



The Availability of Pre-tax Dollars for Healthcare Services

As healthcare costs continue to rise, patients are struggling to pay for medically necessary services that are either not covered by insurance or subjected to a high annual deductible. These high out-of-pocket costs may result in the patient forgoing necessary care or failing to submit payment to the provider. Patients need options to manage and better afford these expenses without sacrificing access to care or penalizing the provider.

Flexible Spending Accounts (FSAs)

Flexible spending accounts (FSAs) were developed in the 1970s due to the increase in the cost of employer-sponsored health benefits. At that time, employers began instituting annual deductibles and co-insurance or excluding coverage for a range of services such as vision, dental and alternative medicine. The Internal Revenue Service (IRS) developed FSAs as a way to allow employees to pay pre-tax dollars for medical expenses not covered by employer-sponsored healthcare plans, thus allowing patients greater flexibility to pay for medically necessary services. Fifty years later, more than 63 percent of employers currently offer FSAs.¹ Patients continue to use their FSAs to pay for deductibles, co-pays and non-covered dental services provided by oral and maxillofacial surgeons, such as dental implants or extractions.

Prior to the adoption of the Affordable Care Act (ACA) in 2010, there was no federally imposed annual limit on the amount an employee could contribute to an FSA but most employers restricted such contributions to \$5,000 annually. These contributions had to be utilized or lost at the end of a calendar year unless the individual's employer offered a 75-day grace period for the use of the funds in the subsequent year. The ACA, however, established a \$2,500 annual contribution limit (indexed annually for inflation) but maintained the "use it or lose it" requirement. This new mandate significantly limited the amount of pre-tax dollars individuals could save to pay for the services. In 2013, the IRS announced individuals were allowed to roll over \$500 of their unused FSA funds to use at any point the following year if their employer chose not to offer the 75-day grace

period.² This provided some relief to patients, but when the average cost of a single dental implant (which is typically not covered by insurance) ranges from \$3,000 to \$4,500, it can be difficult for patients to save enough in a timely manner using an FSA to pay for the care they need.³ This often forces patients, in particular those with significant health issues, to forgo treatment due to lack of financial means.

Health Savings Accounts (HSAs)

Health savings accounts (HSAs) were established as a part of the Medicare Prescription Drug, Improvement, and Modernization Act (Medicare Modernization Act, or MMA), which was signed into law in 2003. These medical savings accounts enable individuals enrolled in high-deductible health plans (HDHPs) to save pre-tax dollars to pay for healthcare expenses such as deductibles, co-insurance or co-payments in addition to non-covered, but medically necessary, services. This allows patients the ability to receive cost-effective, necessary care without the burdensome use of a gatekeeper, primary care provider or insurance company administrator. Finally, employers have the option to contribute into their employee's HSA, providing a significant employee benefit.

Contributions to HSAs are currently capped at \$4,300 for single or \$8,500 for married individuals, and an unlimited amount of unused funds may roll over at the end of the year.⁴ The average general annual deductible for single coverage in an HSA-qualified HDHP is \$2,658, but more than 36 percent of covered workers are currently enrolled in an HDHP with a deductible of \$3,000 or more. Outside the HDHP market, the average deductible for covered workers is \$1,787.⁵ Unfortunately, individuals in this group are prohibited from establishing HSAs and must utilize savings accounts with lower contribution thresholds, such as FSAs, or pay their deductibles utilizing post-tax dollars. In addition, IRS rules prevent an employer from offering an HSA to an employee who has access to other insurance, such as a spouse's FSA plan. Finally, prior to the adoption of the ACA, unqualified withdrawals from HSAs were penalized at 10 percent.

The ACA, however, established a 20 percent penalty for these withdrawals, a significant increase that could potentially deter participation.

Conclusion

Patients should be provided with the best tools to help them manage their healthcare decisions and associated costs. To offset the rising out-of-pocket costs patients face through increased deductibles, co-payments and co-insurance, it is the position of AAOMS that patients be allowed to contribute a larger amount of pre-tax dollars to FSAs and HSAs, establish an HSA with health plans that require a high level of out-of-pocket costs but are not defined by the IRS as an HDHP and roll over from year-to-year any unused portion of their FSA contribution to avoid losing their contributions. In situations where patients have access to their spouse's insurance or FSA plan, patients should be allowed to participate in their employer-offered HSA. Prohibiting participation in such plans unfairly penalizes patients for services they may not utilize, could limit insurance coverage options for those who cannot participate in their employer's HSA coverage and adds barriers to cost-effective saving for healthcare expenses. By increasing the annual contribution caps for HSAs and FSAs and allowing more patients to establish HSAs, patients will be able to access medically necessary care at a more affordable rate. In addition, by allowing a greater portion of FSA funds to roll over, patients will feel comfortable in contributing to a fund to prepare for uncovered or surprise medical expenses without the fear of losing those funds at the end of the year. Both expansions would allow families to save money for their healthcare, encourage consumer engagement in healthcare decision-making and incentivize consumers to become informed about healthcare services.

White Paper



Reference

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