

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

SSB 5351 Collaborative

(Dental Loss Ratio and Relative Payment to Providers Based on Network Status)

Summary of Meeting 2: November 21, 2025

Training Room | WA State Office of the Insurance Commissioner | Tumwater, WA

Member Attendance: *see Appendix*

Ruckelshaus Center Facilitation Team: Amanda Murphy, Chris Page, Gaby Diamond

Meeting Goals:

- Continue to get to know each other and develop common understanding of purpose, roles, and responsibilities of the SSB 5351 Collaborative
- Review and finalize operating procedures including group roster, group agreements, and key process elements
- Review additional information about dental loss ratio (identified during last month's meeting) and discuss whether any additional information is needed to enable productive dialogue and problem solving
- Review and discuss draft goal statement on dental loss ratio
- Develop shared learning and understanding about relative payment for dentists or denturists based upon provider network status – through the lens of each members constituent/entity they are representing

WELCOME AND INTRODUCTIONS

Amanda Murphy (Ruckelshaus Center Senior Facilitator) welcomed members and reviewed the meeting goals. She asked members to introduce themselves with their name, affiliation, and a response to the following question: *“What is one thing you are looking forward to hearing or learning today?”* Responses included:

- The “walk a mile” presentations and learning about issues from new members
- Hearing other organizations’ perspective on relative payment and more information on DLR
- Diving deeper into issues, including Washington state specific DLR data
- Hearing different perspectives
- What it’s like to work in a denturist office
- Hearing from dental providers

Amanda then reviewed the agenda and asked the Collaborative if they had questions, additions, or changes to suggest; there were none.

October meeting summary:

Chris Page (Ruckelshaus Center Senior Facilitator) explained the idea of accepting and approving meeting summaries “for the record.” He explained that these meeting summaries are not meeting minutes, which for example, would have time stamps for each agenda topic and a more rigid structure, but are instead a summary of meeting presentations, discussion topics, and key points. Meeting summaries will be posted on the website once the Collaborative reviews and accepts them as final.

Chris then asked whether members had questions, comments, edits, or changes for the October 30 meeting summary. He asked members to email the Center with any suggested edits, so the group can consider accepting them at its December 12 meeting.

Group Decision: *Amanda asked if members were ok with accepting notes for the record going forward and there were no objections.*

Discussion Group Agreements

Amanda and Chris reviewed the following proposed additions to the group agreements, based on suggestions and feedback members gave during the October meeting:

- Say “ouch” if someone says something that hurts. Say “oops” and genuinely apologize for the ways your intention did not match your impact.
- Proactively communicate to leadership, decision makers, and other key personnel the progress of the Collaborative, including emerging decisions and agreements of the Collaborative and the context or rationale for them.

Consensus Group Decision: *Members adopted these additions to the group agreements. All members gave a thumbs up, thereby agreeing and finalizing the discussion group agreements.*

REVIEW AND FINALIZE OPERATING PROCEDURES AND MEMBERSHIP

At the October meeting, members agreed to review the remaining sections of the operating procedures following the meeting and to send any modifications they propose to the Facilitation Team in advance of today’s meeting. The Facilitation Team did not receive any additional suggested modifications from members.

Membership: At the October meeting the Facilitation Team asked members if there were constituencies or voices not represented in the current member list. Following an in-depth discussion, the group decided to further pursue adding a seat that represents periodontists, endodontists, and orthodontists, and a seat to represent purchasers. Following the meeting, the Facilitation Team worked with members and OIC to identify individuals to contact to gauge their organization’s interest and willingness to participate. The following individuals/organizations expressed interest and willingness to participate as members of the Collaborative:

- Jina Jilek (DoctorPerio) and Ron Gray (Advancedo), representing endodontists, periodontists, pedodontists, and orthodontists. Ron Gray will serve as alternate.
- Patrick Connor, National Federation of Independent Business (NFIB) representing small business purchasers.
- Denise Giambalvo, Washington Health Alliance representing large businesses purchasers.

Consensus Group Decision: *Members discussed and agreed to adding the three additional seats.*

Member Roles and Responsibilities: The Facilitation Team reviewed changes suggested by members during the October meeting (shown in tracked changes). Members discussed the proposed changes, including what the process should be if a member(s) is not adhering to the operating procedures.

