WASHINGTON STATE UNIVERSITY

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 8: May 29, 2026

Member Attendance: *see Appendix to these notes*

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

Meeting Goals:

- Continue to develop shared understanding
- Finalize April meeting summary
- Provide announcements (as relevant/appropriate)
- Hear update from the Workgroup
- Review, discuss (problem-solve as needed), and finalize (call for consensus) dental claims APCD analysis draft recommendation and pricing transparency draft recommendation
- Review and discuss "first offer" of draft out-of-network reimbursement recommendation

WELCOME AND INTRODUCTIONS

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

REVIEW OF AGENDA AND APRIL MEETING SUMMARY

Amanda reviewed the agenda, explaining that the focus will be on the first two recommendations (APCD analysis and pricing transparency). There were no questions about the agenda and no corrections to the April meeting summary.

Group Decision: *The members approved the April 24th meeting summary.*

Action Item: *The Facilitation Team will upload the April meeting summary to the website [Complete].*

UPDATES AND ANNOUNMENTS: There were no updates from members.

DISCUSS AND FINALIZE DENTAL CLAIMS APCD ANALYSIS DRAFT RECOMMENDATION

OIC shared a document with the Collaborative that summarizes the All-Payer Claims Database (APCD) report proposal but shortens the request so the OIC can do the work without waiting for it to be legislatively mandated. Sydney Rogalla (OIC) shared some details: the number of CPT codes will be 50, the data pulled will be from 2023-2025, and OIC will blind any data with less than 10 cells (for privacy). Language was added to allow the OIC to determine "the most appropriate statistics" in addition to or in place of the already listed requested statistics. The work would start after July 1, 2026 with a goal of presenting results by November 1, 2026. The timeline is short, so there may be some delays. The output presentation would show the data, graphs, and trends and released to the Legislature at the same time. Members' questions follow:

- **Q:** Will we receive a follow-up once it is ready? **A:** Yes, the drafts won't be made public but feel free to reach out to Sydney if you have questions. The OIC will send a formal email once it is ready and set up a meeting to discuss it a few weeks after.
- **Q:** To clarify, are you looking at all claims, or only fully-insured? **A:** Fully insured, stand-alone dental plans and PEBB/SEBB. Our team isn't sure if they can pull non-standalone claims.
- **Q:** Pediatric embedded in medical won't be included? **A:** No, it would skew the cost sharing amounts.
- **Q:** Can you explain the codes specialists use? **A:** Lisa Egbert described the types of providers for each code, with a variety of codes for procedures performed by different providers like periodontists, prosthodontists, endodontists, denturists, general dentists, and pediatric dentists.
- **Q:** Where there any codes used by Orthodontists? **A:** Ortho is complex and ranges in price from $4,000 to $10,000 with many variables.
    - Providers felt it would be better to get data on other codes.
- **Q:** Are there any specialties missing from the code representation? **A:** No, just orthodontists. Providers also made sure they added codes used more often and specialties are overrepresented.
- **Q:** Is there a way to sort the data by specialty? **A:** No, we cannot show who performed which procedure, just procedure codes. Providers offered to put together a list of codes and who more commonly performs those procedures to help.
- **Q:** What about rural vs. urban data? **A:** Geographic area was eliminated because of the time constraints.
- **Q:** What information do we expect to learn from this? **A:** Currently there is no data to prove or disprove assumptions and assertions about reimbursement rates. This would back up information presented previously. If there are surprises, they would be helpful to know as well.

Revised APCD Data Collection Recommendation – Call for Consensus
With the above revisions, the recommendation is as follows:

Summary Description: This analysis will look at Washington All Payer Claims Database (APCD) data to better understand charges and paid amount trends for common dental procedures for the commercial dental insurance market in Washington.

Scope: Study population and time period: The study will be restricted to commercial dental claims. The time period will include 3 calendar years, 2023 – 2025. In accordance with standard practice, claims will be limited to those that were paid as primary coverage; denied claims will be excluded.

The particular dental services used in this analysis will be a subset of common dental procedure codes (CDT codes) provided by the work group, in consultation with OIC.

Blinding rules will be applied to the results in compliance with CMS standards. Any cell with a numerator or denominator value of between 1 and 10 will be blinded.

Data elements of interest: The analysis will include the following data elements broken out by each stratification level (described below).

