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HSA Compliance: A Deep Dive into the Rules Surrounding HSAs

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Health Savings Account (HSA)



WHAT IS AN HSA?

Tax-exempt trust or custodial account owned by the individual



WHAT IS IT FOR?

May be used for eligible medical expenses of the individual, and the individual's spouse and dependents



ARE THERE ANY SPECIAL REQUIREMENTS?

Must be covered by a high deductible health plan (HDHP) as defined by law, and not be enrolled in any disqualifying coverage

HSA Eligibility

WHO IS ELIGIBLE TO ESTABLISH AND CONTRIBUTE TO AN HSA?

- **Anyone who is:**
- Covered by an HDHP
- Not **enrolled** in Medicare
 - » Watch out for retroactive enrollment (which can be up to six (6) months) due to events like the start of Social Security distributions
- Not covered under other non-HDHP insurance or health plan
 - » Examples:
 - General purpose Health FSA
 - General purpose HRA
 - Medicare/Medicaid
 - TRICARE
- Not a tax dependent of another individual



Disqualifying coverage does not include separate dental plans, separate vision plans, specific disease or illness insurance, accident and disability insurance and long-term care insurance.

High Deductible Health Plan (HDHP)



Self-Only Coverage

For 2026, self-only HDHP coverage must have an annual deductible of \$1,700 and an out-of-pocket maximum of no more than \$8,500



Family Coverage

For 2026, family HDHP coverage must have an annual deductible of \$3,400 and an out-of-pocket maximum of no more than \$17,000

Satisfied by one or more covered members before plan benefits begin

Preventive care services may be covered before minimum annual deductible is satisfied.

**California state law requires family health plan contracts to include a per-individual (embedded) deductible and out-of-pocket cost sharing limit that is "no greater than the amount for an individual plan or policy." (CA Ins. Stat. AB 1305)*

ACA Impact on HSAs

HSA QUALIFIED HDHP OUT-OF-POCKET MAXIMUM INTERACTION WITH THE ACA'S OUT-OF-POCKET MAXIMUM

HSA qualified HDHP out-of-pocket maximums for 2026:

- Self-Only Coverage = \$8,500
- Family Coverage = \$17,000

ACA out-of-pocket maximums for 2026:

- Self-Only Coverage = \$10,150
- Family Coverage = \$20,300

HHS final rule states that the annual limitation on cost-sharing for essential health benefits for self-only coverage applies to all individuals regardless of whether the individual is **covered by a self-only plan** or is covered by a plan that is “other than” self-only coverage.

HDHP's must embed self-only ACA maximum out-of-pocket (MOOP) for family HDHP coverage even if the family HDHP maximum out-of-pocket is greater. Therefore, under a Family HDHP, no single individual can incur a MOOP greater than \$10,150 because of the ACA limits.

Example: Employee A elects family HDHP coverage in 2026 and incurs \$11,000 in hospital expenses. Cost-sharing for Employee A will be limited to \$10,150 (the ACA limit on cost-sharing for self-only coverage). The plan must cover the difference between the incurred expense and the ACA limit.

Who Is Eligible to Establish an HSA?

Any individual covered under a High Deductible Health Plan (HDHP):

- Not enrolled in Medicare
 - » Watch out for retroactive enrollment due to events like the start of Social Security benefits, which can retroactively apply as early as six (6) months prior to the event
- Not covered under another health plan that is a non-HDHP plan that provides first-dollar coverage (other than preventive care) before satisfying the applicable IRS minimum annual HDHP deductible:
 - » Group or individual health plan with lower annual deductible, higher OOP limit or copays before deductible
 - » General purpose HRA or health FSA
 - » Certain on-site clinics and other supplemental benefits
- Cannot be claimed as a tax dependent on someone else's tax return



Preventive Care

- Qualified HDHPs are permitted to cover preventive care expenses before the minimum IRS annual deductible is satisfied without jeopardizing participants' HSA eligibility.
- Preventive care in this context has a different meaning than preventive care under the ACA's mandate to cover all preventive care at 100% and without cost-sharing.
- In certain cases, items considered preventive care under the Qualified HDHP rules are not required to be covered without cost-sharing under the ACA.
- The IRS has provided a safe harbor when determining whether an item is considered preventive care for Qualified HDHP purposes. The safe harbor is not an all-inclusive list of items that may be considered preventive care.

