

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

SSB 5351 Collaborative

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

DRAFT Summary of Meeting 4: January 30, 2026

Member Attendance: see Appendix to these notes

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

Meeting Goals:

- Continue to develop shared understanding
- Finalize meeting summaries from November and December
- Provide updates and announcements (as relevant/appropriate)
- Hear update from the Workgroup
- Receive presentation from ADA Health Policy Institute on Dental Loss Ratio (DLR)
- Discuss data needs and determine a way forward for DLR

WELCOME & INTRODUCTIONS

Facilitator Amanda Murphy (Ruckelshaus Center) welcomed members. Co-Facilitator Chris Page (Ruckelshaus Center) shared that the group will continue to meet in person as resources allow, with a virtual option available. Amanda began a round of introductions.

REVIEW OF AGENDA AND ACTION ITEMS/DECISIONS FROM DECEMBER MEETING

Amanda reviewed the agenda, highlighting the focus on dental loss ratio (DLR). She noted that if the Collaborative finishes their discussions on DLR early, the remainder of time will be spent discussing relative reimbursement payment to providers based on network status.

- The group approved the November 21st meeting summary with minor edits (submitted via email and reviewed onscreen here) and one spelling error in Advancedo (was spelled Advencedo).
- The group approved the December 12th meeting summary with minor edits (submitted via email and reviewed onscreen).

Group Decision: The members approved the November 21st and December 12th meeting summaries, and **Action Item:** the Facilitation Team will upload both documents to [the website](#).

The Collaborative approved its May 29th meeting date/location: The Washington State Dental Association (WSDA) will host the meeting on the floor above the WSDA Pacific Northwest Dental Conference at the Washington State Convention Center in Seattle.

UPDATES & ANNOUNCEMENTS

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- [HB 2626](#) has a committee hearing next Tuesday at 8am (2/3/2026) and could bring significant changes to a pre-existing premium tax that would impact dental benefits and coverage.
- WSDA and Delta Dental of Washington (DDWA) came together to speak out against [SB 6138](#), a bill that would require a multi-provider model for certain dental procedures.
- There was a legislative work session on dental workforce issues the week before this meeting. A number of members from the Collaborative, including WSDA and DDWA participated. It focused on continuing workforce shortages and ways to address them.

WORKGROUP REPORT OUT

The SSB 5351 Collaborative Workgroup meets every other Friday from 10am-12pm on Zoom. While the Facilitation Team will take meeting notes they will not be as detailed (simply capturing the ideas shared). Amanda shared highlights from the Workgroup meeting and asked members to add any details they wished.

The workgroup conversations on DLR had three common themes: transparency (for all areas of the system), access/affordability/viability, and consistency (or lack of). Members' comments included:

- An emphasis on transparency and remembering that all the issues are intertwined.
- Reminder to read the shared resources on the Center's website: [SSB 5351 Collaborative | The William D. Ruckelshaus Center | Washington State University](#). It was helpful to understand perspectives on DLR and its potential side effects.
- Asking, "If DLR is a tool to drive oral health, does it actually get us there?" Cost is the biggest barrier, so it is important to know how DLR helps if the focus is improving oral health across the state.
- For a system to work, it needs to establish an equilibrium. In some instances, neither the plan nor the provider is happy since they don't feel they have enough money and they feel burdened with too many policies, while in others there are not enough policies and too much money.
- A member shared appreciation for the workgroup and urged the Collaborative to take advantage of the opportunity to not replicate what is happening in the medical system. It is hard for consumers to feel there is transparency when they do not have a lot of choices. How do we ensure everyone's needs are met and ensure access to oral health services for patients?
- The majority of covered patients are a part of self-insured plans, and several group purchasers that contract with insurance carriers dictate what they want their plans to be.

SHARED LEARNING: American Dental Association (ADA) HEALTH POLICY INSTITUTE PRESENTATION ON DLR

Kamyar Nasseh (Health Economist from the ADA Health Policy Institute) presented data and information on the 13 states implementing some type of dental loss ratio or refund/rebate.

