MarshMcLennan Agency

LAW & POLICY
Health & Welfare Compliance Services

July 16, 2025

One Big Beautiful Bill Act Becomes Law

The law includes several changes affecting employee benefits

The President signed the One Big Beautiful Bill Act (OBBBA), H.R. 1, into law on July 4, 2025. While only a small portion of the overall law, the OBBBA does contain several provisions affecting employer-provided health and welfare and other fringe benefits. Employers and/or employees will welcome most of the changes.

Congress used the budget reconciliation process to make it easier to pass the legislation, which is why all of the employee benefits provisions are tax related The benefits-related provisions in the final version of the law changed significantly from the earlier bill passed by the U.S. House of Representatives, so the items discussed in this Alert may differ from content summarizing the OBBBA that you read in May or June.

Our Alert addresses the provisions in the law related (directly or indirectly) to employer-provided health and welfare and other fringe benefits, considerations to aid employers with any necessary decision making, and employer action items for adopting and/or implementing any changes. It does not address the OBBBA's tax cuts, changes to the taxation of certain wages (e.g., tips and overtime), what effect changes to Medicaid might have on access to health care providers, or the Trump Account pilot program.

This Alert is relevant for all employers offering health and welfare and/or other fringe benefits to their employees.

Arrangement for ease of reading

We arranged the material by category and topic. If you are interested in a particular topic, you can use the table of contents on the next page to find it. The table of contents is hyperlinked and will take you straight to the topic if you are reading this electronically.

For your convenience, we provide basic information about each provision and its effective date at the beginning of its corresponding section. Each section includes additional information if you need or want it.

Highlights

Overview

The One Big Beautiful Bill Act (OBBBA) became law on July 4, 2025. It is very broad legislation covering many unrelated provisions.

The OBBBA contains several provisions affecting employer-provided health and welfare and other fringe benefits.

Key provisions

The most significant changes affecting benefits are:

- Permanent relief excluding telemedicine as disqualifying coverage for HDHP/HSA purposes retroactive to January 1, 2025;
- Limited relief excluding direct primary care arrangements as disqualifying coverage for HDHP/HSA purposes in 2026; and
- An increase in the dependent care FSA limit to $7,500 in 2026.

Employer Action Items

Employers should seek the assistance of appropriate advisors and consider whether, how, and when to implement any changes to their benefits.

Certain changes may require revisions to plan materials and trigger certain disclosure requirements.

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Health savings accounts

The following provisions affect or are related to high deductible health plans (HDHPs) and health savings accounts (HSAs).

Permanent HDHP/HSA relief for telemedicine

The OBBBA's major benefits-related headline is the immediate and permanent restoration of relief excluding telemedicine and other remote care services as disqualifying coverage for HDHP/HSA purposes retroactive to HDHP plan years beginning on or after **January 1, 2025**.

The relief allows the telemedicine benefits to bypass the HDHP deductible without affecting a participant's ability to make or receive HSA contributions. This enables employers to offer general telemedicine benefits at no cost (i.e., with a $0 copayment)[1] in conjunction with an HDHP without regard to whether a participant has met their deductible.[2]

We interpret "other remote care services" to include other group health benefits that solely deliver benefits on a virtual basis (i.e., by telephone and/or videoconference without requiring travel or in-person contact). This may include certain behavioral health EAPs and other health benefits that are narrow in scope. The number of potentially available virtual visits does not affect this relief.

A series of temporary relief measures were in effect from 2021 – 2024, but Congress allowed the prior temporary relief to expire for HDHP plan years beginning after December 31, 2024. The OBBBA's permanent relief removes the need for Congress to reauthorize further relief in the future. This provision did not appear in the earlier draft passed by the House and was a late addition made by the Senate. This may be related to the disappearance of several HSA-related provisions from the earlier House bill in the final law (see The price paid? later in this section).

Employer considerations

Employers can now choose whether to offer no cost (or low cost) general telemedicine benefits in conjunction with their HDHP coverage with some flexibility to determine when to implement any changes. We assume most or all employers that took advantage of the prior relief will do so again, and others are likely to join them. For a fully insured HDHP with carved-in telemedicine, an insurer may decide with little or no input from the employer.

The relief is available retroactive to HDHP plan years beginning on or after January 1, 2025. Employers do not have to change their telemedicine cost sharing to take advantage of the relief, although we assume most will. Certain factors may affect timing and limit or delay implementation on either a prospective basis or later (e.g., the beginning of the next HDHP plan year). These factors include: (i) the HDHP plan year; (ii) the plan administration during 2025; and (iii) vendor cooperation.