The following items are included in the safe harbor:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals
- Routine prenatal and well-childcare
- Child and adult immunizations
- Tobacco cessation programs
- Obesity weight-loss programs
- Screening services

Preventive Care

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
Inhaled corticosteroids	Asthma
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Insulin and other glucose-lowering agents	Diabetes
Low-Density Lipoprotein (LDL) testing	Heart disease
Peak flow meter	Asthma
Retinopathy screening	Diabetes
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes



Telemedicine and HSA Eligibility

FIRST DOLLAR COVERAGE FOR TELEMEDICINE

One Big Beautiful Bill Act (OBBBA)

- Applicable for plan years beginning on or after January 1, 2025
- Coverage for “telehealth and other remote care” is disregarded when determining whether someone is eligible for HSA contributions
- A group health plan will not fail to be an HDHP solely because it provides coverage for “telehealth and other remote care” before an individual satisfies their IRS minimum deductible
- No limit in legislation on types of care that may be received as part of “telehealth and other remote care”

First Dollar Coverage for Telemedicine

- The IRS recently published IRS Notice 2026-05 providing guidance on which telehealth/remote care benefits can be offered without disqualifying an individual from HSA eligibility by referencing the list of approved telehealth billing (CPT) codes paid for by Medicare.
- Examples of CPT codes frequently used to bill for telehealth services are listed here:
 - » Cardiovascular conditions
 - » Diabetes
 - » Disease Management
 - » Mental and behavioral health
 - » Primary Care
 - » Pulmonary disease
- Several CPT codes are listed for the following categories:
- Additional information on the available CPT codes is available from CMS:
- The Notice further clarifies that any in-person services, medical equipment, or drugs furnished in connection with telehealth services are not telehealth services themselves and therefore will continue to be disqualifying coverage for an individual with an HSA if such care or services are paid for by the plan before such an individual meets the minimum HDHP deductible.

**BILLING FOR TELEHEALTH |
TELEHEALTH.HHS.GOV →**

**LIST OF TELEHEALTH SERVICES |
CMS →**

Permitted Other Coverage Changes under OBBA

Bronze Plans and Catastrophic Plans

- As of January 1, 2026, bronze and catastrophic plans available through an Exchange are considered HSA-compatible, regardless of whether the plans satisfy the general definition of an HDHP.
- This expands the ability of people enrolled in these plans to contribute to HSAs, which they generally have not been able to do in the past.
- SHOP (small business) bronze plans will not generally not be treated as a HDHP unless they independently meet the standard HDHP rules (minimum deductible and out-of-pocket maximum requirements).
- Notice 2026-05 clarifies that off-Exchange bronze or catastrophic plans will be treated as an HDHP if the identical plan is also offered through an Exchange.
 - » If the bronze or catastrophic plan is only available off-Exchange, individuals can still be considered HSA-eligible if they had no reason to believe the plan was unavailable on an Exchange.



Permitted Other Coverage Changes under OBBBA

Direct Primary Care Service Arrangements (DPCSA)

- Direct primary care service arrangement means an arrangement under which an 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.
- DPCSA does not disqualify an individual from HSA eligibility (assuming they are otherwise HSA-eligible), beginning on or after January 1, 2026.
- The monthly membership fee must be no more than \$150 self-only/\$300 family coverage.
- Certain services specifically excluded from primary care services include:
 - » Procedures that require the use of general anesthesia;
 - » Prescription drugs (other than vaccines); and
 - » Laboratory services not typically administered in an ambulatory primary care setting.
- Individuals may use HSA funds to pay for the DPCSA fee.
- NOTE: This provision does not change prior guidance addressing on-site/near-site clinics and HSA contribution eligibility. An on-site clinic could qualify as a DPCSA, depending on the structure/arrangement.



Other Coverage Issues



ON-SITE MEDICAL CLINICS

If an individual receives medical benefits (or has the ability to receive medical benefits) at no-cost (or below fair-market value cost) to the employee, this coverage disqualifies the individual from contributing to an HSA



EAPS

If an individual can receive significant medical benefits at no cost (or below fair-market value cost) under an EAP, the EAP coverage will disqualify the individual from contributing to an HSA

HSA Contributions



High Deductible Health Plan

MAXIMUM ANNUAL HSA CONTRIBUTION

Self-Only Coverage

2026 Maximum contribution = \$4,400

“Catch-Up” Contributions

Age 55 and older
by the end of the tax year = \$1,000

Family Coverage

2026 Maximum contribution = \$8,750

Source of Contributions

Employer, employee, or both
(or anyone else on behalf of the employee)

Determining Maximum HSA Contribution Limit

TWO METHODS – PRORATED OR LAST “MONTH” RULE

Prorated (Monthly) Maximum Contribution Method

- Will depend on number of months individual is HSA-eligible
- Individual eligible to contribute up to 1/12th of applicable annual maximum for each month they are HSA-eligible
- Example: Employee A enrolled in self-only HDHP for five (5) months of the year and is only HSA-eligible for those five (5) months.
 - » $\$4,400$ (2026 self-only maximum) / 12 months = $\$366.66$ a month
 - » $\$366.66$ a month x 5 months = $\$1833.33$ annual maximum contribution
- Individual may make contributions until April 15 of the following year up to the prorated limit even if not eligible during the particular month.