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(Presentation slides available on the [Collaborative website](#) under the January 30, 2026 drop down). Summary of each state's reporting:

- California reports data by market type and market segment (Health Management Organization, or HMO vs Preferred Provider Organization, or PPO). Every insurer must report all DLR data and information on claims paid, taxes, premiums, covered lives and member months. CA also provides a reporting template for data transparency. They do not collect information on fraud prevention and quality improvement activities.
- Colorado reports detailed DLR data by market type and includes claims paid, quality improvement, fraud prevention, taxes, premiums, and member months.
- Washington reports claims paid, premiums, covered lives, and member months but does not differentiate by market type. Before 2025 (2024?) the data reported was not specific to Washington state.
- Maine reports claims paid, premiums, covered lives, and member months but does not report fraud prevention, taxes paid, and quality improvement activities.
- Arizona reports DLR data for individual and group market (with no differentiation between small and large group), and does not include covered lives, premiums earned, taxes, claims paid, fraud prevention, quality improvement, and member months.
- Virginia reports only large group market DLR data. Additional transparency is needed on covered lives, premiums earned, taxes, claims paid, fraud prevention, quality improvement, and member months.
- Louisiana started reporting market/plan segment DLRs in 2025, but are still missing covered lives, premiums earned, taxes, claims paid, fraud prevention, quality improvement, and member months.

Questions:

- **Q:** In states that track individual, small, and large group markets, are there consistent definitions? **A:** It varies state to state.
 - **Q:** Is it defined in WA? **A:** Yes, 50 and below is small group; some states have it as below 100. It depends on the state.
- **Q:** Why is the DLR lower for individual vs small vs large group? **A:** It can vary depending on whether they do "community rating" (insurers charge the same premium for all individuals within a specific geographic area). The market is not big to begin with, so community rating is used to make it more equitable. With large groups, there is more assessment of the employer as a carrier so they can collect more data.
- **Q:** Which state has the best data? **A:** Colorado is fully transparent and the data is easily accessible and usable.
- **Q:** Are there any impacts to patients based on the premiums or access to plans? **A:** Relying only on data to determine the impact is too simple, and it's important to remember that customers of dental plans are typically employers.

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- **Q:** What are your thoughts on the model legislation from the National Council of Insurance Legislators (NCOIL)? **A:** Legislation based on the model passed in Montana. It looks at outliers while providing incentives to meet their MLR, which is different than setting a floor.
 - **Q:** Does the data show carriers leaving states that have established a DLR? What challenges arise for plans that come and go from the market? **A:** We cannot see insurers that leave, but it would be helpful to know if it reduced choice.
- **Q:** Are there any commonalities from state to state for what goes into the numerator and denominator? **A:** The ADA has developed ideal factors to consider, but overall, the goal is to have clear data on premiums collected versus claims paid out.
- **Q:** Did you notice any state with enforcement (like a rebate)? **A:** Still researching this, but there is a rebate in Massachusetts, North Dakota, and potentially Montana. In MA law, there is language around not raising premiums too high, so it will be interesting to observe.
- **Q:** How does Colorado define quality improvement measures? **A:** Unsure.

GROUP DISCUSSION ON HOW TO PROCEED WITH DLR

Amanda asked Sydney Rogala (OIC) to share what she found out with research on other states. Because it is early and uncharted space, there are not many traceable impacts yet. The most common basic characteristic is that premiums are in the numerator and claims in the denominator. In MA the state requires the DLR for each insurance carrier to meet 83%, in ND it's 75%, and in MT and ME it's based on standard deviation over a 3-year average.

If the group wants to proceed, it should ideally keep in mind a starting timeline, standard deviation, broken down by what markets, and clearly defining the numerator and denominator. The Collaborative's summarized discussion includes:

- **Q:** Was the intent of the DLR (in other states legislation) to drive oral health? **A:** Not specifically, the intent focused on affordability.
 - In my view, DLR is a regulatory tool disguised as affordability. Some states include intent language.
- Reminder to not confuse affordability for value, because we are not discussing quality. Affordable care does not mean quality care.