HDHP plan years beginning January – July 2025

- *Carved-in telemedicine (medical insurer or third party administrator (TPA) also administers telemedicine benefit)* – If participants paid the fair market value (FMV)[3] or any other cost for telemedicine visits during this period, the insurer/TPA likely counted the cost toward the HDHP deductible and possibly also toward the out-of-pocket maximum (OOPM) limit.

[1] Or any other amount greater than $0 but below fair market value (≈$45/visit).

[2] It is possible to offer HSA-compatible telemedicine benefits without the OBBBA relief, but they are rare. These include telemedicine benefits limited to preventive services, dental/vision-related services, and/or medical services after an individual has met their HDHP deductible. These arrangements are not general telemedicine benefits.

[3] The unofficial proxy for FMV is a correlation to the Medicare reimbursement rates for telemedicine visits of different lengths. Without relief, we generally recommended against setting the FMV lower than this amount.

The insurer/TPA should be able to identify the participants that utilized the telemedicine benefit, or the participants could provide receipts or other proof of payment as substantiation. The substantiation should indicate whether the participant paid for the visit from their HSA (directly or by reimbursement).

The employer – directly or through the plan – could refund the cost of the telemedicine visits back to the employees tax-free if the participant paid for them on an post-tax basis.[4] Employers could choose to make an additional HSA contribution as an easier form of refund. Any additional contribution will count towards the annual HSA contribution limit. The HSA contribution approach would also relieve the need for employees to substantiate whether payment was made on a pre-tax or post-tax basis, and it may be the only feasible option to provide a refund for employees that used HSAs to pay for the telemedicine visits.

If the employer provides a refund, the HDHP would need to perform some reprocessing to back these amounts out of the deductible (and OOPM limit, if necessary), which may affect other claims. An insurer/TPA may be reluctant or unwilling to take on this administrative burden for what should be relatively trivial amounts, and a number of employers may feel the same way. Employers in this situation may choose to make any changes to their telemedicine cost sharing prospectively or delay it to an administratively practical later date.

- *Carved-out telemedicine* (*when a separate third-party vendor administers the telemedicine benefit*) – In many instances, the third-party vendor does not track individual participant utilization and there is no coordination with the HDHP's deductible or OOPM limit.

  If participants paid the FMV or any other cost for telemedicine visits during this period, the employer could refund the cost of the telemedicine visits back to employees who provide receipts of other proof of payment as substantiation. The substantiation should indicate whether the participant paid for the visit from their HSA (directly or by reimbursement).

  The employer could refund the cost of the telemedicine visits back to the employees tax-free if the participant paid for them on a post-tax basis. Employers could choose to make an additional HSA contribution as an easier form of refund. Any additional contribution will count towards the annual HSA contribution limit. The HSA contribution approach would also relieve the need for employees to substantiate whether payment was made on a pre-tax or post-tax basis, and it may be the only feasible option to provide a refund for employees that used HSAs to pay for the telemedicine visits.

  If there was no coordination with the HDHP's deductible or OOPM limit, there is no reprocessing issue. This should make it easier for employers with carved-out telemedicine benefits to take advantage of the relief retroactively.

- *Holdouts* – An employer that maintained no cost (or otherwise below FMV) general telemedicine benefits during this period in conjunction with its HDHP coverage does not need to make any changes.

<u>HDHP plan years beginning August – December 2025</u>

- *Prior relief still in effect* – Since the prior temporary telemedicine relief expired for HDHP plan years beginning after December 31, 2024, it is still in effect for non-calendar year HDHPs with 2024/2025 plan years that began in August – December 2024.

  For example, the prior temporary relief runs through August 31, 2025 for an HDHP operating on a September 1st – August 31st plan year. An employer offering $0 telemedicine in conjunction with this HDHP may continue to do so without interruption, as the permanent OBBBA relief will apply to the 2025/2026 HDHP plan year beginning in 2025.

[4] An employer could provide this directly through payroll or separately as a non-taxable item. If through payroll, the employer should be able to reflect the amount in Form W-2, Box 12 using Code DD.

General comments

- *New implementation* – Employers taking advantage of the relief for the first time, such as of the beginning of a new HDHP plan year, have a cleaner implementation with fewer administrative considerations. This includes employers adopting an HDHP for the first time.