Special Contribution Rule

TWO METHODS – PRORATED OR LAST “MONTH” RULE



An individual may contribute the entire annual limit when first eligible for an HSA as long as they are eligible on the first day of the last month of the tax year (December 1 for most individuals) and they remain HSA eligible for the next 12 months of the following tax year.

- This also applies when an employee switches from individual to family coverage.
- If the employee is enrolled in the family tier as of December 1 of the applicable year and remains HSA eligible until December 31 of the following year, the individual is eligible to contribute up to the family maximum for the applicable year.
- However, if an individual joins mid-year and contributes the maximum amount to their HSA, they must remain eligible for at least 12 months after the last day of the last month of that tax year (December 31 for most taxpayers), or they will be subject to taxes and penalties on the excess contribution.

Mid-Year Change from Family to Single HDHP

WHAT IS THE MAXIMUM ANNUAL CONTRIBUTION?

Employee that enrolls in family coverage as of January, but later changes to single coverage in September (2026 amounts):*

$9/12 \times \$8,750 = \$6,562$
(rounded to nearest dollar)

$3/12 \times \$4,400 = \$1,100$
(rounded to nearest dollar)

Maximum Contribution Limit
 $\$6,562 + \$1,100 = \$7,662$

*Don't forget the full contribution rule for changes from single coverage to family coverage.

Multiple HSAs in the Family: Spouses

- If both spouses of a married couple are HSA eligible, and either spouse is covered by family HDHP coverage (other than self-only coverage), then both are treated as having family HDHP coverage and must divide the total family maximum annual contribution amount among the spouses
 - » They may allocate contributions between them per the spouse's agreement
 - » Catch-up contributions are allocated separately to each spouse that is age 55 or older. Therefore, a spouse that is not age 55 or older cannot make a catch-up contribution amount into their own HSA even though they may be married to a spouse who is age 55 or older.





HSA: Adult Dependents and Domestic Partners

- The division of the annual maximum contribution amount between married spouses does not apply to adult dependents (that are not claimed as a tax dependent on the employee's tax returns) or domestic partners, of an employee
 - » An adult dependent or domestic partner that is participating in a family HDHP can generally contribute the full family contribution amount allowed for family coverage into their own HSA(s)

HSA Corrections

MISTAKES HAPPEN

What happens when HSA contributions are made for an ineligible individual?

- The IRS guidance differentiates between contributions for individuals who were never eligible and for individuals who later enroll in Medicare or other disqualifying coverage and have received/made excess contributions into their HSA.

For those that were never eligible:

- No tax deductions for individual contributions
- No tax exclusions for employer contributions
- Corrections required for income reporting and tax withholding
- Employer contributions can be recovered by the end of the tax year with the assistance of the HSA custodian

For those that lose eligibility:

- Curative distributions can be made if the excess contribution (and net income attributable to that excess contribution) are distributed before the account holder's federal income tax return filing deadline
 - » One issue: Employers generally must rely on employees to refund an employer's excess contribution made to an employee's HSA because the contributions are considered non-forfeitable
- Any excess contributions distributed by the tax filing deadline (via curative distribution) will not be subject to the 6% excise tax on excess contributions but will be included the account holder's gross income

HSA Corrections

MISTAKES HAPPEN

What about contributions in excess of the statutory maximum or contributions made due to an administrative error?