- Billed charges: The amount charged by the provider for a service.
- Insurer paid amount: The amount paid for the service to the provider by the health plan.
- Cost-sharing amount: The amount paid for the service by the enrollee. The cost-sharing amount is the sum of the copay amount, coinsurance amount and deductible amount applicable to each claim.
- Allowed amount: The total amount paid to the provider for a ser/vice. Calculated as the sum of the insurer paid amount and the cost-sharing amount.

For each of the elements described above, the OIC will calculate the minimum, maximum, average, median, 25th percentile and 75th percentile, or the most appropriate descriptive statistics, broken out by the different stratification levels.

Data stratifications: Service counts, charges, and paid amounts will be stratified by:

- Year of service
- Network status (In-Network vs. Out-of-Network)
- Carrier
- Procedure code

Output: The final product will include an aggregated Excel dataset, as well as charts and graphics highlighting key trends and findings.

Timeline:

Deliverable	**Due Date**
Summary statistics	7/15/26
First draft data set/work product	8/28/26
Second draft data set/work product	9/18/26
Final draft data set/work product and charts/graphics	11/01/26

Ground Decision/Consensus Agreement: *Amanda called for consensus, asking all parties individually if they support, can live with, or cannot live with the APCD recommendation. She read through the member list and asked each organization, every member said yes.*

Action Item: *The Facilitation Team will draft up the explanation for the report for context and the Facilitation Team will upload the Final APCD Recommendation to the website. [Complete]*

DISCUSS AND FINALIZE PRICING TRANSPARENCY DRAFT RECOMMENDATION

Chris shared the draft pricing transparency recommendation on screen as Amanda read it aloud. Amanda asked Workgroup members in attendance to share any additional thoughts before the full Collaborative discussion. Workgroup members noted that they put a lot of work into problem-solving this recommendation but a few members still cannot live with it. Some members feel requiring pre-determination would lead to more work without compensation for providers. The

last bullet, about a second free or low-cost option for another opinion, has not been discussed by the Workgroup either.

The Collaborative debated whether the language should require pricing transparency only from in-network providers, or from both in-and out-of-network providers. Other members asked if removing the out-of-network requirement would mean there is no obligation to the patient. Most providers do pre-determinations for out-of-network patients regardless, but if they cannot electronically submit forms then it significantly delays responses. Five days would be an improvement, as some carriers cannot commit to a two-day turnaround.

Providers expressed concern about putting something in place that would not be enforced since it could lead to friction between the patient and the provider. Advocates for patients noted that patients can also go directly to the carrier as well, although many patients don't have enough time to make calls to carriers.

Other members noted the burden it could add to dental provider offices, when they are already struggling financially. Some administrative staff in dental offices spend hours on the phone with carriers to ensure the correct information is shared to process a pre-determination. If it became a requirement, it would add extra work to already full loads. Some members noted that the proposed language says, "upon request by a patient," meaning not all patients would request a pre-determination.

This recommendation would also require carriers to allow out-of-network providers access to their portals and online forms, which would be positive for the providers not in the network. Sydney (OIC) also noted that a lot of the details would be worked out in rulemaking.

Some members suggested removing the out-of-network language, and others countered because this process already exists for in-network providers. A member suggested removing the out-of-network language in that bullet and adding another bullet specific to out-of-network.

Employers want their covered lives to have access and ability to request a pre-determination. A member suggested that carriers should suggest ways to address the administrative burden and access issues. Members also agreed to add "electronically" to the recommendation where it made sense, as all pre-determinations will happen quicker if they are not mailed in and all online.

Amanda asked members for a "temperature check," to see where the recommendation stands with members. Most members were thumbs up or thumbs sideways, and three entities were thumbs down. Amanda asked the members who gave a thumbs down to make an alternative proposal in writing that they can live with and how it meets the needs of others. This will be discussed at the next Workgroup meeting.

Members also discussed the last bullet point about free, set cost, or low-cost second opinions and agreed it did not belong in this specific recommendation around price transparency.

Questions:

- **Q:** How do you get the information to provide estimates to patients? **A:** They are based off a database with previous claims data.
- **Q:** Does a pre-determination give more assurance than an estimate? **A:** Just a little more.
- **Q:** How often does an out-of-network provider make a pre-determination request for a patient? **A:** For out-of-network providers it is not routine, and for some there are some limitations or variability in how they receive the pre-determination back.
- **Q:** How much does it cost to submit a pre-determination, including the administrative piece? **A:** The low end would be about $10 and on the higher end it could be between $30-$40.