- *Qualifying life event for mid-year implementation* – A carved-in telemedicine benefit is generally part of the medical plan design. Amending the HDHP during a plan year to change the telemedicine cost sharing to $0 may be a significant improvement to the medical plan option triggering a qualifying life event (QLE). This would allow employees who did not previously enroll in the HDHP to enroll, or participants enrolled in other coverage to change to the HDHP plan option. Employers may wish to discuss whether this is a QLE with their legal counsel or other advisors.

  This should not be a QLE issue for carved-out telemedicine, since changing the telemedicine cost sharing does not amend the underlying HDHP medical plan.

- *Standalone telemedicine benefits* – We recommend limiting participation to employees enrolled in employer group medical coverage (see the next section below).

Standalone telemedicine benefit issue remains

While the OBBBA explicitly excludes telemedicine as disqualifying coverage for HDHP/HSA purposes, it did not reclassify employer-provided telemedicine as an "excepted benefit"[5] or otherwise explicitly exclude it from any other group health plan compliance considerations. This means most general telemedicine benefit plans are subject to the same compliance rules and considerations as an employer's group medical coverage. This includes the Affordable Care Act's plan design and administration requirements, which telemedicine cannot satisfy on its own.

For this reason, we continue to recommend that employers limit participation in their general telemedicine benefit plans to individuals enrolled in employer group medical coverage. We are not aware of any specific enforcement initiative by the U.S. Department of Labor or other federal agencies for this issue. This is a business decision for employers based on their own risk tolerance.

The myth of the EAP exception

Under existing law and guidance, we believe most general telemedicine benefit plans cannot qualify as an "excepted benefit" under what is commonly referred to as the EAP exception.[6] As written, the EAP exception can apply to a broad range of benefits and services and does not solely apply to behavioral health care.

In addition to other limitations, the EAP exception requires that the benefit does not provide significant medical care. We believe a general telemedicine benefit provides significant medical care if either of the following are true:

1. It allows for a large (e.g., >10) or theoretically unlimited number of visits per plan year without regard to a participant's actual number of visits during the plan year; and/or

2. The telemedicine benefit providers can write prescriptions, even if the allowable list of prescriptions is limited.

Relief as evidence: The various temporary relief measures applied to telemedicine benefits during the COVID-19 pandemic and the OBBBA's permanent relief excluding telemedicine as disqualifying coverage serve as evidence that the federal government does not believe most employer-provided general telemedicine benefits qualify as excepted benefits. There would not have been any need for relief otherwise.

[5] ERISA, 29 USC §1191a(c); Internal Revenue Code, 26 USC §9831(c); and PHSA, 42 USC §300gg-21(c)

[6] Treasury Reg. §54.9831-1(c)(3)(vi); DOL Reg. §2590.732(c)(3)(vi).

The price paid?

As mentioned earlier, the restoration of telemedicine relief may have come with a price. The following HSA-related provisions appeared in the earlier House bill but were all cut from the final law:

- Increased annual HSA contribution limits for many taxpayers (up to specific income limits),
- The ability for spouses to make age 55+ catch-up contributions to the same HSA instead of the current requirement that each contribute their respective catch-up contributions to their own HSA,
- Other exclusions from disqualifying coverage:
  - Medicare Part A, allowing individuals to remain HSA-eligible without deferring Social Security benefits,[7]
  - Coverage under a spouse's health FSA (under certain circumstances), and
  - A limited exclusion for onsite clinics;
- The ability to roll over health FSA and HRA balances into an HSA for new HDHP participants, and
- The ability to use an HSA to pay for gym memberships and exercise equipment.

Limited relief for direct primary care arrangements

Subject to certain conditions, the OBBBA excludes direct primary care (DPC) arrangements as disqualifying coverage for HDHP/HSA purposes beginning on **January 1, 2026**. The effective date is not based upon an HDHP's plan year, meaning the relief is available during a plan year already in progress. This includes during the plan year for non-calendar year HDHP plan years beginning in 2025 and ending in 2026.

The relief allows the DPC services to bypass the HDHP deductible without affecting a participant's ability to make or receive HSA contributions. The relief also allows individuals to use their HSAs to pay (or reimburse) for DPC membership or subscription fees.[8]

The relief is not specific to employer-provided DPC arrangements, and it also applies to DPC coverage individuals may purchase on their own.

Limited relief for DPC coverage: The devil is in the details.

The relief is subject to certain conditions.

- *Coverage limitations* – The DPC only provides an individual with primary medical care services performed by primary care practitioners.[9] The OBBBA does not provide a specific definition for primary medical care services, but it does expressly exclude the following:

  1. procedures requiring general anesthesia,
  2. prescription drugs (this does not include vaccines), and
  3. laboratory services not typically administered in an ambulatory primary care facility.

