EXPLAINER

Health Savings Accounts and Eligible Health Plans

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CHBRP

California Health Benefits Review Program (CHBRP)
University of California

Many bills analyzed by CHBRP touch on cost sharing (e.g. deductible, coinsurance, copayment) for covered benefits. To help reduce the financial burden of cost sharing for enrollees, health savings accounts (HSAs) were established in the early 2000s and can be used to pay for eligible health care expenses, including cost sharing. Contributions to an HSA reduce an enrollee's taxable income. Federal regulations permit HSA-qualified plans to cover certain services without an enrollee meeting their deductible; however, there is some overlap and interaction with other federal rules regarding cost sharing. It is important to understand how federal regulations pertaining to HSA-qualified plans may interact with California legislation.

This explainer provides an overview of HSAs, what types of plans they can be used with, and what services can be covered without cost sharing.

What is an HSA and Who Can Enroll in One?

HSAs are tax-advantaged savings accounts available to enrollees in certain health plans, allowing them to pay for qualified medical expenses (KFF, 2025). Contributions to HSA accounts reduce a person's taxable income. HSAs are typically administered by a third party unrelated to their health insurance company, such as WEX or Fidelity. Enrollees may open an HSA either independently or through an arrangement established by their employer. Enrollment in an HSA is optional: an enrollee can enroll in an HSA-qualified health plan without obtaining an HSA.

What are the Features of an HSA?

Table 1 provides an overview of the features of HSAs. HSAs obtained through an employer arrangement and those obtained independently are largely similar, with the most notable difference being how contributions are made and how the associated tax benefits are applied. Appendix A describes other types of tax-advantaged accounts enrollees can use alongside their health insurance to pay for qualified medical expenses, such as flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs).

Table 1. Features of HSAs

Category	Description
Ownership	Owned by the enrollee for life. Funds can be used for qualified medical expenses when enrollees change to other forms of insurance, including Medicare.
Eligibility	To establish an HSA and contribute to it, an enrollee must be enrolled in a qualified high-deductible health plan, bronze plan, or catastrophic plan. The enrollee cannot be enrolled in other health insurance or Medicare, and cannot be claimed as a dependent on someone else's tax return.
Annual contribution limit in 2027	$4,500 for individual coverage, $9,000 for family coverage. Additional $1,000 catch-up for those ages 55 years and older.
Contributions and taxes	Contributions can be made on an ongoing basis while an enrollee is enrolled in a qualified plan and the amount can be changed mid-plan-year. For employer-sponsored HSAs, the employer can deduct pre-tax contributions from the employee's paycheck and may also contribute to the account directly. For HSAs obtained independently, the enrollee instead claims a tax deduction for their contributions when filing taxes.
End of year contribution roll over	100% of unused contributions roll over to the next year without limit.
Investment opportunities	Funds can be invested, similar to a retirement account, allowing the balance to grow tax-free over time.
Withdrawal rules	Withdrawals are tax-free when used for qualified medical expenses. Withdrawals for non-qualified expenses are subject to income tax and a 20% penalty if taken before age 65; after age 65, the penalty no longer applies, but the withdrawal is still subject to income tax.
Qualified medical expenses	• Copayments, coinsurance, and deductible for covered benefits • Out-of-pocket expenses for noncovered benefits (e.g. braces, fertility services, therapy services) • Over-the-counter items (e.g. medicines, bandages) • Durable medical equipment and supplies (e.g. breast pumps, hearing aids) • Long-term care insurance premiums and other specified premiums • Fees for direct primary care service arrangements

Source: California Health Benefits Review Program, 2026, based on Elevance Health, 2026; Ferraro, 2025; Fidelity Learn, 2025; Notice 2026-5.