Related Issue Raised: Delta Dental of Washington (DDWA) shared concerns regarding recent actions by the Washington State Dental Association (WSDA) that seemed inconsistent with Operating Procedures. DDWA explained and shared communications, including social media, which called upon dentists not to participate in the DDWA annual member meeting in order to prevent a quorum, and to continue withholding participation until DDWA changes its out-of-network policy. DDWA felt the group should know about it, given that this is about one of the policy issues the Collaborative is to address as part of this process (relative payment based on network status) and the intent as communicated in social media by some WSDA members was to impact DDWA’s ability to conduct business. DDWA asked the group to consider discussing and developing a process to address violations of the Operating Procedures.

WSDA thanked DDWA for raising the concern. They provided additional context about the importance of this issue to their member dentists and their views about DDWA’s out-of-network reimbursement policies being anticompetitive. They also explained that this call to action of dentists to not participate in the annual member meeting started before this Collaborative’s first meeting and before these Operating Procedures were drafted. WSDA noted that a letter or statement from DDWA expressing their commitment to this Collaborative process and addressing the issue of reimbursement payments relative to network status would help.

Amanda thanked the members for modeling problem-solving in the discussion and asked other members to weigh in on the issues and how to address them.

Discussion:

- Is there a preferred process for how to adhere to the “No Surprises” responsibility? How should potential issues be brought to the group?
- If a member has something they think should be brought to the group, the process could be to first bring it to the facilitation team, and they will determine with the entity how and if it needs to be brought to the full group.

- What if a member is not adhering to the operating procedures? What should be the process for addressing that? How will the group hold each other accountable?
 - Bring it to the Facilitation Team.
 - Daylight the issue to the full group. If the issue continues, then perhaps report it to the Legislature.
 - If the issue persists, report to the Legislature to have the member removed.
 - To address the issues that the Legislature tasked this group to work on, all members at this table are important. We cannot solve these issues if an entity is not at the table. Part of our task is to work together, understanding that conflicts will occur.
- The Operating Procedures are intended to support improved relationships among the parties, which most members have talked about as a desired outcome from this process.

Amanda thanked the members for modeling respectful problem-solving during a difficult discussion. She suggested the Facilitation Team draft a section on the process for adherence to the operating procedures for the group to review at the December meeting.

Action Item: *The Facilitators will draft a new section about adherence to the operating procedures for the group to review at the December meeting.*

In the spirit of “no surprises,” as articulated in the Operating Procedures, WSDA informed the group about potential legislation for the upcoming legislative session that may interest other members. If members wish to learn more or discuss, please contact WSDA’s contract lobbyist Chester Baldwin (chet@lobbywa.com) .

DENTAL LOSS RATIO (DLR): WASHINGTON-SPECIFIC DATA AND INFORMATION

At the October meeting, Steve Drutz and Jane Beyer from the Office of the Insurance Commissioner (OIC) gave a high-level presentation about Dental Loss Ratio (DLR). During the ensuing discussion, members requested additional data and information about DLR, including DLR data specific to Washington State dental insurance carriers. While such data is not yet fully available, since legislation requiring the reporting of WA specific data just passed during the last session), OIC filtered out WA specific data from the 2024 national data.

Q&A and Discussion:

OIC walked through the DLR spreadsheet. The DLR calculation has claims paid in the numerator and total payments from premiums in the denominator. OIC reiterated that the numbers shown are only part of the story; numbers don’t capture nuance or tell you why.

- Do all the percentages add up to 100%?
 - No, 93.1%
- One of the carriers has a DLR at 100%... is this correct? Does that mean they did not have any administrative expenses?
 - Given that the usual (MLR) calculation is based on a three-year rolling average, and the data from only one year of reporting, it could be skewed. This is why looking at

data from only one year isn't necessarily informative. Data from a three- or five-year period better allows us to see what is happening - outliers versus trends.

- When will 2025 data be available? If we are unable to collect another year of WA-specific data before this process concludes, would carriers in the room be willing to share their data?
 - Carriers submit to OIC in April 2026 and will probably be published by June 2026.
- In general, do loss ratios stay consistent?
 - They are relatively consistent, with small fluctuations, aside from events like Covid-19.
- What about the variations in levels of coverage?
 - This is a financial calculation and does not consider the differences in coverage.
- It is important to note that for MLR calculations under the ACA, there are different percentages for large vs small scale carriers. DLR would also need to differ in this way.
- The national-level data that OIC collects comes from uniform NAIC (National Association of Insurance Commissioners) annual filings. To get any sort of loss ratio lens on formulas or methodology would require a separate worksheet to get different data. It's feasible to do a separate financial undertaking but hard to envision in this timeline.

