7/7/2025 | 2025-02 Employee Benefits Compliance

Group Health Plan Impacts of the One Big Beautiful Bill Act

Overview

On July 4, President Trump signed into law the One Big Beautiful Bill Act (OBBBA), sweeping, budget-related legislation with significant implications for defense spending, corporate and individual taxes, energy policy, and health policy. While the bill most significantly impacts Medicaid and contains fewer group health plan developments than initially proposed, the final bill does include certain key provisions directly impacting group health plans. Moreover, changes to Medicaid and Affordable Care Act (ACA) marketplace rules may have an indirect impact on employee group health plans, including potential migration on to employer plans, especially in regions where cuts to Medicaid spending could be the most impactful. Employers with populations in those regions should consider whether their plans could be impacted by this legislation.

Health Savings Account Provisions, Including First Dollar Telehealth

Permanent Telehealth Relief: General purpose telehealth coverage has historically been disqualifying coverage for purposes of health savings account (HSA) eligibility, but a series of pandemic-related legislation in recent years provided temporary relief that allowed telehealth services to be permitted coverage for HSA purposes, regardless of whether such services were preventive. The OBBBA has made that relief permanent, allowing high deductible health plans (HDHPs) to provide first-dollar telehealth and other remote care services without impacting HSA eligibility. The bill makes this change retroactive to plan years beginning after December 31, 2024, which was the date the last extension expired. Employers should work with their carriers and TPAs to update plan documents, claims systems and participant communications. For additional information on these issues, see our HSA FAQ, our Alliant Insight on Compliance Issues with Telemedicine and Table on Remote Care programs.

Direct Primary Care: Under previously issued IRS regulations, direct primary care (DPC), which was defined as "a contract between an individual and one or more primary care physicians under which the physician or physicians agree to provide medical care (as defined in IRC 213(d)) for a fixed annual or periodic fee without billing a third party," was deemed to constitute medical care and, in many cases, considered insurance. As a result, individuals covered by these arrangements were generally not eligible to contribute to an HSA. In order to avoid this implication, employees seeking to contribute to an HSA often had to be charged full fair market value of the DPC plan until the deductible of the HSA compatible HDHP was met, which created complexities for employer plan sponsors that wanted to offer DCP alongside an HDHP.

The OBBBA contains two key provisions that allow employer group health plans more flexibility with respect to DCP. First, effective January 1, 2026, the law excludes DPC arrangements from being a form of HSA-disqualifying coverage. In order to qualify for this exclusion, DPC fees cannot exceed $150/month (indexed) for an individual or $300/month (indexed) for family coverage, and cannot include (1) procedures that require general anesthesia, (2) prescription drug coverage, or (3) laboratory services not typically administered in an ambulatory primary care setting. In addition to the exclusion as disqualifying coverage, the OBBBA specifically provides that a DPC arrangement is a qualified medical expense that can be reimbursed by an HSA.

Alliant Note: The final version of the OBBBA did not include the House-proposed provision that would have allowed limited rollovers from FSAs or HRAs into HSAs, nor did it adopt the proposed income-based increase to HSA contribution limits for individuals with lower modified adjusted gross incomes.

Other Key Provisions: Dependent Care Contribution Limit Increase and Student Loan Repayment

In addition to the HSA-related provisions, the OBBA contains several other developments that will impact employer group health plans and should be incorporated into plan administration, relevant plan documents and participant communications.

DCAP Increase. After decades of a $5,000 limit for contributions to a dependent care assistance program (DCAP), effective 2026 (taxable years after December 31, 2025), this limit increases to $7,500 (not indexed for inflation). While employers are not required to amend their plans to allow for this limit increase, most employers likely will and should work with their vendors and TPAs to ensure plan documents are updated. In addition, employers should include this new limit in all open enrollment communication for plan years beginning on or after January 1, 2026.

Student Loan Repayment. Under Internal Revenue Code (IRC) section 127, employers may offer a qualified educational assistance program, which permits employers to provide up to $5,250 annually in tax-free compensation to employees for certain educational expenses. Prior legislation provided that employers could use IRC section 127 pay for or reimburse up to $5,250 of an employee's student loans on a tax-free basis, initially through the end of 2020, and then with an extension through 2025. The OBBB makes this extension permanent, and also allows for indexing of the $5,250 qualified educational assistance limit beginning in 2026.

Notably Missing: ICHRAs

Individual Coverage Health Reimbursement Arrangements (ICHRAs) are health reimbursement arrangements (HRAs) that allow employees to integrate account-based coverage with a comprehensive individual health care plan. ICHRAs can specifically reimburse individual market premiums (and other 213(d) medical expenses if the employer chooses such a design) or Medicare premiums. ICHRAs have been of increasing interest to employers that may be considering whether to limit their offer of comprehensive health care coverage. The ICHRA related rules, however, have historically made it challenging for many employers to offer an ICHRA as a meaningful alternative. For additional information and background on this topic, please see our Alliant Insight on ICHRAs. While the original version of the OBBBA contained a provision that codified ICHRAs into federal law and allowed for increased ICHRA flexibility and tax credits for small employers, the final version contained no such provisions. The impact here is most significant for small employers given that key ICHRA provisions in the original bill were limited to employers with fewer than 50 employees.

Next Steps

The final OBBBA version contains fewer group health plan provisions than anticipated, but employers—especially those offering or seeking to offer telehealth and/or direct primary care—should be aware of those provisions that do impact group health plans and update their plan documents and participant communications accordingly. As noted, employers with employees in states impacted by cuts to Medicaid may also want to consider what potential impact that may have—if at all—on their group health plan enrollment. We will continue to monitor the developing impact of the OBBBA.