  We will refer to these collectively as "prohibited services." We are aware that existing DPC arrangements may offer one or more prohibited services or other services that may not qualify as primary medical care.

[7] Medicare Part A is generally automatic when receiving Social Security benefits, although there may be a delay for individuals receiving Social Security benefits before age 65.

[8] This provision applies only to HSAs and not to other spending accounts.

[9] Primary care practitioners means physicians, nurse practitioners, clinical nurse specialists, and physician assistants whose primary specialty is family, internal, geriatric, or pediatric medicine.

As written, the statute appears to address the availability of the relief in terms of the services the individual actually receives instead of explicitly in terms of all services that may be available under the DPC. We will excerpt the relevant portion of the statute below and bold certain text for emphasis:

> New Internal Revenue Code §223(c)(1)(E)(ii)
>
> "*(ii) Direct primary care service arrangement.—For purposes of this subparagraph—*
>
> *(I) In general.—The term 'direct primary care service arrangement' means, with respect to any individual, an arrangement under which such individual* ***is provided*** *medical care (as defined in section 213(d)) consisting solely of primary care services provided by primary care practitioners (as defined in section 1833(x)(2)(A) of the Social Security Act, determined without regard to clause (ii) thereof), if the sole compensation for such care is a fixed periodic fee.*"

If the intent is to limit the relief based upon the services received under the DPC arrangement, this largely shifts the compliance obligation to an honor code system between the individual and the IRS. If the intent is to limit the relief based upon the services offered under the DPC arrangement, DPC vendors will need to specifically tailor their programs to enable individuals to qualify (a "self-qualifying" DPC arrangement).

We hope the IRS will provide clarification in subsequent guidance. In any event, we expect vendors will begin marketing self-qualifying DPC arrangements that expressly claim HSA-compatibility later this year.

- *Cost limitation* – The membership/subscription fee for the DPC arrangement cannot exceed $150/month for one individual or up to $300/month if the DPC arrangement covers two or more individuals (e.g., a couple or family).[10] The membership/subscription fee limits are indexed annually for inflation. There can be no other fees or cost sharing for DPC services. As written, the cost limitation is absolute without regard to whether the coverage limitation rules allow DPC arrangements to offer other disqualifying services so long as the individuals do not receive them.

Employer considerations

Employers will have the option to offer HSA-compatible DPC arrangements in conjunction with their HDHP coverage beginning in 2026. An employer wishing to provide this coverage may find it more administratively practical to wait until the beginning of their 2026 plan year – or a later plan year – rather than attempting to implement the DPC arrangement during a plan year in progress.

We hope the IRS will clear up any uncertainty around the coverage limitation rules and whether the relief depends upon the services received or the services offered. Future guidance notwithstanding, we recommend employers intending to take advantage of the relief offer self-qualifying DPC arrangements that only cover primary medical care services. Among other reasons, this should prevent a covered employee from making a mistake that affects their HSA eligibility. Employers may wish to discuss this issue with their legal counsel.

We recommend limiting participation to employees enrolled in employer group medical coverage (see the next section below). Remember, employees can purchase HSA-compatible DPC coverage on their own and pay for the membership or subscription fee from an HSA. An employer is not responsible for policing compliance issues outside its knowledge and control.

DPC arrangement through a cafeteria plan: Under longstanding cafeteria plan rules, an employer can enable employees to pay for their DPC membership/subscription fees on a pre-tax basis through the employer's cafeteria plan. Employers should limit this to employer-sponsored group DPC arrangements. Employees cannot both pay for the fees on a pre-tax basis and seek reimbursement from their HSA.

[10] If the fee must be paid annually or quarterly, the cost limitation applies as an average for that period (i.e., $1,850/annually or $450/quarterly for one individual; $3,600/annually or $900/quarter for coverage for two or more individuals).

Standalone DPC benefit issue

Just like the telemedicine relief described earlier, the OBBBA explicitly excludes DPC arrangements as disqualifying coverage for HDHP/HSA purposes, but it does not provide any broader exceptions excluding it from any other group health plan compliance considerations.

The argument that a DPC arrangement provides significant medical care is even more compelling than it is for telemedicine. For this reason, we recommend employers limit participation in an employer-provided DPC arrangement to individuals enrolled in employer group medical coverage.