Recommendation after Discussion:
The SSB 5351 Collaborative recommends requiring full transparency in the pricing practices of all dental providers and the reimbursement rates by carriers. This should include:

- Upon request by a patient, dental providers should be required to disclose prices, at a minimum for routine procedures prior to a visit.
- Upon request by a patient, dental providers must make a pre-determination request of the carrier. Upon receipt of sufficient information, the carrier must respond within five calendar days. Carriers must disclose electronically to in-network providers what information is required to fulfill a pre-determination request. The pre-determination information from carriers must include the specific denial or adjustment codes applied to reduce costs or deny a procedure, along with a clear, definitive list of the factors (i.e. clinical criteria, processing guidelines or otherwise) that determine eligibility for coverage.
- Upon request by a patient, for out-of-network providers: to address existing administrative burdens, carriers must grant access to their portals or develop another electronic mechanism for providing the above pre-determination information to all out-of-network providers within five calendar days. If a plan does not have out-of-network coverage, these requirements do not apply.

"FIRST OFFER" OF OUT-OF-NETWORK REIMBURSEMENT DRAFT RECOMMENDATION
Amanda explained that this proposal came to the Workgroup first and some members could not support it because there is no relevant data available. Other members wanted to bring it to the Collaborative for discussion. Feedback from members who could not support the proposal was attached to the document, so everyone could review the feedback before the meeting. Providers (who drafted the potential recommendation) felt their proposal (below) could address issues patients face when seeking care with an out-of-network dental provider, like not being able to use more of their benefits.

Providers Out-Of-Network Dental Claims Reimbursement Recommendation:
This proposal recommends that dental insurance carriers reimburse **out-of-network (OON) dental claims at the <u>minimum</u> of**:

- The applicable in-network contracted rate, or

- 80% of Usual, Customary, and Reasonable (UCR) charges, determined by geographic area code or region as based on Fair Health Consumers available data or any nationally recognized UCR data source, and the rates are updated at least annually.
- Applies to all covered dental procedures where an in-network contracted rate exists
- Applies only to OON claims; in-network contracts remain unaffected
- Policy stays in effect until future legislative policy supersedes it.

Members discussed the proposal and providers noted that they were open to adjusting it; they wanted to put something on the table to start with. Most members agreed that they would be prepared to discuss a proposal like this once OIC makes the APCD data available.

Members expressed concerns about how something like this could disincentivize providers from joining a network, which could lessen patient protections. One member shared that in Texas their providers are paid the same for in and out of network services, and there are still providers in networks and more competition. The OIC pointed out that in Texas there is a "any willing provider law" which makes it different than Washington's "every category" model. Members would like to see more data and information about the impacts that Texas faces in their model.

Questions:

- **Q:** Have members gone through the Workgroup feedback? **A:** Yes, and a few share the same concerns as the comments from Regence/USAble Life, which states:
    - "Mandating OON reimbursement at the lower of in-network rates or 80% UCR would:
        - Increase costs for many existing plans
        - Erode network participation and in-network steerage
        - Raise premiums and member out-of-pocket exposure
        - Reduce flexibility needed to manage diverse employer and market needs.
    - True premium stability and member protection are best achieved through strong networks, accurate provider data, transparent OON methodologies, and plan flexibility, not by setting a uniform reimbursement floor that shifts cost upward across the system."
- **Q:** Can we have across-the-board rate setting? **A:** Prices cannot be set because that would be regulated by federal anti-trust laws.
- **Q:** Can you have a combination of "any willing provider" and "every category"? **A:** No, they are mutually exclusive.
- **Q:** Is there nothing in the network adequacy calculation about whether rates proposed to providers cover the expense of the procedure? **A:** The OIC has no jurisdiction for network adequacy of rates. We ensure contracts filed are following state and federal law. The OIC cannot approve or disapprove the contract based on rates and those are not subject to public disclosure.

Members concluded that more data and analysis is needed before a decision on a proposal like this one can be made. The group also discussed networks, their importance for cost savings and

protection to patients, and the reality that dental benefits are not a requirement. Members noted that financing models, workforce structures, and overall oral health need attention as well.