Action Item: OIC will confirm with Steve Drutz (OIC) whether the data in the table is data from 2024 or is data submitted in 2024.

DRAFT GOAL STATEMENT – DENTAL LOSS RATIO

Amanda introduced the “first offer” of a DLR policy goal statement for the group to consider, based on input the group provided during the October meeting. She proposed the Collaborative consider establishing a DLR workgroup to go more in depth on data and information and bring their findings back to the full group. Chris explained that any workgroups would run parallel to the Collaborative, with the facilitation team organizing, tracking, and facilitating meetings.

Members agreed to establish a DLR workgroup and discussed the goal statement as follows:

- Can the first paragraph be written as a question? More of an exploration about whether establishing a DLR would help? The legislation does not give direction as to whether there should be a statutory DLR, just that it should be discussed.
- Believe the Legislature put this group together because they do believe a DLR policy is needed.
- Don't carriers currently report DLR to the OIC, and OIC has the discretion to not approve DLR rates? If so, then why would a policy be needed?
- What is required for DLR reporting in other states? For example, MA and OR?
- Can we collect more data to get to a target loss ratio?
- When it comes to MLR and DLR policies, it is the carriers and the providers that benefit. What about patients? The consumers? How do they benefit from these policies? Some data has shown that such policies have led to increased premium costs.

- There is some early research on the MLR that shows carriers paying their own subsidiaries, and that payment amount goes into the numerator of the MLR calculation.
- A similar group in Arkansas is looking at DLR policy and has decided to hold off on creating anything until there is at least 2-3 years of DLR reported data. There is not enough information available to make informed policy.
- The goal is to ensure the money goes to patient care, so there is value in having a metric attached to mechanisms that can support that.

Amanda called attention to the following three bullet points articulating a potential policy goal rationale for DLR and asked the group to consider:

The goal of a Dental Loss Ratio policy is to:

- *Ensure that a sufficient percentage of collected premiums is allocated to clinical dental services and quality improvement activities.*
- *Ensure a sufficient percentage of collected premiums is allocated for the maintenance and promotion of operational efficiency and cost-effectiveness in insurer administrative functions.*
- *Promote affordability, transparency, and equitable access to high-quality dental treatment along with sustainable business models for both dental care providers and insurers.*

Action Item and Decision: *Members agreed to establish a DLR workgroup. One of the first tasks of the group will be to discuss and refine the DLR goal statement and bring back to the full group to discuss. Members that expressed interest in participating in the work group included: John Quirk, Bracken Killpack, Lisa Egbert, Jenna McKenzie, Ron Gray, Carolyn Logue, and Kim Hudak. The consumer representatives will discuss and will let the Facilitation Team know which of them will participate in workgroup meetings. The Facilitation Team will be in contact with those that indicated interest to schedule the first meeting of the working group.*

SHARED LEARNING: RELATIVE PAYMENT BASED ON PROVIDER NETWORK STATUS

The Facilitation Team asked each member to present a “Walk a mile in my shoes” description of what “*Relative Payment to Providers Based on Network Status*” is like for the constituency they represent. Each member had ten minutes to share and 10 minutes for questions.

Perspective of Washington State Dental Association (WSDA—Lisa Egbert & Bracken Killpack)

WSDA has a clear vision of an optimal oral health marketplace where decisions are made collaboratively by patients with their dentists rather than dictated by insurers. WSDA believes that benefits providers should assist clinical decisions of dentists, not overrule them. When dental benefit payments fail to keep pace with inflation, it compromises patient choice and care; the time spent on patients; and which treatments, materials, and labs dental providers can use. Young dentists entering the field have \$300,000-\$400,000 to pay in loans. Patients want choice and should receive the full benefits they or their employer has paid for. DDWA’s practices are

uniquely anticompetitive compared to others in the state and Delta Dentals in other states, forcing patients to pay for more care or to move dentists, especially those in rural areas.

Over the last several years we have seen an increase in costs in some elements of dental care: dental hygiene wages have doubled in many locations in Washington while the scarcity of dental hygienists and dental assistants has gotten worse. Many material and equipment costs have also increased dramatically. Costs to practice are increasing at the same time that practice revenues are declining. We try to keep patients happy but if they decide to leave, they can, and dentists feel they cannot leave the network. To make ends meet, I have had to submit insurance claims on my time off.