Amanda asked the Collaborative whether it had enough data and information yet to craft a policy recommendation. If not, what does it look like?

- We can reach out to Milliman, since they have independent studies on Massachusetts and California.
- We do not have enough information. Unless we did a standard deviation with a look back period, but that will not include blind spots.
- The healthcare environment is changing rapidly, and will be chaotic in the coming years, so we should be discussing which elements of data to collect, then collect 3-5 years of it before making an informed decision.

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- We should see if we can differentiate between rural versus urban data. It would also help to find the difference between individual, small, and large group plans.
- It is important to be intentional about the data collected, so it is not too much of a burden for administrators.
- It would be helpful to have visuals both on how premiums are spent and on the various costs to operate a dental practice.

Does anyone feel like a percentage or floor needs to be recommended?

- The NCOIL model has a basic piece of advice: “don’t do too much too fast until you know the data and understand the effects to costs.” The data will inform a lot, and whatever is done with relative payments will impact loss ratios.
 - Another member agreed and noted that self-insured people do not negotiate contracts.
- **Q:** Does the recommendation need to be in the form of a bill? **A:** Not necessarily, since legislative staff can work with OIC to create bill language. OIC cannot regulate more than the law allows, so there is value in having it clearly defined in law.
- Sydney (OIC) will look into the Revised Code of Washington and the Washington Administrative Code to see what changes (i.e. whether administrative or legal) are needed to enable the collection of the needed data.

Group Decision: *Amanda asked the members if anyone was unable to live with the OIC looking into what is doable around the laws on collecting data. No members objected. Sydney will share OIC’s needs at the next collaborative meeting.*

Members discussed the different elements mentioned in the ADA presentation earlier. One sentiment that emerged is that ideally there should not be too much additional work to collect the data and report it, since that can be a heavy lift for administrators. Some members are not concerned with collecting too much additional data, instead suggesting to focus on the definitions of what’s included in the numerator and denominators.

The members decided to have the workgroup discuss on the Colorado and California data sets and legislative language to develop draft language for a potential recommendation to the legislature on data reporting and collection and bring that draft recommendation back to the Collaborative. It was also suggested to form an advisory type of board to review the collected data after this group ends. Another member suggested reaching out to Milliman for more context.

BONUS DISCUSSION: RELATIVE PAYMENT BASED ON PROVIDER NETWORK STATUS

The Collaborative shifted discussion to the issue of relative payment after deciding on ways forward for DLR. Amanda asked members for their thoughts on priorities and shared commonalities while Chris shared a document compiling and group issues on reimbursement payments relative to network status from the workgroup meeting. Amanda highlighted the

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following themes: transparency, consistency (the lack of it), affordability/viability, accessibility, and opportunity.

Workgroup members reflected on the importance of transparency, in-network vs out-of-network access and costs, and the importance of focusing on the patient and their experience. Delta Dental of WA volunteered to present a few slides on in-network vs out-of-network transparency and patient experience. If other carriers can do the same, the group can potentially find the gaps. Beyond transparency and accessibility, network adequacy comes into play. Are we addressing reimbursement directly or addressing network participation to get to reimbursement? They are intertwined, and yet mutually exclusive policy discussions.

Full group discussion:

- The focus should be on in- vs. out-of-network and where this problem impacts patients/consumers the most. The Collaborative needs to understand who is most impacted from all three perspectives (patients, providers, and carriers).
- Understanding PPO vs HMO products could help patients/consumers become more educated on types of products available to purchase.
- Typically, patients/consumers don't know their specific coverage until they need to set up an appointment or have a dental emergency. If the Collaborative wants to drive oral health, then oral health needs to be a central goal when designing a new system.
- A fair, more competitive marketplace with more patients purchasing benefits would be ideal, so patients can have more control over their choice.
- More information on network adequacy would be helpful in understanding the urban vs. rural choice.
 - The OIC can give high-level information about this, but Washington is an "every category" state, where contracts are expected to have services available to all.
- Dental benefits are not a requirement and are mostly distributed through employers. From a carrier perspective, most employers want and value a robust in-network experience.

