

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 5: February 27, 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 January meeting summary
- Provide updates and announcements
- Discuss draft Dental Loss Ratio (DLR) data collection recommendation prepared by the Workgroup
- Discussion on In-Network vs. Out-of-Network Reimbursement: give Workgroup direction on how to proceed to draft recommendation(s) regarding relative payments based on network status.

WELCOME & INTRODUCTIONS

Facilitator Amanda Murphy (Ruckelshaus Center) welcomed members and asked them to introduce themselves.

REVIEW OF AGENDA & ACTION ITEMS/DECISIONS FROM JANUARY MEETING

Amanda reviewed the agenda and asked if there were any questions. There were no questions from members and no edits to the January meeting summary.

Group Decision: *The members approved the January 30th meeting summary, and Action Item: The Facilitation Team will upload it to the [website](#). [Complete].*

UPDATES & ANNOUNCEMENTS

There were no updates from members of the Collaborative.

WORKGROUP REPORT OUT & DRAFT DLR DATA COLLECTION RECOMMENDATION

Amanda recapped the Workgroup meetings (held every other Friday, 10am-12pm; if you wish to join, please contact the Facilitation Team). The Workgroup reviewed Colorado and California's DLR data reporting templates and heard from carriers about their ability to provide the data elements. They also prepared a draft "first offer" of a DLR data collection and reporting recommendation for the full Collaborative to consider. Workgroup members also sent the Facilitation Team the terms they'd like to see defined in a DLR recommendation. Amanda asked the Workgroup members to add any additional information from the meetings:

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- Sydney Rogalla (OIC) reported that depending on what the Collaborative decides to recommend for DLR data collection and the terms needing to be defined, changes may be needed in the Revised Code of Washington, depending on how specific the rulemaking needs to be. OIC would create a new form to collect information and house it on WA.Data.gov. She suggested that enough data would be available by about 2030 to draw any conclusions: (rule changes by 2027 then collecting three years of data). Going back to collect 2024 and 2025 data for a “lookback period” would be a significant lift.
 - Members asked for more detail on why the lookback period might be difficult. The main reason is that carriers have not had to report all elements of the data, so they may not have the data to look back on.
 - For ideas about how an Advisory Committee could be incorporated, Sydney suggested looking at the [Ground Ambulance group and she will provide a link and materials.](#)

Q: Did the Workgroup discuss frequency of submission for reporting?

A: Yes, carriers would report annually.

- Important to note that the OIC cannot mandate self-insured plans to report. They are allowed to voluntarily report.

Amanda read the Workgroup’s “first offer” of a draft DLR recommendation aloud to the Collaborative, noting that it incorporates some of the verbiage from the Colorado and California bills. Feedback from members included:

- Make clear how to break out the data: HMO, PPO, large group market, small group market, individual, etc.
- Include in the recommendation to convene an advisory group for OIC once data has been collected
- Talk about the possibility of a one- to two-year lookback on the data
- Discuss required vs. optional data reporting
- Make clear the role of national data collection vs. Washington-specific
- There is risk in getting too granular with the data elements. Eventually it can start to skew the data if the dataset is smaller.
- Don’t let perfect be the enemy of good. Allow room to modify.

Action Items: *The Workgroup will discuss the feedback provided at their next meeting and will draft a second draft recommendation for the full Collaborative to review at the march meeting.*

Sydney Rogalla (OIC) will try to meet with California and/or Colorado about collecting data and then bring back information to the Workgroup. She will also ask Steve Drutz (OIC) about the timeline for data collection.

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IN-NETWORK VS. OUT-OF-NETWORK PRESENTATIONS, Q&A, AND DISCUSSION

General Scenario – Presented by Sydney Rogalla, OIC

Scenario: A patient (Leslie) needs a root canal due to an untreated cavity in her first molar on the right side, lower jaw. She is experiencing discomfort with chewing and drinking cold liquids but is not in pain. The root canal was diagnosed at Leslie's preventive service visit. Leslie does have dental insurance.

Key Information: - A root canal removes infected pulp from the inside of the tooth by drilling a hole in the tooth, removing the infected pulp, and then sealing the canal to prevent further damage to the tooth. The patient will need a second appointment to place the custom crown to seal the tooth. Root canals require at least two appointments. One for the procedure and one to place the crown. For this example, we are assuming Leslie has no complications that would require a second root canal or referral to a specialist, such as an endodontist.

See Appendix B for detailed visual of the In-Network and Out-of-Network Processes.