Questions for WSDA (with Responses):

- Does WSDA have any programs to encourage people to become hygienists?
 - We don't need to since there are not enough spots at schools to accept all the current applicants. However, two new dental hygienist schools are coming online.
- Does contracting with dentists play an important role in making dental care affordable?
 - Dentists see a lot of value in being a part of multiple networks. We know that people are more likely to go to the dentist if they have benefits and are more likely to see in-network dentists. Also think carriers and providers should be able to have fair and open discussions to join a network.
- Is there an issue of dentists feeling that they cannot choose their network?
 - Yes. Several dentists feel on the verge of not being able to care for patients because they feel they have no choice of networks. That's because for many dentists as many as 70-80 percent of their patients have a benefit from one carrier. Many markets (such as PEBB and SEBB) are 90% controlled by DDWA. It's problematic when anyone feels like they don't have a choice. The market choice situation shouldn't be as extreme as it is.
- From the patient's perspective, is there value in a network in terms of pricing, protections against balance billing, and knowing the dentist is certified?
 - As a dentist, my fees were the same for every person. We didn't surprise bill either: you had an exam, created a treatment plan with pricing before leaving the office. The Dental Quality Assurance Commission protects patients; it should not be the place of a benefits organization to make those decisions.
- Dentists think they can't leave a network because of the potential loss of business, is that because of unfair reimbursements or administrative work?
 - Both.

Washington Denturist Association (WDA—Carol Carbone and Carolyn Logue)

In 1994 the state passed a law to allow denturists to practice. Denturists are small manufacturers and work directly with the public. Most insurance plans, including DDWA, do not allow denturists to join their network, and the insurance carriers pay a lower rate to denturists than they do to dental offices. Because of this lack of access, we often estimate costs for patients.

Denturists work hand in hand with dentists; however, many denturists feel they are not seen or treated like the professional practice that they are. There have been a few laws passed intended to ensure those with dental-only plans have access to denturists.

There used to be multiple programs like Veteran's Affairs (VA) vouchers and flex debit cards that could have been used to help patients access denturists. A lot of those in rural areas don't have denturists in their plans, meaning those who need care must travel to Seattle. We are trying to create a category for denturists on the national level with Delta Dental.

Questions for WDA (with Responses):

- Could you describe your average customer?
 - All ages, but average around 50.
- Do you need a referral to see a denturist?
 - No, but if the patient is not ready for dentures, they will be referred to a dentist.
- How has demand for services been?
 - There is a high demand for services. If people can afford them, implants are common, especially the more affordable snap-ins versus permanent implants.
- Have advances in dental care impacted the business?
 - No.
- Do you do partial implants?
 - Yes.
 - How often do you do full sets?
 - At just my practice, about 500 a year.

American Association of Retired Persons (AARP—Marguerite Ro)

AARP represents those who are 50 and older, about 40% of Washington's population. In 20 years, that population will quadruple, so whatever financing system we have then will need to take that into account. AARP does not have a policy for in-network versus out-of-network payments, but do have a strong interest when it comes to access and affordability of care, which are outlined in AARP's health principles:

- Engage with communities in healthy living,
- Ensure adequate and affordable care that is not burdensome to consumers,
- Provide sufficient financial assistance,
- Deliver high quality care and maintain costs, and
- Ensure access and equity.

AARP is a data driven organization. Two of the most recent surveys about oral healthcare were done in 2019 and 2021. Highlights from those surveys show cost is a key reason for people to delay or not access dental care. Having dental insurance was not a guarantee of getting dental care; 41% of those with dental insurance earning less than \$50,000 are likely to forgo care. That percentage changes to 20 something when looking at those earning over \$50,000.

There is also significant misinformation around Medicare coverage. It does not cover dental care. Rural populations also face significant barriers like traveling long distances for care or not having insurance at all. Even if they go to the dentist, they have difficulty paying their bills.

We are dealing with an aging population with not enough workforce entering the geriatric dentistry field. Some counties in Washington have over half of the population already over 65 years old, and with transportation and affordability issues this will present challenges for care access. Dentists play a key role in primary care, even if they are completely separate from medical care, so we need to pay attention to the gaining population.