Individual bronze and catastrophic marketplace coverage treated as an HDHP

An individual bronze or catastrophic policy purchased through the public health insurance marketplace (the "marketplace") will automatically qualify as an HDHP beginning on **January 1, 2026**. The marketplace includes Healthcare.gov and state-run public marketplaces such as Covered California.

This does not apply to bronze or catastrophic group medical coverage available in the marketplace, such as the Small Business Health Options Program (SHOP), or any bronze or catastrophic coverage available outside the marketplace that does not otherwise qualify as a traditional HDHP.

The marketplace does offer traditional HDHP coverage, but availability may depend upon location. By including bronze and catastrophic coverage, this relief will expand access to HSAs by increasing the availability and number of HSA-eligible plan options.

Employer considerations

This relief will not affect many employers and may only present an educational opportunity about marketplace coverage. The relief may be relevant to employers offering an individual coverage HRA (ICHRA) to one or more classes of employees.

ICHRAs that can pay for general medical expenses in addition to premiums are generally disqualifying coverage for HDHP/HSA purposes. An ICHRA is HSA-compatible if: (i) it can only pay for medical premiums; or (ii) it can only pay for medical premiums and expenses for dental, vision, or preventive care.[11]

An employer could tailor its ICHRA to enable employees enrolling in traditional HDHP, bronze, or catastrophic marketplace coverage to establish HSAs. For practical reasons, employers may prefer not to facilitate the HSAs and let employees establish and contribute to them on their own.

This discussion applies equally to smaller employers offering qualified small employer health reimbursement arrangements (QSEHRAs).

[11] An ICHRA that can pay for general medical expenses after the individual meets their minimum statutory HDHP deductible is HSA-compatible, but this may be too administratively burdensome for ICHRA administrators or employers to attempt.

Child care and adoption

The following provisions affect or are related to child care and adoption expenses.

Increase to annual dependent care FSA limit

The OBBBA increases the annual tax exclusion limit under a dependent care FSA (also known as a dependent care assistance program or DCAP) beginning with the **2026 tax year** as follows:

2025	2026 and subsequent years
$5,000 ($2,500 each for married couples filing separate tax returns)	$7,500* ($3,750 each for married couples filing separate tax returns)

**The revised $7,500/year limit is fixed and not indexed annually.*

The tax exclusion limit includes reimbursements for eligible child care expenses from a dependent care FSA funded through employee pre-tax payroll contributions and any employer contributions. It also applies to other employer tax-free subsidies for eligible child care expenses such as onsite day care services.

The tax exclusion limit technically applies to individuals on a calendar year basis (i.e., the individual's tax reporting year) and not the dependent care FSA's plan year. This is rarely an issue for non-calendar year dependent care FSAs, except in certain situations.[12]

Thanks for something? The existing $5,000/year limit has been in effect since 1986. The new limit is a 50% increase, but $7,500 will fall far short of the annual child care expenses for most parents. By comparison, The American Rescue Plan Act of 2021 provided a temporary limit increase to $10,500 for 2021.

Employer considerations

Employers offering dependent care FSAs can increase the annual limit to $7,500 beginning in 2026, and we expect an overwhelming majority will adopt the change as of the beginning of their 2026 dependent care FSA plan years.

There is another consideration. In our experience, most employer-sponsored dependent care FSAs fail nondiscrimination testing under the Internal Revenue Code (IRC) every year.[13] The revised $7,500 limit is unlikely to help and may make the situation worse.

For dependent care FSA purposes, an employee is highly compensated (an HCE) if:

- The employee is a >5% owner of the company; or
- The employee's compensation from the company for the *prior year* exceeded an indexed amount ($155,000 in 2024; $160,000 in 2025).[14]

All other employees are non-highly compensated employees (NHCEs). This includes non-owner employees hired during the current year, because their prior year company compensation will usually be $0 (unless a rehire).

[12] For example, it is possible for a participant to exceed the calendar year limit if the plan allows participants joining mid-year to elect the maximum amount (i.e., instead of pro-rating the election amount). This does not affect the employer, but it will affect the employee's federal tax return.

[13] Specifically, the 55% average benefits test under IRC §129(d)(8).

[14] The definition for compensation is the same definition used for an employer's required end-of-plan-year nondiscrimination testing for its retirement plan(s) (e.g., 401(k) and 403(b) plans). This is basically Box 1 of Form W-2 with all pre-tax deductions added back in. Gross compensation will work for many employees, but stock options or other related incentive compensation will distort the results.