- Typically, an employer cannot initiate a curative distribution to reverse an excess contribution that they made
- However, if the employer made the excess contribution or a contribution **as the result of an administrative error**, the employer may seek to recoup the erroneous contributions directly from the HSA administrator



Qualified Medical Expenses



HSA Funds

HSA funds may be invested and can grow on a “tax-qualified” basis

- Funds can roll over from year-to-year and an individual can keep the money even if they change jobs
- Investment options often include a minimum amount

Claims are “Self-adjudicated”

- Individuals should save receipts in case of an IRS audit

HSA funds may be used for “qualified” out-of-pocket medical expenses (generally not medical premiums)

- Code 213(d) – medical expenses incurred by the employee, spouse and/or dependents
- A dependent child is considered a dependent under the IRS rules until age 19, or age 23 if they are a full-time student

Note: This is different from the medical plan coverage definition of dependent that health FSAs are subject to

Qualified Medical Expenses

EXAMPLES



- Most medical care that is subject to a deductible:
 - » Copays
 - » Coinsurance
 - » Doctor visits
 - Inpatient or outpatient treatment
- Prescription and OTC drugs
- Insulin (with or without a prescription)
- Dental and vision care
- Select insurance premiums:
 - » COBRA
 - » Qualified long-term care insurance
 - » Health insurance premiums paid while receiving unemployment benefits
 - » Health insurance after an individual turns age 65, except for a Medicare supplemental policy

Non-Qualified Medical Expenses

EXAMPLES



- Insurance premiums (other than the exceptions listed on the previous slide)
- Surgery purely for cosmetic reasons
- Expenses covered by another insurance plan
- General health items such as tissues, toiletries and hand sanitizer

HSA Distribution Rules

TAX QUALIFIED

- HSA distributions may only be taken for qualified medical expenses
 - » Non-qualified medical expense HSA distributions are included in gross income and generally subject to an additional 20% excise tax
- HSA distributions can only be applied to expenses incurred on or after the date the HSA was established
- May use HSA funds for expenses incurred in a prior year if the HSA was established on or after the date the expense was incurred



Distributions for non-qualified medical expenses for **age 65 or older:** ordinary income taxes will apply but the 20% penalty would not apply.

Interaction with Health FSAs and HRAs



Interaction of Health FSAs with HSAs

HEALTH FLEXIBLE SPENDING ARRANGEMENT (HEALTH FSA)

- A general purpose health FSA will reimburse all otherwise unreimbursed, out-of-pocket 213(d) (medical) expenses (except for individual premiums)
- Generally, a general purpose health FSA allows for reimbursement of medical expenses prior to an individual satisfying their IRS HDHP minimum deductible. Therefore, participation in a health FSA would disqualify an individual from contributing to an HSA (i.e., make an individual HSA ineligible)
- Typically, a general purpose health FSA will also provide reimbursement for the medical expenses of a spouse and dependent child
 - » This means an employee's enrollment in a general purpose health FSA could also cause a spouse to be ineligible to contribute to their HSA



Health FSA Grace Period Impact on HSAs

HEALTH FLEXIBLE SPENDING ACCOUNT (HEALTH FSA)

- A health FSA may have a grace period of up to 75 days (2.5 months) following the end of the plan year
- Claims incurred during the grace period may be reimbursed from the prior plan year funds (if available)
- For a calendar-year health FSA: If it is a “general purpose” health FSA, the covered individual will not be HSA-eligible until April 1 (assuming the grace period is the full 75 days) if there are any funds remaining in the FSA as of the last day of the plan year, as determined on a cash accounting basis
 - » If there’s a \$0 balance on the last day of the plan year, an individual would be eligible to contribute to an HSA during the grace period



The individual could contribute 9/12ths of the annual maximum – unless the individual follows the “last month” rule.

Health FSA Grace Period Impact on HSAs

DESIGNING AN HSA COMPLIANT GRACE PERIOD



- The plan may be amended (before the end of the plan year) to provide that during the health FSA grace period, employees may only seek reimbursement of limited purpose healthcare expenses (e.g., dental and vision care expenses) incurred during the grace period
 - » This must apply to all health FSA participants, not only those enrolling into the HDHP
- Other options could include automatic termination of health FSA participation (with no grace period) after the end of the plan year

Interaction of Health FSAs with HSAs

DESIGNING AN HSA COMPATIBLE HEALTH FSA

LIMITED PURPOSE HEALTH FSA

A health FSA that only provides reimbursement for dental and vision expenses

POST-DEDUCTIBLE HEALTH FSA

- A health FSA that only provides reimbursement of health care expenses after the employee satisfies their HDHP minimum annual deductible
 - The health FSA could track an employee's cumulative satisfaction of the HDHP minimum deductible or could be designed to pay after the minimum statutory deductible is satisfied

Health FSA Carryover Impact on HSAs

HEALTH FLEXIBLE SPENDING ACCOUNT (HEALTH FSA)

The health FSA may include a carryover of up to \$680 in 2026 (indexed for inflation) into the following plan year