Eligibility

Historically, to be eligible to enroll in an HSA, an enrollee had to be in a qualified high-deductible health plan (HDHP). The federal House of Representatives Bill (HR) 1 of 2025 expanded eligibility so that, as of January 1, 2026, enrollees in

bronze or catastrophic health plans offered on the individual market[1] are also HSA-eligible.[2] HR 1 also newly permits enrollees to establish an HSA while enrolled in a direct primary care service arrangement (DPCSA). These are arrangements where an enrollee pays a flat monthly fee in exchange for their primary care and are available through companies such as One Medical as well as independent or group physician practices. See Figure 1 for a breakdown of the types of health insurance that can be used with an HSA.

Enrollees establishing an HSA must not be covered by other health insurance,[3] enrolled in Medicare, or eligible to be claimed as a dependent on someone else's tax return.

High-deductible health plans (HDHPs): HDHPs are a type of health plan with requirements set by federal regulation. These plans typically have higher cost sharing and lower premiums than other plans. Not all HDHPs are HSA-qualified. For the 2027 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least $1,750 for an individual and $3,500 for a family.

HDHPs

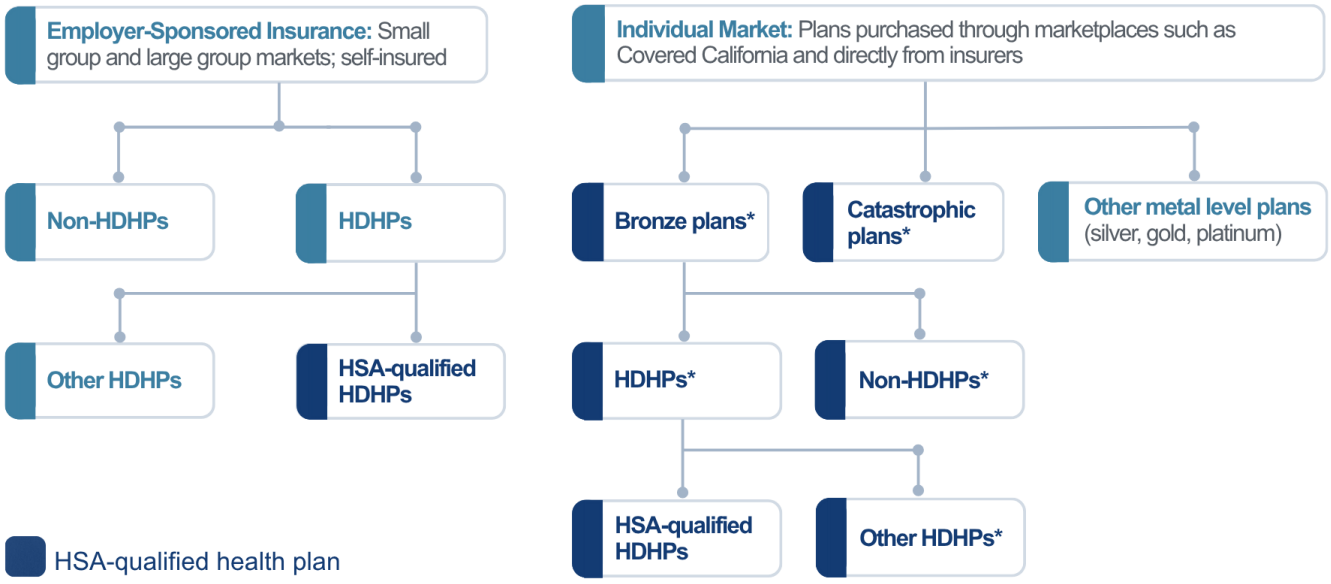
In order for an HDHP to be HSA-qualified, it must follow specified rules regarding cost sharing, including deductibles, as set by federal regulations.[4] Generally, an HSA-qualified HDHP may not provide benefits for any service until the deductible for that year is satisfied, although federal law permits specified services (e.g., services under the federal preventive services mandate and certain additional preventive services) to be covered without an enrollee meeting their deductible. Deductibles are the amount an enrollee is required to pay out-of-pocket before the health plan or policy begins to reimburse medical practitioners for medically necessary use of covered benefits; HDHPs have higher deductibles than other types of plans, but generally lower premiums.[5] HSA-qualified HDHPs may be offered by employers or are available to purchase on the individual market. An enrollee is not required to enroll in an HSA if they are enrolled in an HSA-qualified HDHP.