The applicable nondiscrimination rules prohibit discrimination against NHCEs, but they do not prohibit discrimination against HCEs. An employer could choose to adopt the revised $7,500 for its rank-and-file employees (i.e., the NHCEs) while continuing to limit its HCEs to $5,000 or some greater amount below $7,500.

This approach may not be enough to cause the employer's dependent care FSA plan to satisfy nondiscrimination testing, but it should have a net positive effect on the results and eliminate or reduce the need to cut back tax-free benefits for the HCEs by the end of the year. For practical reasons, an employer taking this approach may choose to apply the lower limit to certain job titles and above rather than trying to fine-tune it based upon each employee's actual compensation for the prior year.

There is another OBBBA provision that may have a negative effect on dependent care FSA nondiscrimination testing discussed in the next section (see Expansion of dependent care tax credit below).

Expansion of child and dependent care tax credit

The OBBBA significantly expands the child and dependent care tax credit (DCTC) beginning in the **2026** tax year.

The DCTC is not an employer-provided benefit and does not require employer involvement. We are covering it because the DCTC tends to negatively affect dependent care FSA nondiscrimination testing, and it appears the expansion of the credit may make this worse.

The DCTC in a nutshell

The DCTC allows a taxpayer to pay for child or other eligible dependent care expenses and claim a percentage of the following amounts as a credit against taxes owed on their federal personal income tax return:

- up to $3,000/year in qualifying expenses for a single eligible individual, or
- up to $6,000/year in qualifying expenses for two or more eligible individuals.

No double-dipping: The rules prohibit double-dipping on tax breaks for the same expense, so an expense reimbursed tax-free through a dependent care FSA is not eligible for the DCTC.

The DCTC for 2025

The existing credit is tied to a taxpayer's adjusted gross income (AGI).[15] It begins at 35% of the eligible qualifying expenses and rapidly tapers down to 20% for taxpayers with an AGI of $43,000 or more. For taxpayers with two or more children and <$50,000 in household income, this tends to produce a better tax outcome than a dependent care FSA. For this reason, the DCTC siphons away some employees who might otherwise elect to participate in a dependent care FSA.

The DCTC for 2026 and subsequent years

Beginning in 2026, the credit starts at 50%, tapers down more slowly, and is still 35% for taxpayers with an AGI of $75,000. The potential value of the DCTC appears to grow faster than the corresponding dependent care FSA savings for lower- and middle-income households. This may increase the number of employees who waive FSA coverage in the future.

[15] Adjusted gross income is gross income minus certain deductions (known as "above-the-line" deductions) and appears on the 2024 Form 1040, Line #11. Standard and itemized deductions occur *after* the AGI calculation, so AGI does not reflect them.

Other comments

- *Must owe tax to benefit from DCTC* – For planning purposes, anyone can benefit from a dependent care FSA. By contrast, the DCTC is a non-refundable credit against tax liability. It cannot reduce a taxpayer's income tax liability below $0. In other words, you cannot receive any part of the credit as a tax refund and must otherwise owe income tax to benefit from it.[16]

- *Not mutually exclusive* – Dependent care FSA and DCTC benefits are not completely exclusive despite the prohibition on double-dipping for expenses.

    - For 2025, a taxpayer with two or more children can receive up to $5,000 in tax-free reimbursements from a dependent care FSA and still potentially claim a DCTC credit for up to an additional $1,000 in qualifying child care expenses. This may only be worth one or two hundred dollars, but it's available. For 2026, the dependent care FSA limit increase to $7,500 makes this moot.

    - The DCTC remains a useful tool for HCEs who experience cutbacks to their tax-free FSA benefits due to a nondiscrimination testing failure. If an HCE loses tax-free dependent care FSA benefits, it is not a double-dip for the HCE to claim a DCTC credit for those expenses.

Examples

The following examples are intended to compare the potential outcomes between a dependent care FSA and the DCTC. These are merely simplified examples used as illustrations. Please consult your tax advisor regarding which approach might be the best option. You should not rely on these examples for your own tax planning.

In the examples below, the "combined effective federal/state tax rate" is an attempt to reasonably reflect both income and payroll taxes. We are aware that some states have higher income tax rates than others while some states have no income tax.

Example 1 (2025)
An employee is married, has one eligible child, and at least $15,000 in qualifying child care expenses. Assume the employee has $75,000 in adjusted gross income, a combined effective federal/state tax rate of 25%, and uses the standard deduction on their federal personal income tax return.