Amanda asked members where they would like to go with the recommendation. Members decided that they do not have enough agreement or time on this proposal to continue discussions in the Workgroup or Collaborative.

Some members suggested adding language to the APCD recommendation around next steps to reconvene, similar to the DLR recommendation. The OIC suggested asking the Legislature to do a work session in the House and Senate health committees once the APCD data is ready. Members liked this idea and requested the OIC share the data with the Collaborative first, then the group can discuss before going to the Legislature.

Amanda asked members how they would like this proposal reflected in the final report. Members would like a high-level summary of the different points of view and the Facilitation Team will draft the language.

REVIEW WORKPLAN AND DRAFT REPORT

Amanda thanked members for their time and willingness to problem-solve. She also thanked the Workgroup members for their additional time, talent, and expertise. She recalled all the progress the group has made before sharing a visual of the draft report so far and summarizing its contents. The draft report will be sent to the Collaborative in the next couple weeks for initial feedback and corrections. She asked if Workgroup members would like to meet one more time before the next Collaborative meeting in addition to the June 12th Workgroup meeting. Members decided that the meeting on the 12th would be sufficient and there is no need for an additional Workgroup meeting.

ACTION ITEMS, CLOSING, AND REFLECTION

- The Pricing Transparency Recommendation will go back to the Workgroup for more discussion. If members cannot live with the recommendation, they will submit in writing to the Facilitation Team what they can't live with, why, and what they could live with that meets the needs of other members.
- The Out-of-Network proposal is off the table
- The OIC will draft language for the legislative work session to accompany the recommendation on the analysis of the APCD data.
    - The Facilitation Team will summarize the issues and concerns on the Out-of-Network proposal for the report.
- Jane Beyer (OIC) is retiring on June 15th, and Ingrid Ulrey will be taking her place and will join the remaining meetings.

Amanda asked members to close out the meeting by reflecting on something they learned from another member (not related to their own) that they did not know before. Members' responses included:

- I appreciated your attempts to find win-win solutions, especially in a policy area that might not be your focus.
- I was surprised to learn that with MLR in some areas the premiums increased due to vertical integration. With insurance companies owning medical practices and paying themselves higher fees, premiums increased for patients.
- I learned that dental brokers are a thing. I worked in oral health and not dentistry and I also learned about denturists.
- I also learned about denturists, and that they are able to join our network.
- I enjoyed meeting people from different areas I probably would not have met. It was also interesting to hear carriers recognize that reimbursement rates are an issue.
- I learned that at least one carrier operates through paper and not electronically.
- The complexity of Orthodontics and their codes.
- There's difficulty for some providers to access portals.
- Appreciated the openness and learned a lot about the provider's frustrations
- I am heartened by the kindness and friendliness everyone is affording each other.
- I appreciated learning about denturists and the complexity of the clinical side. It's interesting to hear how things have changed.
- It was sad to hear stories about difficulties and disappointing we could not come to more agreement. I hope our work provides the Legislature the information they need to move forward and make decisions that impact Washingtonians and give providers relief.
- It was helpful to hear about the providers perspectives, knowing that if we were to lose practices to private equity or larger corporations it would not be good for anyone.
- I wanted to acknowledge how hard it is to get to where we are. Any policy is a byproduct of everyone's input or output. I can't recall a time we've had anything close to this, and there is progress and substance in this Collaborative.
- I appreciated the purchasers' representative for their professionalism and historical knowledge of medical systems.
- I learned from providers their perspective on the challenges to run a practice and everything that goes into providing care to patients.

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

Member	**Attend?**	**Alternate Member**	**Attend?**
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
Jim Freeburg, Patient Coalition of Washington	X		

Jane Beyer, WA State Office of the Insurance Commissioner	V	Sydney Rogalla	X
Carol Carbone, Washington Denturist Association	V	Carolyn Logue	V
Bracken Killpack, Washington State Dental Association	X	Lisa Egbert	X
Matthew Sinnott, Willamette Dental	V	Melissa Johnson	V
Jenna McKenzie, Washington State Society of Oral and Maxillofacial Surgeons	V		
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)	X
Patrick Connor, National Federation of Independent Business		Lois Cook (America's Phone Guys)	
Denise Giambalvo, WA Health Alliance	X		