What would a system look like with no networks?

- It could look like a single-payer network that becomes a discount program. We might see quality decrease and costs increase because it changes the nature of credentialing and oversight of the accountable payer and provider.
- A membership structure like a gym with a monthly fee for services.
 - What is the threshold for when a membership program becomes insurance?
- This is about all networks, not one specific entity's networks. Orthodontists run a membership program currently regulated by the OIC. Dentists also have membership plans.
- Insurance (like medical or automobile) is typically framed as to not be used, but dental is different.
- If the goal is to incentivize people to go to the dentist, we need to figure out how to incentivize people and make it affordable.

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What is the value of a network? What happens if you are reimbursing in-network vs out-of-network equally, then what is the value?

- The way it runs now, that value to the patient is free cleanings.
- Dental insurance is not always thought of as insurance; we call it a pre-paid benefit.
- Cost drives outcomes. Insurance benefits dictate what patients do.
- Patients/consumers assume dental insurance is like health insurance. More education is needed.
- There is no perfect system. At some point everyone has to decide: do you want a plan similar to medical or something different? Someone has to pay the bill at the end of the day. How do we move the needle to benefit the providers and hold carriers accountable?
 - Integrated health systems are under attack because they are not producing affordable care.

Amanda thanked the members for a great discussion. She pointed out that to help make sure the Collaborative knows how to make it better, people need to have a collective understanding about how the system operates. The workgroup will start to examine the system.

ACTION ITEMS, CLOSING AND REFLECTION

Amanda recapped the following action items to the Collaborative:

- The November and December meeting materials have been uploaded to the website. If any members notice anything is missing, please let the Facilitation Team know.
- DLR conversations were robust and the group has a path forward to create a recommendation on methodology for data collection.
- OIC will report back what needs to change (statute or agency policy) for data collection. Also, what they need to do to collect.
- The workgroup will investigate CA and CO models, including required data reporting elements, and the ADA NCOIL model.
- DDWA will reach out to Joanne Fontana from Milliman to see what definition information is already available.
- The workgroup will discuss DLR and potentially develop a draft recommendation on it to bring back to the Collaborative, then will start to look at systems.

Amanda asked members to share one takeaway from the meeting and thanked everyone for a robust and productive discussion. The Facilitation team will send out the action items and agenda for the next workgroup meeting the week after the meeting.

ADJOURN

Appendix: Meeting Attendance X= attended in-person, V= attended virtually

Member	Attendance	Alternate Member	Attendance
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John Quirk, Delta Dental of Washington	X	Sean Pickard	X
Mackenzie Stewart, Lifewise Assurance Co./Premera Blue Cross		Megan Hartman and/or Christina Mojica	V both attended virtually
Jim Freeburg, Patient Coalition of Washington	V		
Jane Beyer, WA State Office of the Insurance Commissioner		Sydney Rogalla	X
Carol Carbone, Washington Denturist Association	X	Carolyn Logue	
Bracken Killpack, Washington State Dental Association	X	Lisa Egbert	X
Matthew Sinnott, Willamette Dental	V	Melissa Johnson	
Lisa Trussell, Dental Health Services Inc.	V		
Jenna McKenzie, Washington State Society of Oral and Maxillofacial Surgeons	X		
Jennifer Muhm, Association of Washington Healthcare Plans and Regence		Kim Hudak (USABLElife)	V
Marguerite Ro, AARP	X		
Jina Jilek, DoctorPerio (specialty practices like orthos, endos, perios, etc.)	X	Ron Gray (Advancedo)	X
Patrick Connor, National Federation of Independent Business		Lois Cook (America's Phone Guys)	
Denise Giambalvo, WA Health Alliance	V		