Dependent care FSA		DCTC	
$5,000	eligible child care expenses	$3,000	eligible child care expenses
25%	combined effective federal/state tax rate	20%	credit percentage for an AGI of $75,000
$1,250	tax savings	$600	maximum tax credit

Example 2 (2025)
An employee is married, has two eligible children, and at least $25,000 in qualifying child care expenses. Assume the employee has $75,000 in adjusted gross income, a combined effective federal/state tax rate of 25%, and uses the standard deduction on their federal personal income tax return.

Dependent care FSA		DCTC	
$5,000	eligible child care expenses	$6,000	eligible child care expenses
25%	combined effective federal/state tax rate	20%	credit percentage for an AGI of $75,000
$1,250	tax savings	$1,200	maximum tax credit

[16] Using the 2024 Form 1040 as a guide, this means there must be a number greater than $0 in Line #16.

Example 3 (2026)
An employee is married, has one eligible child, and at least $15,000 in qualifying child care expenses. Assume the employee has $75,000 in adjusted gross income, a combined effective federal/state tax rate of 25%, and uses the standard deduction on their federal personal income tax return.

Dependent care FSA		DCTC	
$7,500	eligible child care expenses	$3,000	eligible child care expenses
25%	combined effective federal/state tax rate	35%	credit percentage for an AGI of $75,000
$1,875	tax savings	$1,050	maximum tax credit

Example 4 (2026)
An employee is married, has two eligible children, and at least $25,000 in qualifying child care expenses. Assume the employee has $75,000 in adjusted gross income, a combined effective federal/state tax rate of 25%, and uses the standard deduction on their federal personal income tax return.

Dependent care FSA		DCTC	
$7,500	eligible child care expenses	$6,000	eligible child care expenses
25%	combined effective federal/state tax rate	35%	credit percentage for an AGI of $75,000
$1,875	tax savings	$2,100	maximum tax credit

Remember: The dependent care FSA is more valuable for higher income households, but the available benefits may be affected by the nondiscrimination rules. By contrast, the DCTC is potentially more valuable at lower income levels, but it can only benefit taxpayers who would otherwise owe income tax.

Increase to employer-provided child care credit

IRC §45F provides a non-refundable tax credit to employers that provide child care facilities for their employees (e.g., onsite day care). The existing credit is:

- 25% for costs to build and operate the facility, and
- An additional 10% for other resource and referral costs,
- Up to a maximum tax credit amount of $150,000 for a tax year.

The OBBBA increases the credit for expenses paid or incurred on or after **January 1, 2026** as follows:

- 40% for costs to build and operate the facility (50% for eligible small businesses), and
- An additional 10% for other resource and referral costs,
- Up to a maximum tax credit amount of $500,000 for a tax year ($600,000 for eligible small businesses). This amount is indexed annually for inflation.

A business that meets the gross receipts test under IRC §448(c) over a 5-taxable-year period (instead of 3) qualifies as an eligible small business. Further discussion is outside the scope of this Alert.

Improvement to adoption assistance credit

The OBBBA improves the adoption assistance credit by making up to $5,000 of the adoption-related expense credit refundable beginning with the **2026** tax year.

The adoption assistance credit is not an employer-provided benefit and does not require employer involvement. We are covering it because it interacts with tax qualified employer-provided adoption assistance programs under IRC §137.

Adoption-related tax assistance for 2025

The maximum adoption assistance credit allowed under IRC §23 is $17,280. This is a non-refundable credit against tax liability. It cannot reduce a taxpayer's income tax liability below $0. In other words, taxpayers cannot receive any part of the credit as a tax refund and must otherwise owe income tax to benefit from it.[17]

The maximum amount that an employer can exclude from an employee's taxable income under IRC §137 for adoption assistance benefits is $17,280.

The 2025 income threshold at which both the credit and income exclusion for employer provided benefits begins to phase out is a modified adjusted gross income (MAGI) of $259,190, and it is completely phased out for taxpayers with MAGIs of $299,190 or more.

Adoption-related tax assistance for 2026

The 2026 adoption-related assistance limits for 2026 are not available as of the publication date of this Alert. The OBBBA will make up to $5,000 of the adoption assistance credit refundable. This means up to $5,000 of the credit can count toward a tax refund.

No double-dipping: The rules prohibit double-dipping on tax breaks for the same adoption-related expense, so an expense reimbursed tax-free through an employer's adoption assistance program is not eligible for the adoption assistance credit.

Other benefit-related provisions

The following are additional benefit-related provisions unrelated to HSAs or child care and adoption expenses.

