jenkins
dentistry for kids

Date: February 8, 2022

To: The House Committee on Health and Human Services

From: Kevin J. Robertson, CAE
Executive Director

RE: **Support of HB 2545** – de minimis coverage

Good afternoon, I'm Dr. Jill Jenkins, a pediatric dentist practicing in Shawnee, Kansas and I'm the Current President of the Kansas Dental Association (KDA). Thank you for the opportunity to appear before you today. As a dental professional, we diagnose dental needs specific to each patient. Our treatment recommendations are based on many factors including: cavity risk, gum health, overall health, grinding, alignment and the list goes on. Patients expect that their dentist will formulate a treatment plan specific to their dental needs taking into account these many diagnostic factors. It then falls on the dentist to explain to patients the associated costs for their recommended care, while taking into account the patient's insurance coverage. If a procedure is not covered by insurance, the patient understands it is their responsibility to pay for that service, and can choose to move forward or not, as legislation passed in 2010 for non-covered services provides for.

Obviously the more covered services a dental insurance plan has, the more attractive that plan seems in the marketplace. By finding and exploiting a loophole in the current law, insurance carriers are now claiming many more covered services by reimbursing dentists a small, very minimal fee for these previously not covered services. Essentially, this allows insurance carriers to technically abide by the language of the 2010 law, but in practice now circumvents the intent and spirit of that law. By placing this nonsense reimbursement fee, insurance companies can now claim the procedure is "covered", and therefore are contractually able to set a top limit on what dentists can charge patients for a previously uncovered procedure. This top limit is often below what it costs a dentist to perform that procedure. How does this affect dentists? We are now backed in a corner with options to: 1.Provide necessary services that will be reimbursed at fees below the cost of the materials and lose money (for example surgical guides are highly recommended for certain dental surgical procedures, but de minimis coverage in one insurance plan places a top end of $100, when lab costs top $300 to fabricate the surgical guide); 2.Decide to eliminate the ideal treatment option when presenting options to the patient, or 3.Get fed up by being in this position and drop the insurance plan all together.

How does this affect the patient? The patient now effectively has lost the right to opt for this service, because insurance coverage (in a de minimis fashion) has taken that option out of the dentist's toolkit and stripped the patient of the ability to choose to pay out of pocket for this non-covered service, if they so desired. Or worst case scenario, a patient's trusted dentist will no longer accept their insurance and they are forced to pay completely out of network fees or find a new provider.

This practice harms the dentist-patient relationship by forcing the dentist to make decisions based on insurance limitations that may not always be in the best interest of the patient, which causes distrust and potentially jeopardizes a valued relationship.

If you agree with the intent of the 2010 legislation, then you will agree with HB 2545 which seeks to honor the ability for dentists to propose all treatment plan options to a patient and provide the patient with fully transparent costs, allowing them to make a decision based on their true needs, and not options limited by an insurance carriers de minimis loophole.