- The carryover amount is available to the individual for the entire following plan year

If the health FSA is “general purpose” (will reimburse all otherwise unreimbursed out-of-pocket-medical expenses), the covered individual will not be HSA-eligible for the entire plan year

- Because the health FSA provides coverage before the minimum HDHP deductible has been satisfied

Some employers allow participants to waive their carryover to avoid this issue

The health FSA may also be amended (before the end of the plan year) to provide conversion of carryover funds into a limited purpose health FSA

- Unlike the health FSA grace period, the carryover provision can provide the participant a choice of whether to carryover into a limited purpose health FSA or a general purpose health FSA
- Also, the plan may provide that the carryover is automatically credited to a limited purpose health FSA if the individual elects the HDHP
 - » The health FSA may also be amended (before the end of the plan year) to permit participants to either suspend or waive the carryover amount



Interaction of HRAs with HSAs

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

A health reimbursement arrangement (HRA) provides for reimbursement of 213(d) medical expenses

- 100% employer dollars
- Claims are typically paid from the employer's general assets

If the HRA is “general purpose” (will reimburse all otherwise unreimbursed out-of-pocket-medical expenses), the covered individual will not be HSA-eligible for the entire plan year

- Generally, the HRA provides coverage before the minimum HDHP deductible has been satisfied

Interaction between HRAs and HSAs

DESIGNING AN HSA COMPATIBLE HRA

LIMITED PURPOSE HRA

Provides reimbursement for dental and vision expenses only

POST-DEDUCTIBLE HEALTH HRA

Provides reimbursement after the IRS HDHP minimum annual deductible has been satisfied

- » The HRA could track with the HDHP deductible or could be designed to pay after the minimum statutory deductible is satisfied

RETIREMENT HRA

Provides reimbursement after the individual has retired and is no longer eligible to contribute to an HSA

HSA's and Cafeteria Plans



HSAs and Cafeteria Plans

PRE-TAX HSA CONTRIBUTIONS

- Employers may permit employees to make pre-tax contributions to their HSA accounts through an employer's Section 125 cafeteria plan
 - Employers are also permitted to make contributions to employee HSA accounts, which may be excluded from income tax and FICA withholding, if amounts are within the annual maximum contribution limit when combined with all other contributions to the account

Pre-Tax Election Changes

- Employers must allow employees to prospectively start, stop or otherwise change their pre-tax HSA elections at least once per month during the plan year

Nondiscrimination Rules

- Employer HSA contributions through the cafeteria plan will be subject to the Section 125 cafeteria plan nondiscrimination rules
- Rules prohibit discrimination in favor of highly compensated or key employees
 - » Contribution strategies that include contributing different amounts to different categories of employees should be closely monitored
- If a Section 125 plan fails nondiscrimination testing, all benefits provided to highly compensated or key employees will be considered taxable income to those employees

Cafeteria Plan Eligibility

HSA-ELIGIBLE VS. CAFETERIA PLAN ELIGIBLE

Are owners, partners, and other self-employed individuals eligible to contribute to an HSA?

- HSA eligibility is distinct from cafeteria plan eligibility
 - » An individual who is not eligible to participate in a cafeteria plan may otherwise be eligible to contribute to their HSA on a post-tax basis

HSA-eligible:

- Covered by an HDHP
- Not **enrolled** in Medicare
- Not covered under other non-HDHP insurance or health plan
- Not a tax dependent of another individual

Cafeteria plan: Ineligible individuals

- Self-employed individuals
- Sole proprietor
- Partner in a partnership (general partners and in some cases limited partners)
- More-than-2% shareholder in S corporation
- Outside directors
- Members of LLCs and partners in LLPs generally cannot participate

HSA Contributions Outside of Cafeteria Plan

COMPARABLE CONTRIBUTION RULE

- Applies when employer does not permit employees to make pre-tax contributions to their HSA account through the employer's Section 125 cafeteria plan and the employer makes contributions to the HSA.
 - » Rules require employer contributions to be the same for all comparable participating employees
 - » May differentiate based on the following classifications only:
 - Based on HDHP coverage tier
 - Employer contributes \$500 to all participants with single-only coverage and \$1,000 to all participants with other than single-only coverage
 - Current active employees vs. former employees
 - Non-union employees vs. employees in collective bargaining unit
 - Full-time vs. part-time employees
- Prevents the employer from making matching contributions based on the employee's elections
- As previously noted, allowing employees to make their contributions through operation of the cafeteria plan will avoid these comparable contribution rules

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