Questions and discussion from members:

- It is standard to do a diagnosis at every step of the process. If a dentist refers a patient to the endodontist, the endodontist will charge for an exam regardless of if the patient is in or out of the network.
 - A diagnosis also depends on the dentist; if they are experienced, they can do different procedures, so might not refer their patient out to a specialist.
 - Dentistry work is done in tenths of millimeters, so it can get very complicated. It is up to each dentist to know their skills and refer out the rest.
- There is no coverage for denturists and prosthodontists, as they are not allowed to be in network. Yet not a lot of general dentists can do those services.

Q: Is there a wide variation in what dentists charge for general services like cleanings?

A: That information is not available since there are no requirements for dentists to post their fees.

Dental Carrier Presentation: Delta Dental of Washington (DDWA), Sean Pickard and John Quirk. Presentation slides can be found here on the [website](#)).

DDWA provides patients seeking an in-network dentist a welcome email, the “find a dentist” tool, a cost estimator, and access to the “MySmile” patient and dentist dashboard. Patients can also call, chat, or text a DDWA customer representative. DDWA or any out-of-network carrier does not have control over the price and could result in balance billing to the patient.

Questions and comments from members:

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Q: Are dentists still doing pre-determinations?

A: DDWA encourages dentists to do them, but not sure if it's a requirement.

- There are no state laws requiring consistency in customer experience. Most plans offer pre-determinations, but it's not required to do so.
- On average, a pre-determination takes three days to complete.
- Pre-determinations are not a guarantee of benefit coverage- if a patient has another treatment done between the pre-determination and the service it was done for, it no longer applies.
- Three variables determine the out-of-network scenarios:
 - the allowed amount that DDWA pays out of network
 - the cost sharing percent of co-insurance (varied by network)
 - balance billing.

Q: For Delta's cost estimator tool, where does the data come from?

A: Data comes from estimates derived from aggregated data. for out-of-network services more globally, based on zip code.

Q: How often are these online tools used?

A: DDWA's public website has 2.4 million active users, 12% of which use the "find-a-dentist" tool.

Q: How many patients submit claims for out-of-network services?

A: Don't have exact number, but do know that 97-98 percent of all claims are for in-network care.

Dental Care Provider Presentation: Washington State Dental Association (WSDA), Bracken Killpack and Lisa Egbert. provided handouts (posted on the [website](#) under the February 27th Meeting section):

- An "[Initial visit for a new patient](#)" diagram, showed the perspective of the patient seeking care through both in-network and out-of-network lenses
- "[Patient costs for a typical restorative procedure based on a \\$200 fee.](#)"
- "[Patient out-of-network expenses](#)"
- "[Financial realities of owning a dental practice in WA.](#)"

Before a patient's visit, a dental office collects patient and payment/benefits information. At the initial visit, the patient gets an evaluation, x-rays, and anything else needed; they also receive a diagnosis and a treatment plan. Regardless of network status, each patient receives the same process.

Questions and comments from members:

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Q: Do the Explanation of Benefits (EOB) examples show fully insured and self-insured?

A: The focus was on preventative care visits, so I'm not sure if they are fully insured or self-funded.

Q: How do dental offices set fees?

A: Dentists can choose their price points, but most new dentists don't set their own fees, they are set and regulated and based off multiple factors like experience, specialty, usual customary rate (UCR), and location.

- The last resource shared, "Financial realities of owning a dental practice in WA" shows how as costs increase dentists are receiving less pay to keep their practices running.

GROUP DISCUSSION: RELATIVE PAYMENTS BASED ON NETWORK STATUS

Sticky note exercise: Members were given two large sticky notes and asked to respond to the following two questions:

1. *In 1-2 sentences, what is the specific issue/challenge/opportunity to address when it comes to relative payments based on network status?*
2. *In 1-2 sentences, how do you propose to address this issue/challenge/opportunity and how does your proposal also meet the needs of the other members at this table?*

Responses were as follows:

Relative Payment to Providers Based on Network Status

Issue to Be Addressed (Problem to Be Solved)?	Solution That Works for All?
Provider greater transparency for patients to get the oral health care they need and lowest cost possible.	A new financing system that encourages dentists and patients to collaboratively advance oral health.
Current dental insurance system does not do enough to encourage dental health	Making it easier and less costly for people to access preventive dental services and to understand the importance of taking care of their teeth
Affordability and accessibility for patients	Providing greater transparency for patients through patient tools
From OMS perspective, the issue is reimbursements from insurance providers and updating fee schedules. (A) How do we make sure providers can stay in business? (B) How do we keep care affordable (and accessible)?	Increase reimbursements from insurance companies to providers. Uniform information to patients from insurance companies. Transparency within/without providers on fee schedules / cost to patients with or without insurance.
Insurance companies' fees are too low and dental offices' businesses are suffering. Need to include all providers in network.	Insurance companies need to increase fees paid out, which will help businesses run a more successful practice & mean lower fees for patients.
A non-competitive market for dental benefits forces some patients to pay much more for non-network care. WA is different than the rest of the country.	Fair out-of-network rates required for all dental benefits carriers.
Largest WA carrier penalizes patients who go out of network by paying almost nothing. This traps patients into staying in network. Therefore, dentists can't leave network. Other carriers	Carriers should either: Pay the same amount for patient care whether a patient is in or out of network or pay a minimum of 85% UCR for out of network care. This would reset the market and make it fair for patients, practices and other carriers

