

SSB 5351 Collaborative – Workgroup
Draft Recommendation: Out-Of-Network Dental Claims Reimbursement
as of 5.15.26

This proposal recommends that dental insurance carriers reimburse **out-of-network (OON) dental claims at the lower 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.

Rationale for the Proposed Standard

1. Cost Control and Premium Stability

Paying the lower of in-network rates or 80% of UCR prevents perception of excessive reimbursement while maintaining reasonable access to care. It discourages artificially inflated billed charges without suppressing legitimate market-based compensation.

2. Fair and Geographic-Specific Reimbursement

Using area- or region-based UCR ensures reimbursement reflects local economic conditions, rather than outdated or national averages that may not align with real-world costs.

3. Reduced Member Financial Burden

Limiting reimbursement to predictable benchmarks reduces unexpected billing and improves members’ ability to estimate out-of-pocket expenses.

4. Alignment With Network Economics

Because in-network rates are negotiated and actuarially validated, using them as a reimbursement ceiling prevents OON payments from exceeding amounts deemed reasonable for the same service in the same area.

5. Administrative Simplicity and Transparency

A standardized rule reduces claim appeals, provider disputes, and administrative overhead for insurers and plan administrators.

This approach balances cost containment, fair provider reimbursement, and member affordability while promoting transparency and predictability across dental benefit plans.

Expected Outcomes

Stakeholder	Impact
Members	More predictable costs; More patient choice from whom they receive care.

Insurers	Improved cost management; fewer disputes
Employers	Better premium stability and plan sustainability
Providers	Clear expectations regarding OON reimbursement
Regulators	Policy consistency and consumer protection

Workgroup Member Input:

1. **Patient Coalition of Washington Comments:** We are opposed to setting a mandatory rate for out of network providers at such a high rate. We believe the proposal weakens the incentive for dentists to join a network and thus increases the risk that patients would incur additional costs unnecessarily. If the rate were significantly lower (such as 50% of in-network rates – not including the 80% of UCR), it would compel more dentists to join networks and thus lower the costs for patients. We could live with that lower threshold. Alternatively, if there were to be one set of reimbursement rate for all providers/carriers (both in and out of network, though with some allowance for regional variation), that would significantly benefit patients from a predictability and affordability perspective.
2. **Regence/USABLE Life Comments:** Mandating OON reimbursement at the lower of in-network rates or 80th 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.

3. **Willamette Dental Comments:** This proposal is misaligned with our model and the network. It should not be applied to a DHMO or at least not a vertically integrated delivery system model like ours. However, even if exempted, we still have concerns about the market implications and risks this proposal would yield. As stated, we understand both the providers and carriers’ concerns – we live it every day in our model. In our case, the higher the overhead and infrastructure costs for our integrated delivery system (labor, physical plant, technology, equipment, supplies, etc.) the more pressure it places on premiums and plan affordability.

In effect, we believe this would result in OON providers getting in-network provider reimbursement, which threatens the stability of the market. In-network providers’

reimbursement is virtually never going to be more than 80% UCR, which means providers would not be motivated or incentivized to join a network unless the carrier significantly increased in-network reimbursement. The effect is akin to an “any willing provider” dynamic absent explicit intent or formal policy action. It would force a carrier to completely reestablish their reimbursement approach; in doing so they may create a one-size-fits-all reimbursement that is less than in-network currently to mitigate utilization and cost risks due to lack of predictability.

4. **Delta Dental of WA Comments:** Delta Dental of WA (DDWA) appreciates the opportunity to review and discuss (with the Collaborative) the “First Pass” proposal of potential mandated reimbursement requirements for dental carriers’ payments to non-participating, out-of-network providers. For the reasons we presented during the May 1, 2026 Workgroup meeting and in several other prior meetings and communications throughout the Collaborative process since October 2025. DDWA does not support this proposal as a general policy framework. In short, any mandate of this type would adversely impact patients in WA by increasing patients out-of-pocket costs, exposing patients to balance billing, reducing cost transparency for patients, and reducing access to in-network care and associated patient protections inherent in dental benefits.

Key Concerns:

1. **Lack of a clearly defined problem:** Based on the discussion and participant engagement during the May 1 Workgroup meeting and in prior meetings, there is no consensus that a “problem” exists in WA state in relation to out-of-network reimbursement for dental professionals. DDWA member and other purchasers of dental benefits in our community do not seek or want out-of-network services (notably, only ~2% of claims submitted to DDWA are for out-of-network services). Additionally, as evidenced by the variation in rate/standard for out-of-network care; out-of-network rates are set by carriers based on their independent network strategies and strength (notably, more than 9 of 10 dentists in WA are in DDWA’s network). As DDWA has presented to the Collaborative, DDWA is committed to always putting patients/members at the highest level of priority – and DDWA is therefore not able to support any policy that would negatively impact affordability, transparency, and/or access for patients/members.
2. **Potential harm to patients:** Several Workgroup participants have raised concerns that the proposal (for a mandated out-of-network reimbursement amount) would: lead to higher patient out-of-pocket costs (in part as patients are subject to balance billing for out-of-network services) and incentivize dental providers to leave established networks (disrupting patients care while also removing the availability of patient protections that are core to in-network services). Purchasers and patients have long made it clear to DDWA that they are interested in a robust network of in-network dental providers, along with the critical protections that are core to in-network services.
3. **Insufficient and incomplete data:** The Collaborative formally agreed through its operating principles that it will “base decisions and recommendations on evidence and data.” The “First Pass” proposal notably relies on an incomplete data set from Fair

Health, which does not meet the standard agreed upon by Collaborative participants to based recommendations on robust, relevant, and evidence-based information. DDWA is however supportive of the transparency-focused proposal through which the OIC would provide assistance in relation to presenting relevant data as derived from the WA APCD. With relevant data, stakeholders would then be positioned to begin to understand applicable variations in dental benefit product designs, network strategies, and associated reimbursement models in WA, while also evaluating/considering the reasons/basis for such variations.

- 4. Areas of Agreement and Forward Progress:** It is clear that the Collaborative has made meaningful progress toward consensus recommendations in multiple other areas relevant to SB 5351. With respect to in-network and out-of-network care, DDWA supports the concepts and efforts aimed at improving patient transparency into the cost of dental care by carriers and providers alike. Solutions include potential collaboration between dental carriers and out-of-network providers to deliver timely, pre-service cost estimates or pre-determinations to patients, empowering patients to make informed decisions based on the total cost of care. This also includes the proposal to prioritize obtaining relevant reimbursement and payment data for review via the OIC's efforts in relation to the WA APCD. DDWA also supports efforts to facilitate in-network participation by WA denturists as a practical way to address challenges that arise when providers operate in an out-of-network context.

Taken together, these transparency-focused recommendations—along with the Collaborative's consensus recommendations related to enhanced reporting of DLR experience—represent a constructive path forward for patients, providers, and carriers in WA's dental care and dental benefits marketplace.

DDWA remains committed to engaging constructively with Collaborative participants on consensus-based recommendations that are data-driven, patient-centered, and supportive of a sustainable dental care system in WA state.