Bronze and Catastrophic Plans

As of January 1, 2026, all bronze and catastrophic plans sold on the individual market are HSA-eligible, even if the plans do not meet the federal qualifications for HDHPs or HSA-qualified HDHPs. As a result of this eligibility change, the number of enrollees who can use HSAs with their health plans is expected to grow in the years following the change in eligibility rules (KFF, 2025).

[1] The individual market refers to health insurance coverage purchased directly by a single person or family, rather than through an employer. This coverage can be purchased through a state marketplace, such as Covered California, or directly from an insurer. The Affordable Care Act (ACA) established different categories of individual market plans, identified by "metal level," based on the overall amount of cost sharing an enrollee is responsible for. Bronze plans typically have the lowest monthly premiums among the four metal levels but also carry higher deductibles and cost sharing. Catastrophic plans typically carry lower premiums but higher deductibles than bronze plans (KFF, 2025). Enrollment in catastrophic plans is limited to individuals under age 30 or those who meet specified income or hardship criteria (CMS, 2025). More information about metal levels is available through Covered California.
[2] IRS Notice 2026-5.
[3] Exceptions include having one of the following arrangements: limited-purpose flexible spending account (FSA) or Health Reimbursement Arrangement (HRA); suspended HRA; post-deductible health FSA or HRA; retiree-only HRA; health FSA during a grace period.
[4] Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code.
[5] For more information about deductibles, see CHBRP's Resource *Deductibles in State-Regulated Health Insurance*.

Figure 1. Types of Plans that are HSA-qualified



Source: California Health Benefits Review Program, 2026.
Note: *As of January 1, 2026.
Key: HDHP = high deductible health plan; HSA = health savings account.

What Services Can Be Covered Before an Enrollee Meets Their Deductible?

Several federal and state rules govern which services HSA-qualified plans are required, or permitted, to cover without cost sharing before an enrollee meets their deductible. Some of these rules apply to all HSA-qualified plans, while others apply to specific plan types.

- Nearly all California health plans and policies must cover specified preventive services (e.g. immunizations, cancer screenings, annual wellness exams) without cost sharing and without requiring the enrollee to first meet their deductible, under the ACA's Federal Preventive Services Mandate and California's Preventive Services Mandate.[6]
- For bronze plans that are not also HSA-qualified HDHPs and catastrophic plans, no additional federal regulations govern pre-deductible coverage of benefits. This means that health plans and insurers may choose whether and which services to offer on a pre-deductible basis (beyond those required by the preventive services mandates noted above).
- Beyond what is required by state and federal preventive services mandates, HSA-qualified HDHPs are permitted – but not required – to cover certain additional federally specified services[7] without the enrollee first meeting their deductible[8]. These services include chronic condition management and other preventive services, listed in Table 2. Services outside of these categories of preventive care can be covered only after the enrollee meets their deductible. Federal regulation refers to these services, together with those services identified under the federal preventive services mandate, as "preventive care."

[6] See more information about these preventive services in CHBRP's resource *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*. Grandfathered plans and policies are not required to cover preventive services without cost sharing.
[7] For more information on screening services, see Notice 2004-23 , 2004-15 I.R.B. 725. For additional guidance on preventive care, see Notice 2004-50, 2004-2 C.B. 196, Q&A 26 and 27; and Notice 2013-57, 2013-40 I.R.B. 293.
[8] HSA-qualified HDHPs may also impose a deductible below the minimum annual deductible for these specified services.

Table 2. Additional Services HSA-Qualified HDHPs Can Cover Prior to Enrollee Meeting Deductible

Service	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
Breast cancer screening	N/A
Glucometer and continuous glucose meter	Diabetes
Hemoglobin A1c testing	Diabetes
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	N/A
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Male Condoms	N/A
Oral Contraception	N/A
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes
Telehealth and other remote services	N/A

Source: California Health Benefits Review Program, 2026 adapted from V-BID Center, n.d.; Notice 2026-5.
Note: N/A means an enrollee does not need to be diagnosed with a specific condition in order to receive coverage for the service prior to meeting their deductible.