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cannot compete because delta has the advantage of trapping 90% of dentists in their network.	
Is there legislative action or a role for OIC to assure that a contract & payment incentives/arrangements are in place that also results in wins for the “4 Ps” (payors, providers, purchasers, patients)?	Leg could set performance and contract metrics (think value-based payments)
Opportunity to learn from healthcare (financing) & pilot improvements (or at a minimum, create info) that helps us design a better dental system	Create financing pilots (look to other nations)
Not a problem to solve, but opportunities across industry (payors & providers) to find more opportunities for transparency	Not a problem to solve, but opportunities across industry (payors & providers) to find more opportunities for transparency
Not enough clarity for PTs or providers on reimbursements & what coverage looks like, which makes it difficult to give the care as a provider as PTs are driven by cost (rightfully so)	Collect the data for DLR in a way that is the same for all carriers to make it easier to digest.
What are the next steps to determine effectiveness (appropriate level of) DLR?	Gather data to assess what an affordable premium rate is that also sustains the dental system.
	Agree on common language for consumer-facing materials
Best I can tell, this question is about payments to out-of-network providers.	It would help to know if there is currently an industry standard or average percentage allowed by the insurers for OON claims. If there is not, perhaps discussions could begin with 50% of the average reimbursement amount allowed to in-network providers for the same services provided by an OON provider.
Dental HMO does not cover non-contracted providers.	So the out of network provider reimbursement isn't relevant to DHMOs. That is part of the trade-off for lower costs.

Discussion:

In the remaining time of the meeting, members got up and read what each other wrote. Amanda asked members to share their thoughts and reflections:

- Is there a problem we are trying to solve for patients? Affordability could be solved by new financing, efficiencies, and or mechanisms. The system needs to work for more people.
- The costs of running a dental practice have increased and the priority is still the patient, but if there is no change the independent practices may have to become corporate dental offices.
- Discussing the larger financial dental system doesn’t fit within the elements of SSB 5351, but I would like a larger discussion on that.
 - There are a lot of people in WA without dental benefits; how can we address this?
- We are increasingly in a dental benefits market with monoculture, and if the market share for other carriers gets smaller and less competitive, choice will decrease.
- Employers/purchaser groups want a robust network.

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- From a dental provider perspective, it can be difficult to negotiate rates with one benefits company.
- We need more information and data about drop-off providers after legislation, and out-of-network claims.
- Dental benefits are not required. If prices go up there is a real threat to care.

Action Item: The Workgroup will review the responses to the sticky note exercise to inform their work to draft recommendations for the full group to consider at the next meeting.

ACTION ITEMS, CLOSING, AND REFLECTION

Chris and Amanda thanked members for a productive discussion, great engagement, and noted that the group has reached the “groan zone” of the collaborative process, when parties express divergent perspectives. The following action items were discussed:

- The Workgroup will continue to discuss relative payment, and keep in mind the scope to focus on moving forward.
- The Workgroup will work on a “second offer” of the DLR recommendation on data collection and reporting.

ADJOURN

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

Member	Attendance	Alternate Member	Attendance
John Quirk, Delta Dental of Washington	X	Sean Pickard	V
Mackenzie Stewart, Lifewise Assurance Co./Premera Blue Cross		Megan Hartman and/or Christina Mojica	V (Christina)
Jim Freeburg, Patient Coalition of Washington	V		
Jane Beyer, WA State Office of the Insurance Commissioner	V	Sydney Rogalla	X
Carol Carbone, Washington Denturist Association	X	Carolyn Logue	V
Bracken Killpack, Washington State Dental Association	X	Lisa Egbert	V
Matthew Sinnott, Willamette Dental	V	Melissa Johnson	
Lisa Trussell, Dental Health Services Inc.			
Jenna McKenzie, Washington State Society of Oral and Maxillofacial Surgeons	X		

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Jennifer Muhm, Association of Washington Healthcare Plans and Regence	X	Kim Hudak (USABLElife)	V
Marguerite Ro, AARP	X		
Jina Jilek, DoctorPerio (specialty practices like orthos, endos, perios, etc.)	X	Ron Gray (Advancedo)	
Patrick Connor, National Federation of Independent Business		Lois Cook (America's Phone Guys)	
Denise Giambalvo, WA Health Alliance	X		

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Appendix B: Dental Insurance in and out of network process

