clarifications about concierge care and services ancillary to primary care:

- *Concierge care.* A DPCSA doesn't include concierge care, where members pay a periodic access fee but the provider bills separately for healthcare items and services, whether through insurance or otherwise.

*Example:* Employees of Company A like to use a popular provider for their healthcare needs. The provider has luxury offices and provides same day visits and special email access to those who pay an annual fee of \$1,000 and then bills the employees' health plan for services and items provided at office visits. Under the recent guidance, this type of organization is not a DPCSA.

- *Ancillary items and services.* A DPCSA can offer ancillary healthcare items and services outside of primary care services to individuals regardless of membership in the DPCSA and separately bill both members and nonmembers for those items and services, whether through insurance or otherwise. Nonprimary care items and services must be provided outside of the DPCSA; an individual can't simply decline to use such services within a direct primary care arrangement.

*Example:* Company B pays the periodic fee for a direct primary care arrangement for its employees in a certain region. It is also open to the public. Patients (either employee members or the general public) may purchase certain prescription medications (e.g., antibiotics) and durable medical equipment (e.g., crutches) from the provider. Assuming other requirements are met, this arrangement does not fail to be a DPCSA because it offers ancillary healthcare items.

*Example:* Company B provides the direct primary care arrangement described in the example above but also provides access to a massage therapist who is paid for services outside of the primary care arrangement by employees as well as the public. Assuming other requirements are met, this arrangement does not fail to be a DPCSA because it offers ancillary healthcare services.

## Can an HDHP offer a DPCSA?

Notice 2026-5 precludes an HDHP from paying the fees or providing membership in a DPCSA without a deductible or before its statutory minimum deductible has been satisfied. Similarly, the fees paid for membership in a DPCSA can't count toward an HDHP's statutory minimum deductible and out-of-pocket maximum. An HDHP may, however, cover *some* primary care services on a pre-deductible basis — but is limited to items and services within the preventive services safe harbor or the definition of "telehealth and other remote care services."

## When can an HSA reimburse fees for a DPCSA?

OBBBA allows fees for a DPCSA to be reimbursed from an HSA on a tax-free basis beginning in 2026. Notice 2026-5 provides additional details, explaining that an HSA:

- Can't reimburse DPCSA fees when paid by the employer, including pre-tax salary reductions through a cafeteria plan. (Those payments are excluded from the employee's gross income under IRC section 106.)
- Can reimburse fees when paid by the individual.
- Can reimburse DPCSA fees incurred before the coverage period begins. An HSA is permitted to treat a DPCSA expense as incurred on the:
  - First day of each month of coverage on a pro rata basis
  - First day of the coverage period, or
  - Date the fees are paid

*Example:* Ellen submits a reimbursement request for a DPCSA that began on Jan. 1, even though she paid the fee prior to the first day of the year. The HSA may immediately reimburse that fee. Ellen should retain proper substantiation for the reimbursement.

## Open issues for DPCSAs

*Federal compliance issues.* OBBBA amends the IRC so that a DPCSA is not treated as a health plan for purposes of HSA requirements, which generally disqualify otherwise HSA-eligible individuals who are covered by any health plan other than an HDHP. Notice 2026-5 clarifies that DPCSA fees are compensation excluded from employees' gross income under IRC section 106 (as employer-provided coverage under an accident or health plan when the employer pays those fees, including by salary reduction through a cafeteria plan).

But neither OBBBA nor Notice 2026-5 answer whether a DPCSA offered (or paid for) by an employer is a "group health plan" or an "excepted benefit" for purposes of ERISA, other IRC provisions and the Public Health Services Act. Group health plans are subject to a variety of other federal compliance obligations; and certain exceptions apply to some (but not all) laws for excepted benefits. If the DPCSA is a component of another ERISA plan (e.g., a wraparound ERISA plan), that plan may be able to satisfy federal requirements for the DPCSA as well. If a DPCSA is offered on a stand-alone basis to all employees regardless of whether they are enrolled in another health plan of the employer, compliance may be even more challenging.

Examples of federal requirements for group health plans that could apply to DPCSAs include:

- ACA benefit mandates

- ACA employer-shared responsibility and reporting
- COBRA
- ERISA
- Genetic Information Nondiscrimination Act (GINA), Titles I and II
- HIPAA nondiscrimination and special enrollment rights
- HIPAA privacy and security
- Medicare notice of creditable or noncreditable coverage
- Medicare secondary payer rules
- Mental Health Parity and Addiction Equity Act
- Michelle's Law
- Patient-Centered Outcomes Research Institute (PCORI) fees
- Surprise billing ban
- Transparency requirements

Additional guidance from regulators would be helpful to resolve these DPCSA compliance issues. In the meantime, employers considering offering or paying for a DPCSA should review these issues with counsel.