Questions for AARP (with Responses):

- Do you feel consumers have any idea how many dollars go into care?
 - No, it would be positive just to have people going to the dentist.
- Can you share the demographic data by county in Washington?
 - Yes.
- Have you seen difficulty accessing care due to older people retiring?
 - Not in quantitative data but anecdotally have heard this as a reason.
- Is the access to care a lack of providers in general or lack of providers in network?
 - The data is not differentiated; there are other factors like delayed care as well.

Delta Dental of Washington (DDWA—*John Quirk & Sean Pickard*)

Maximized care involves a balance of purchasers, patients, and provider partners. DDWA is constantly looking at ways to remove barriers, create access and affordability, and stabilize costs. DDWA covers 2.2 million people in WA or about 37-54% of the population. Networks are optimized for in-network dentists with eight out of ten dentists participating.

Adults with dental coverage are three times more likely to get care than those without, and in-network benefits provide the patient with a range of protections and a negotiated discount. The OIC regulates all contracts between insurance carriers and in-network providers, which is another benefit of being in-network. Other benefits include zero co-pay preventative care, negotiated contractually guaranteed dental service fees, protections from balance billing, rigorous credentialing process, and dedicated customer service.

DDWA has a statement in the benefits booklet regarding out-of-network practices. There is no national standard in terms of specific out-of-network reimbursement rates. Usual, customary, reasonable (UCR) out-of-network payments could incentivize dentists to leave networks. More than 90 percent of care for Delta patients is provided by Delta dentists. Patients want a robust network, predictability, and pricing. There are no requirements to be in a network; some dentists are and some are not; some are in multiple networks.

Currently DDWA pays denturists out-of-network rates, but we want to engage more with denturists to learn the best ways to bring them into the network.

Questions and Comments for DDWA (with Responses):

- How is regulation a benefit for in-network and out-of-network?
 - It comes down to indirect expenses. For in-network practices, you need to follow the requirements in a contract filed (with OIC) that must follow state law.
- How many members does Delta Dental have nationwide?
 - About 70 million members nationwide. DDWA covers 4 million.
- Example: Say I'm a Meta employee with Delta Dental of California coverage. Do I get counted as a member in the DDWA data?
 - No.
 - Is there any sense of how many patients in this state are covered by a different Delta Dental? No.
- Could many of the benefits of having an in-network provider also be protection that could be required via state law? For example, laws that protect against balanced billing.
- There are no requirements under state and federal law to require out-of-network rules.

ACTION ITEMS, CLOSING AND REFLECTION

Amanda recapped the meeting with the following action items:

- Members shall send any edits to the October 30 meeting summary to the facilitation team. The facilitation team will incorporate these and share them before the next meeting so the members can accept them for the record.
- The November meeting summary (this document) will be ready for review with the meeting materials before the next meeting.
- The group came to consensus on discussion ground rules. They will be posted to the website.
- The facilitators will provide draft verbiage for adhering to operating procedures. There was consensus on all the other sections.
- More information and data (see above) for the OIC to collect and bring back to the group.
- AARP's survey information will be shared with the members.
- The group agreed to form a DLR Work Group. If additional members are interested in participating, please contact the facilitation team.
- General/conceptual agreement on the three bullet points of the draft DLR problem statement.

December and January meetings: Some members expressed concern over hosting the December meeting in Seattle, as the traffic north from Olympia can be very bad. Chris asked members if they wanted to discuss the location of meetings again. Members suggested having the December meeting in the SeaTac area (or south of Seattle), and the meetings during legislative session will be in the Olympia area. Because session begins in January, the group may consider having two working group meetings each month in place of a full group meeting.

Amanda then asked members to share something they learned or are taking away from the meeting, their responses follow:

- A better sense of the areas of contention between key parties
- Appreciation for everyone bringing up their issues
- Appreciated the “walk a mile” presentations and learned a lot of new things, including about the denturist profession
- Appreciation for the DLR conversation
- Hearing other perspectives
- Robust conversation and being uncomfortable
- The complexity of the issues, affirming this is the right process
- Appreciated meeting the full group and the quick turnaround time that OIC and the facilitators took to get the new members involved
- Talking to others who understand different parts of the issues
- Adapting, changing the agenda, having dialogue that’s positive even if challenging
- Only 20% of the state’s population has dental insurance, hopeful we can broaden the horizon
- Figured out how we would react to a stress test, and the group remained engaged even when uncomfortable

ADJOURN