Conclusion

HSAs are tax-advantaged saving accounts available to enrollees in HSA-qualified HDHPs, bronze and catastrophic plans sold on the individual market, and enrollees in these plans also enrolled in a DPCSA. HSAs stay with an enrollee for life, and funds may be used to pay for qualified medical expenses. Funds can also be invested, allowing the balance to grow tax-free over time. Enrollees may continue to use funds for qualified medical expenses after leaving their employer, and after age 65 may use the funds for Medicare premiums or withdraw funds for any purpose without penalty (though funds are still subject to income tax).

Federal regulations have recently updated both who is eligible to enroll in an HSA and which services can be covered before an enrollee meets their deductible. These changes are expected to increase the number of Californians using HSAs alongside their health insurance, potentially reducing financial burden through lower taxable income and expanded pre-deductible service coverage. However, because federal regulations impose specific requirements on HSA-qualified HDHPs, state laws that change cost sharing for covered benefits will need to ensure these changes do not put such plans at risk of losing their HSA-qualified status. All HSA-eligible plans must cover preventive services without cost sharing in accordance with federal and state preventive services mandates before an enrollee meets their deductible. While HSA-qualified HDHPs are also permitted to cover a specified additional set of services before the deductible is met, bronze plans that are not HSA-qualified HDHPs and catastrophic plans are permitted to cover any benefit pre-deductible, at the insurer's discretion.

Appendix A. Comparison of HSAs, FSAs, and HRAs

Beyond HSAs, enrollees can use other types of tax-advantaged savings accounts alongside their health insurance to pay for qualified medical expenses, such as flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs). While these accounts share similarities, they differ across several categories, including ownership, eligibility, and contribution amount. Table 3 outlines these categories.

FSAs are employer-offered accounts into which enrollees and their employer can contribute pre-tax dollars. Enrollees can use these funds for qualified health expenses and are also able to enroll in an FSA without enrolling in their employer's health plan. Employers are permitted but not required to contribute to an employee's FSA.

HRAs are employer-funded accounts used to reimburse employees for medical costs and/or premiums. There are three types of HRAs discussed here: group health plan HRAs, qualified small employer HRAs (QSEHRAs), and individual coverage HRAs (ICHRAs) (Rosso, 2022). A group health plan HRA is an employer-funded account that employees can use to pay for qualified medical expenses if they are enrolled in employer-sponsored coverage. The second and third types of HRAs (QSEHRAs and ICHRAs) require employees to purchase health insurance and use HRA funds to reimburse premiums and associated cost sharing. QSEHRAs require employees to enroll in a plan that qualifies as minimum essential coverage, such as coverage purchased on the individual market, a spouse's employer, or Medicare. HRAs can generally be used alongside an HSA or FSA, whereas HSAs and FSAs typically cannot be used at the same time.

Table 3. Comparison of the Features of HSAs, FSAs, and HRAs

Category	Health Savings Accounts	Flexible Spending Accounts	Health Reimbursement Arrangements
Ownership	Owned by the enrollee for life.	Owned by the employer; funds are typically forfeited if the enrollee leaves their job.	Owned by the employer.
Eligibility	To establish and contribute to an HSA, an enrollee must be enrolled in a qualified HDHP, bronze plan, or catastrophic plan, and must not be enrolled by other health insurance, Medicare, or eligible to be claimed as a dependent on someone else's tax return.	Must be offered by an employer in conjunction with a group health plan; not available to self-employed individuals or those purchasing insurance through the individual market.	Offered by an employer that chooses to offer this benefit. For group health plan HRAs, an employee may receive employer contributions even if enrolled in a spouse's employer-sponsored insurance.
Annual contribution limit in 2027	$4,500 for individual coverage, $9,000 for family coverage. Additional $1,000 catch-up for those ages 55 years and older.	$3,500 per enrollee*	Determined by the employer. Group health plan and individual coverage HRAs: no limit. Qualified small employer HRAs: $6,450 for individual coverage, $13,100 for family coverage in 2026.

