March 24, 2025

RE: SB 2280 – Oppose

Chair Warrey and Members of the Committee,

On behalf of the National Association of Dental Plans (NADP)[1], we appreciate the opportunity to share our concerns with SB 2280 that would apply the medical prior authorization process to dental plans. We respectfully oppose the bill due to the inclusion of dental plans.

Dental Is Different

Including dental plans in the prior authorization process would significantly disrupt how the dental market currently operates. Dental plans offer a wide variety of products and benefit designs compared with medical plans. Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventative services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. Over the last five years, the industry has had negative price growth in some years and the highest yearly increase was only 2.5 percent.

In dental, pre-treatment estimates are utilized to develop a treatment plan with a patient. For example, a patient needing multiple root canals could consult with their dentist on a timeline for care based on their dental needs. The dentist in turn could submit a pretreatment estimate to the patient's insurance plan to determine the coverage and medical necessity standards of their coverage. This healthy engagement through a pretreatment estimate allows a patient to receive care covered by their plan and develop a thorough care plan for the dentist.

The pretreatment estimate process works in the dental market because the claims tend to be less complex than medical claims, which require a prior authorization process. The pretreatment estimate process allows patients to receive more timely care and reduces the administrative burden on both providers and carriers. Today, many medical providers report that they spend at least 16 hours a week on prior authorizations.[2] The prior authorization process can take as long as three weeks. In turn premiums and cost of care may increase to meet the expanding administrative costs, feeding a cycle of cost increases that harms access to care and outcomes. For example, patient care would likely be delayed as carriers require prior authorization before many basic and major treatments can be provided so consumers, in addition to carriers and providers, would be negatively impacted.

Pretreatment Estimates

The key distinguishing feature between prior authorizations and pretreatment estimates is that the latter is an optional process where providers and insureds can request information about benefit coverage and

[1] NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

[2] American Medical Association. 2017. Prior Authorization Physician Survey. https://www.ama-assn.org/sites/default/files/media-browser/public/government/advocacy/2016-pa-survey-results.pdf

cost to receive an estimate. Requiring carriers to undertake the prior authorization process for proposed dental treatment not required as part of the plan will add tremendous expense to the claims process, which ultimately is reflected in premiums. It will also add to the amount of time it'll take for the patient to receive needed treatment.

Prior authorization is most commonly used as a managed care tool to control costs and avoid unnecessary expensive procedures. A prior authorization requires advance approval for, usually higher cost services following a review to determine if the proposed service is medically necessary. Once issued, a prior authorization is generally valid for a period of time and represents the carrier's promise not to subsequently deny payment for that service on the ground that it was not medically necessary.

However, in dental insurance, a pretreatment estimate is intended to serve as a confirmation that the patient is covered by the dental plan as of the date of inquiry and that the proposed treatment is a covered benefit under the patient's dental plan. A pretreatment estimate is neither a guaranty of payment nor a determination of the necessity for the service. It is essentially an assurance to the dentist that the patient has insurance coverage as of that date, provides an estimate of the patient's likely out-of-pocket expense and, provided the patient has not used up all of their benefits when the claims is submitted, what the plan will pay.

Unlike the prior authorization, the dental plan makes no determination as to the medical/dental necessity for the procedure and the carrier has the right to determine retrospectively that the treatment was not required. Providers have a mechanism to appeal these decisions if they disagree. Because of the limited narrow scope of a pre-determination, it can be processed far more quickly than a prior authorization. This process helps keep dental premiums affordable.

Thank you for your consideration.

Respectfully submitted,

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National Association of Dental Plans