*Health reimbursement arrangements and flexible spending accounts.* Health reimbursement arrangements (HRAs) and health flexible spending arrangements (FSAs) can only reimburse qualified medical expenses as defined by IRC section 213(d) (with certain exceptions). Notably, OBBBA doesn't amend IRC section 213(d), so whether DPCSA fees can be reimbursed from an HRA or health FSA will require a separate analysis.

In 2020, IRS [proposed rules](#) under IRC section 213(d) about when expenses for direct primary care arrangements are qualified medical expenses, but the proposal was not finalized. Hopefully, those rules will be updated and finalized to provide guidance for health FSAs and HRAs. The preamble to the proposal states: “[D]epending on the specific facts regarding an arrangement, a payment for a direct primary care arrangement may be a payment for medical care under section 213(d)(1)(A) or may be a payment for medical insurance under section 213(d)(1)(D). Regardless of the characterization of an arrangement as medical care under section 213(d)(1)(A) or medical insurance under section 213(d)(1)(D), an amount paid for the arrangement will qualify as a medical expense under section 213.”

*On-site and near-site clinics.* Additionally, certain on-site or near-site clinics offered by employers might meet the DPCSA requirements and thus be HSA-compatible. Unless or until guidance is issued, we recommend that clients consult with counsel on questions related to employer involvement with a DPCSA, including any potential impact of [IRS Notice 2008-59, Q&A-10](#). This guidance states that to avoid ineligibility for an HSA, an employer's on-site clinic can only provide insignificant benefits in the nature of medical care.

## Bronze and catastrophic plans as HDHPs

Starting in 2026, under a provision of OBBBA, individual bronze and catastrophic insurance policies sold on the ACA marketplace are HDHPs. As a result, enrollees in such plans — provided that they don't have other disqualifying coverage — would be eligible to make or receive HSA contributions. The White House Council of Economic Advisers [estimates](#) that this change will result in an additional 7.25 million individuals becoming HSA-eligible.

Notice 2026-5 explains the scope of this OBBBA provision. Most significantly for employers, the notice confirms that an employer-sponsored ICHRA can reimburse premiums for bronze or catastrophic plans.

## Background on bronze and catastrophic plans

Bronze plans are one of four metal levels of qualified health plans (QHPs) offered on the ACA marketplace. All metal levels — bronze, silver, gold or platinum — must cover essential health benefits, but each metal level differs by actuarial value (i.e., the cost sharing in each metal level differs). A bronze plan, which has a 60% actuarial value, has the highest cost sharing of the four metal levels sold on the ACA marketplace.

[Catastrophic plans](#) are also individual insurance policies available on the ACA marketplace, but they can only be sold to individuals who are younger than 30 or who have a hardship exemption. Catastrophic plans have lower premiums and higher cost sharing than a QHP. Catastrophic plans must cover essential health benefits, but coverage kicks in only after the annual deductible — which is the same as the catastrophic plan's out-of-pocket maximum — is satisfied (in 2026, \$10,600 for individual coverage or \$21,200 for family coverage). Only ACA preventive care services that must be provided free of cost sharing and coverage for at least three primary care visits are covered before the deductible is met. In September 2025, the Trump administration [relaxed](#) the hardship exemption process, making catastrophic plans available to those who are ineligible for federal subsidies to purchase ACA marketplace coverage.

Before OBBBA, catastrophic plans could not satisfy the HDHP standards because they cover three pre-deductible primary care visits and because their deductible exceeds the statutory out-of-pocket maximum for HDHPs (for 2026, \$8,500 for individual or \$17,000 for family HDHP coverage). A bronze plan might qualify as an HDHP, but many did not qualify (for example, bronze plans that covered benefits other than preventive care (e.g., urgent care) before the statutory HDHP minimum deductible is met).

## After OBBBA, bronze and catastrophic plans can be HDHPs — even those purchased with an employer-sponsored ICHRA

Notice 2026-5 clarifies that starting in 2026 individual bronze and catastrophic insurance plans can be HDHPs, even if they don't satisfy the HDHP statutory requirements. For example, a bronze or catastrophic plan that pays benefits before the minimum statutory deductible (for 2026, \$1,700 for self-only and \$3,400 for family coverage) is satisfied or has an out-of-pocket maximum in excess of the annual limit (for 2026, \$8,500 for self-only and \$17,000 for family) would still be an HDHP. IRS Notice 2026-5 also expands the definition of HDHP to include individual bronze and catastrophic policies purchased outside of the ACA marketplace (provided that the same plan is available on the ACA marketplace).

**ICHRAs.** The guidance clarifies that use of an employer-sponsored ICHRA to purchase an individual bronze or catastrophic plan will not result in the loss of HDHP status for the bronze or catastrophic plan. The guidance notes that an ICHRA that reimburses *only* insurance premiums would not disqualify an individual from making or receiving HSA contributions. By contrast, an ICHRA that also reimburses any pre-deductible medical expenses (beyond excepted benefits such as vision and dental expenses) would be HSA-disqualifying coverage.