Contributions and taxes	Contributions can be made on an ongoing basis while enrolled in a qualified plan and can be changed mid-plan year. Employers can deduct pre-tax contributions from an employee's paycheck and may also contribute directly. For HSAs obtained independently, the enrollee claims a tax deduction for contributions when filing taxes.	Enrollees choose a contribution amount at the start of the plan year, which cannot be changed during the year. Employers can deduct pre-tax contributions from employee's paycheck and may also contribute.	Only employers can contribute. Enrollees receive tax-free reimbursement from the HRA.
End of year contribution roll over	100% of unused contributions roll over to the next year, with no limit.	Funds must usually be used by the end of the plan year, though some plans allow a small rollover amount or grace period.	Employers determine whether unused funds roll over to the next year.
Investment opportunities	Funds can be invested.	Funds cannot be invested.	Funds cannot be invested.
Withdrawal rules	Withdrawals are tax-free for qualified medical expenses. Withdrawals for non-qualified expenses are subject to income tax and a 20% penalty before age 65; after age 65, the penalty no longer applies but the withdrawal is still subject to income tax.	Withdrawals are tax-free for qualified medical expenses. Withdrawals for non-qualified expenses are subject to income tax.	Withdrawals are tax-free for qualified medical expenses.
Qualified medical expenses	• Copayments, coinsurance, and deductible for covered benefits • Out-of-pocket expenses for noncovered benefits (e.g. braces, fertility services, therapy services) • Over-the-counter items (e.g. medicines, bandages) • Durable medical equipment and supplies (e.g. breast pumps, hearing aids) • Long-term care insurance premiums or other specified premiums • Fees for direct primary care service arrangements	Same as HSAs, except FSA funds cannot be used for: • Long-term care insurance premiums or other specified premiums • Fees for direct primary care service arrangements	The IRS determines which expenses qualify overall, but the employer defines eligible expenses for its specific plan. Eligible expenses may include: • Premiums for health insurance (ICHRAs only) • Copayments, coinsurance, and deductible for covered benefits • Dental and vision care

Source: California Health Benefits Review Program, 2026, based on Elevance Health, 2026; Ferraro, 2025; Fidelity Learn, 2025; Healthcare.gov, 2026; Notice 2026-5; Rosso, 2022.
Note: *FSA contribution limits for 2027 are not yet final, but are projected to be $3,500. The contribution limit in 2026 was $3,400.
Key: FSA = flexible spending account; HDHP = high deductible health plan; HRA = health reimbursement account; HSA = health savings account; ICHRA = individual coverage HRA; IRS = Internal Revenue Service.

Appendix B. HSA-related IRS Notices

Below is a list of relevant IRS notices pertaining to HSAs.

- Internal Revenue Bulletin: 2004-15.
- Internal Revenue Bulletin: 2004-33.
- Internal Revenue Bulletin: 2013-40.
- Internal Revenue Bulletin: 2013-57.
- Internal Revenue Bulletin: 2018-27.
- Internal Revenue Bulletin: 2019-45.
- Internal Revenue Bulletin: 2024-25.
- Internal Revenue Bulletin: 2024-75.
- Internal Revenue Bulletin: 2026-5.

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About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource Academic Rigor on a Legislature's Timeline.

To read any of the 200+ bill analyses CHBRP has completed, see the Completed Analysis page on CHBRP's website. In addition to analysis of introduced legislation, CHBRP produces other publications including several annually updated resources, as well as issue briefs and explainers

CHBRP Staff

Garen Corbett, MS, Director
Adara Citron, MPH, Associate Director
An-Chi Tsou, PhD, Principal Policy Analyst
Anna Pickrell, MPH, Principal Policy Analyst
Karen Shore, PhD, Contractor*
Nisha Kurani, MPP, Contractor*
*Independent Contractor working with CHBRP to support analyses and other projects.

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116
info@chbrp.org
(510) 664-5306

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