Permanent relief for employer-provided educational assistance programs

The provision permitting employer-provided educational assistance programs under IRC §127 to reimburse for existing student loans on a tax-free basis up to an annual limit was set to expire at the end of 2025. The OBBBA makes this feature permanent.

The annual limit remains $5,250 for 2025 and 2026. The annual limit is indexed annually for inflation for later years.

Modification to qualified transportation fringe benefit rules (no bicycles)

The OBBBA made two revisions affecting employer-provided qualified transportation fringe (QTF) benefit plans under IRC §132(f).

No bicycles

The earlier Tax Cuts and Jobs Act of 2017 suspended bicycle commuting expenses as QTF benefits from 2018 through 2025. The OBBBA makes this permanent.

[17] Using the 2024 Form 1040 as a guide, this means there must be a number greater than $0 in Line #16.

Various state and local laws may require employers to offer bicycle commuting benefits and/or provide incentives to do so. Any bicycle commuting benefits provided by an employer will be subject to federal income tax when paid to employees. An employer should be able to take a corresponding deduction as a business expense.

Inflation calculator

The OBBBA makes a small improvement to the inflation adjustment calculation that should increase the annual limits for vanpooling, transit passes, and parking beginning in 2026.

Improvement to paid family and medical leave credit

The OBBBA makes certain improvements to the existing paid family and medical leave credit for employer tax years beginning in **2026**.

- The paid family and medical leave credit was set to expire at the end of 2025. The credit is now permanent.
- The existing credit applies only to wages paid by the employer to eligible employees on qualified leave. The improved credit is also available for premiums paid by an employer for insurance coverage that provides the required leave benefits.
- The credit is now available to employers providing paid leave benefits in states that mandate paid family and medical leave benefits. The credit is only available to the extent the benefits exceed the state mandates.
- Employers may reduce employee eligibility from one year of employment to six months (or any period between six months and one year).

Wait, there is a federal tax credit for providing paid family and medical leave?

Yes, it first appeared for 2018, but please do not feel like you missed something critical if you haven't heard of it. The credit ranges from 12.5% to 25% of the wages paid to employees on qualified leave, but it comes with a few catches:

- The employer must operate a documented leave program that meets specific requirements.
- The employer cannot take a tax deduction and claim the credit for the same paid wages (i.e., no double-dipping).
- The credit is non-refundable and cannot reduce the employer's income tax liability below $0. In other words, it cannot result in a tax refund

Relatively few employers take advantage of the credit, and we assume the primary issue is that the tax deduction for paid wages is more valuable. The perception is that allowing the credit against insurance premiums will increase adoption, but an employer should not be able to take a business expense deduction and also claim the credit for the same insurance premiums (i.e., no double-dipping again).

ICHRAs: Status quo

The earlier House bill included an extensive section for individual coverage health reimbursement arrangements (ICHRAs) and renamed them custom health option and individual care expense (CHOICE) arrangements. This section was cut from the final law.

The ICHRA language that appeared in the House bill was nearly identical to the existing ICHRA regulations except for two minor changes. The primary intent behind this effort was to protect ICHRAs by writing them into federal law and making it harder to repeal them. Since ICHRAs exist only in regulations, a future administration could get rid of them by simply having the respective federal agencies withdraw their regulations.

The existing ICHRA regulations remain valid and enforceable, and we are not aware of any significant risk to ICHRAs in the foreseeable future.

Employer action items

We addressed specific employer considerations for most of the OBBBA provisions directly affecting employer-provided health and welfare and other fringe benefits in their respective sections in this Alert.

Employers should consider whether, how, and when to implement certain changes, including: (i) changes to telemedicine benefits to take advantage of the HDHP/HSA relief; (ii) offering HSA-compatible direct primary care arrangements in conjunction with an HDHP; and (iii) taking advantage of the increased annual limit for dependent care FSA benefits.

We recommend employers seek the assistance of appropriate advisors to assist with decision making and any implementation. Appropriate advisors include, but are not limited to, legal counsel, tax advisors, insurance brokers, and consulting firms. Employers should discuss the potential risks associated with offering telemedicine and DPC arrangements on a standalone basis with legal counsel.

Certain changes – or the timing of certain changes – will require the participation and cooperation of insurers, third party administrators, or other vendors. Employers wanting to implement changes during a plan year in progress may face greater resistance and those mid-year changes may prove particularly difficult to administer . Please be aware that changes to plan design and/or administration may require amendments to plan materials and may trigger various disclosure requirements.

About the author

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