## Next steps

OBBBA eases the path to allow greater access to telehealth and DPCsAs to otherwise HSA-eligible employees, and Notice 2026-5 fills in some of the key implementation details. Employers should consider whether to take advantage of these HSA enhancements. Additionally, the guidance about bronze and catastrophic plans should be considered by any employer implementing an ICHRA strategy.

## Telehealth relief

- Consider adopting provisions to allow an HSA-qualifying HDHP to cover telehealth and other remote care services on a pre- or no-deductible basis. Analyze whether such coverage will improve provider access and health outcomes in a cost-effective manner.
- Ensure that any new or existing HDHP coverage of telehealth and other remote care services on a pre- or no-deductible basis complies with IRS Notice 2026-5.
  - Confirm with vendor that its pre-deductible telehealth coverage is either limited to services listed on the annual Medicare telehealth service list or that the vendor has analyzed any service not listed as instructed by the guidance. Review the vendor's response with legal counsel to confirm compliance.
  - Confirm with legal counsel that any in-person visits, medical equipment or drugs provided in connection with a telehealth visit are not covered by an HDHP before the statutory minimum deductible is satisfied, unless the ancillary item or service can be considered within the scope of "telehealth and other remote care services" or preventive care under existing IRS guidance. (This

can but does not have to be an ACA preventive service that must be covered without cost sharing by any nongrandfathered group health plan.)

- Update plan documents and communications as necessary.
  - Ensure that the Summary Plan Description accurately describes the telehealth services and items that are (or are not) covered by an HDHP before the minimum statutory deductible is satisfied.
  - Make any required revisions to the Summary of Benefits and Coverage (such as the information about services covered before the deductible is met).
- Watch for changes in the annual Medicare telehealth services list that might impact plan design or confirm that a vendor will be responsible for monitoring changes to Medicare's list.

## **DPCSA**s

- Review any existing direct primary care arrangement offered by the employer for compliance with Notice 2026-5.
- Analyze whether it would make sense to convert a current on-site clinic to a DPCSA (potentially with ancillary healthcare items and services).
- If not already doing so, consider whether to offer a DPCSA to employees. Employers can provide coverage under a DPCSA to employees tax-free (including through pre-tax salary deductions under a cafeteria plan). A separate arrangement would be required to provide pre-deductible access while preserving HSA eligibility. An HDHP itself apparently can't offer a pre-deductible DPCSA to participants.
- Monitor the evolution of vendor solutions. Many vendors with features that don't comport with the guidance may offer new solutions.
- Review with counsel how a DPCSA offered through the employer would comply with the various federal compliance requirements. Confirm that vendors can provide required support.
- Work with counsel to update plan documents and communications as necessary.
- Look for additional guidance on whether a DPCSA is a group health plan and/or an excepted benefit.

## **Bronze and catastrophic plans**

- If implementing an ICHRA strategy, consider offering HSA-compatible ICHRAs (or the choice of an HSA-compatible ICHRA) to allow more employees to take advantage of the benefits of HSAs and consider a communications strategy.

## Related resources

### Non-Mercer resources

- [Notice 2026-5](#) (IRS and Treasury, Dec. 9, 2025)
- [List of telehealth services](#) (CMS, Dec. 4, 2025)
- [Expansion of HSA Eligibility Under OBBB Act to Improve Marketplace Coverage, Affordability, and Access](#) (White House Council of Economic Advisers, Sept. 26, 2025)
- [Telehealth for older adults: billing for telehealth](#) (HHS, July 29, 2025)
- [Pub. L. No. 119-21, One Big Beautiful Bill Act](#) (Congress, July 4, 2025)
- [Enrollment in catastrophic plans](#) (45 CFR 156.155)

### Mercer Law & Policy resources

- [Top 10 health, fringe and leave benefit compliance and policy issues in 2026](#) (Oct. 30, 2025)
- [2026 HSA, HDHP and excepted-benefit HRA figures set](#) (June 27, 2025)
- [IRS outlines how individual-coverage HRAs can meet ACA employer mandate](#) (Oct. 29, 2019)
- [Final rules ease restrictions on health reimbursement arrangements](#) (June 14, 2019)

### Other Mercer resources

- [Wondering if ICHRAs have a role in your program? What you need to know](#) (Sept. 18, 2025)
- [One Big Beautiful Bill includes employer-friendly provisions](#) (July 8, 2025)
- [Employers support HSA changes to make them more flexible](#) (April 3, 2025)

*Note: Mercer is not engaged in the practice of law, accounting or medicine. Any commentary in this article does not constitute and is not a substitute for legal, tax or medical advice. Readers of this article should consult a legal, tax or medical expert for advice on those matters.*