KANSAS DENTAL ASSOCIATION

Date: February 4, 2026

To: Senate Committee on Financial Institutions and Insurance

From: Daniel C. Nielson DDS, FACD
Owner Great Plains Oral & Maxillofacial Surgery, PA

RE: **Support of HB SB 330**– ensuring transparency in prior authorization act

Chairman Deitrich and members of the Committee, I am Daniel Nielson, an Oral & Maxillofacial Surgeon practicing in Olathe, and a Past President of the Kansas Dental Association (KDA) representing the dentists in the state of Kansas. Thank you for the opportunity discuss my and the KDA's **support of SB 330.**

Kansas dentists are in strong support of SB 330. Health care costs are increasing, and the patients we care for want to know what their treatment will cost before it is performed. SB 330 will provide the people of Kansas aspects of transparency in both the prior authorization process as well as the post treatment/ post payment phase. By allowing this change, Kansans will know how much their insurance company will pay on their behalf, and that the payment may not be revoked or altered after the treatment has been performed. This is the only way a level of trust can be established with our patient. Our wonderful patients know they need dental treatment; they just want the financial impact so they can determine if they can afford it. Additionally, a frequently incurred issue addressed by this bill is retroactive denial, which is just as it sounds, after the treatment has been completed the payment is reduced or not revoked.

As a private practice Oral Surgeon, I can attest we make great efforts to walk our patients through the process of explaining their diagnosis, what treatment options are appropriate for them and lastly how the treatment will impact them financially. If a patient has insurance coverage, both medical or dental, the process can be complicated and intimidating. Dental offices across Kansas make great efforts to guide our patients through the maze that is their insurance benefits and make sure they are comfortable with the financial aspects of the proposed treatment. Despite my office's extensive time and best efforts, weekly I see payments not received as stated on the prior authorization and even worse retroactively denied after treatment is completed and the dental office has closed the claim!

Currently, without a prior authorization, the best a dental financial coordinator can do is hope they gain access to a policy document that states a fee schedule for or certain category or specific treatment codes of the Usual Customary Fee (UCF). Even if this information was readily available, it can still be extremely inaccurate. This is because it does not reflect the many exclusions, restrictions and caveats insurance companies place in their polices, which seem to be almost impossible to find and drastically effect the benefit to the patient. Insurance

companies include many caveats: is the service covered, are their stipulations for that coverage like a “missing tooth clause”, is prior treatment needed before a particular code will be covered, is medical necessity criteria required and/or satisfied, and the list goes on and on. This brief, but non-inclusive list is just to see if the code “could be paid,” then the task of determining who pays what portion of the fee comes next. This is usually broken down to the amount the insurance company will pay, what the patient will pay and what will be “written off.” If this sounds daunting, it is, and not uncommon to take a minimum of an hour of a dental staff member time spent on a phone call or internet inquiry for a single patient! If a typical dental office has 15-25 patients per day you can see how this can monopolize a staff members’ time, increasing the overhead of a dental office, thereby driving up the cost of their care for needed additional staff and finally adding a level of stress on staff members that lead to employees leaving the dental field and staff shortage issues.

To circumvent the above mentioned inaccurate and laborious process, we then offer our patients a service of sending off for a prior authorization from their insurance company. This request from an insurance provider requires a dental office to file documents, x-rays and an appropriately coded treatment plan for the insurance company to review. Occasionally the insurance company will require further information, but at the end of the process an official written document is provided as the prior authorization. This document in my practice usually takes 3-5 weeks to get, although this delay is not ideal for patients who need treatment in a timely manner, many patients need to know the financial burden of treatment before committing to the procedure. This document appears to answer all the above variables for the dental office and the patient, but unfortunately this insurance provided document is frequently not honored by the insurance company and both the patient and the dental office are left in a horrible situation.

An overwhelming majority of dentists across Kansas operate a dental practice that are small businesses in communities where the patients are their neighbors, friends, basically folks they could see every day. I feel we all would agree, in efforts to be a respected member of a community you would stive to foster trust by providing a good service, at a fair price and to be honest in business dealings. All dentist I have spoken to say, in our current dental insurance environment it is impossible to be transparent and to be perceived as honest, when the cost we quoted them for treatment is not correct! This is despite the time, effort, and delay to get an official document from the patient’s insurance company, that they will possibly not honor. This breaks down, if not destroys, the trust in the doctor/patient’s relationship and even effect how neighbors perceive one another in a community.

If a prior authorization has been received and the patient agrees to move forward with treatment, we are not out of the woods yet! That second issue of **retroactive denial** is commonly incurred, both at the time of initial insurance payment and even several months after the treatment is done with payment received and the claim closed. Despite the delay to treatment from numerous communications between dental office and insurance company, dental office and the patient, benefits are not as the insurance company put in their prior

authorization. Now the patient is "stuck" with owing a much larger amount, and they are mad! For example, in my office the extraction of a set of four wisdom teeth under IV anesthesia is a very common procedure and this situation could make a difference of the cost to a patient increasing $1,000 -$2,000, above what was initially quoted by my staff. Unfortunately, this situation is forced to be handled by the dental office and not rectified by the one who caused the situation, the insurance company with their current business practices. Rightfully so, the patient is upset and surprised, usually asking if we are being deceptive in our business practices or are we incompetent in our knowledge of insurance coverage. Neither is the case, but I can understand their frustration and questions!

The scenario is this – the current legal practice of insurance providers in Kansas, regarding prior authorization and retroactive denial, is without transparency and causing the trust of patients to be lost. As a dental provider and an owner of an oral surgery practice I strive to gain the trust of my patients, from both a surgical and business practice standpoint. SB 330 is a big step in financial transparency for the people of Kansas. Furthermore, it would align us with 11 other states with similar prior authorization protections for its citizens, while not effecting the dental insurance providers ability to provide coverages in those states. I ask for you to support SB 330 and let's regain some of the trust that has been chiseled away from the people of Kansas! Thank you for the opportunity to provide written testify today in **support of SB 330**.