

SSB 5351 Collaborative
Draft Recommendation: Pricing Transparency

Pricing Transparency - Draft Recommendation *as of 5.29.26 Collaborative Meeting*

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-~~and out-of~~-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.

Workgroup met on 6.12.26. Based on alternative proposals (see below) and multiple attempts to problem-solve to address all members concerns, the Workgroup concluded their meeting with the following options. **Highlighted in yellow** are those where there was some coalescing around. **Highlighted in green** are areas/components unresolved.

First Bullet

As of the 5.29.26 meeting	Alternative proposed at 6.12.26 Workgroup	Alternative proposed at 6.12.26 Workgroup
Upon request by a patient, dental providers should be required to disclose prices, at a minimum for routine procedures prior to a visit. <i>(as of the 5.29.26 meeting)</i>	That all dental providers be required to disclose all fees to patients prior to all non-emergency treatment.	That all dental providers be required to disclose fees to patients for a defined set of standard dental procedures, to be determined by OIC following consultation with dental providers, dental carriers and patients.

* Workgroup also discussed having a more general recommendation/statement that the Legislature address the issue of price transparency and to look at the process and approach used by Colorado as a model:

In 2017, the Colorado state legislature passed Senate Bill (SB) 65, which requires all healthcare providers and facilities to publish a list of cash pay prices (fees). Dentists are specifically included in the scope of the law, and it appears to apply to dental hygienists as well. Under the law, a

document listing at least the fees for the 15 most common healthcare services provided by the office is required to be made available electronically or on the provider's website and needs to be updated at least annually. If provider practices within a small group practice of six or fewer identically licensed providers (includes both dentists and dental hygienists), they may post the information in the patient waiting room for their practice, as opposed to providing it electronically or on a website. As long as fees do not vary substantially between providers in a dental practice who practice under a single tax ID number, fees may be posted in aggregate for the practice as a whole.

Disclosure Language

As part of fee list, disclosure language is required indicating that the fee published is not a guarantee of cost to an individual. Use the following statement or a statement containing substantially similar information on your fee list:

“The health care price listed for any given health care service is an estimate. Actual charges for the health care service are dependent on the circumstances, including any complications or exceptional treatment, at the time the service is rendered.

If you are covered by health insurance or a dental plan, you are strongly encouraged to consult with your insurer or plan to determine accurate information about your financial responsibility for a particular health care service provided by a health care provider at this office. If you are not covered by health insurance or a dental plan, you are strongly encouraged to contact our billing office at [insert telephone number] to discuss payment options prior to receiving a health care service from a health care provider at this office since posted health care prices may not reflect the actual amount of your financial responsibility.”

There is no regulatory or enforcement agency responsible for the interpretation of SB 65,

complicating the implementation of this new law. As the law takes effect and more guidance or case law becomes available, the CDA will publish additional information for its members.

Second Bullet

As of the 5.29.26 meeting	Alternative proposed at 6.12.26 Workgroup	Alternative proposed at 6.12.26 Workgroup
<p>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- and out-of-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</p>	<p>Upon request by a patient, dental providers must make a pre-determination request of the carrier. That all carriers be required to provide electronically accessible pathways for all dental providers to submit pre-determination requests.</p>	<p>That all carriers be required to provide electronically accessible pathways for all dental providers to submit pre-determination requests. That current OIC rules be amended to include a requirement that dental insurers provide an estimate of the allowed amount a dental insurer would pay for the service that is the subject of the predetermination request.</p>

(i.e. clinical criteria, processing guidelines or otherwise) that determine eligibility for coverage.		
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Below are what members submitted as alternative proposals (modifications that they could live with) to the Workgroup in advance of the 6.12.26 Workgroup meeting. What is provided above resulted from the discussion of this info that members submitted.

Providers alternative proposal:

The SSB 5351 Collaborative recommends:

- That all dental providers be required to disclose all fees to patients prior to all non-emergency treatment.
- That all carriers be required to provide electronically accessible pathways for all dental providers to submit pre-determination requests.

Premera: Change the required turnaround time for carriers to complete the pre-determination from 5 calendar days to 7 business days.

NFIB Washington: Support the proposed recommendation with exception of the use of calendar versus business days. Concerned that situations where a holiday business closure typically extends more than just one calendar day, plus a weekend, would necessitate either a same day or one working day response. Independence Day, Thanksgiving, Christmas, and New Years all come to mind as examples of this type of situation. For example, a pre-determination request is received on the Wednesday before Thanksgiving. The insurer's administrative office is closed on Thanksgiving,

Black Friday, and the weekend. That would leave one day, Monday, for the determination to be processed and a response provided to meet the five calendar day requirement.

Willamette Dental: Here is our input/feedback in terms of can vs. cannot live with. We didn't draft actual proposals as, admittedly, a lot of our feedback like situational context or clarification. Note, we didn't include 3rd bullet based on same reasoning (just juxtaposed application) – our position seems reasonably assumed/implied and will simply say “support” the language.

1st bullet: Upon request by a patient, dental providers should be required to disclose prices, at a minimum for routine procedures prior to a visit.

- We don't operate like a private practice – essentially 100% of our providers' patients are members of our insurance plans.
- Given virtually all patients are also our insurance members, quoting fees would really be a noncovered service situation which would most often be outside of “routine services” minimum.
- Moreover, in terms of the “...prior to a visit” condition, again, it would be immaterial (a moot point) for a WD-insured patient and covered services, and would be limited to noncovered services which may be outside of routine services minimum.

2nd bullet: 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.

- We currently provide more than this and without it being formally requested by patient, which makes us worried about conformity to some TBD prescriptive standard that might not fit our situation and would equate to or at least risk regressive disruption.
 - Absolutely support it being limited to in-network providers.
 - No concerns about disclosure of what information is required to fulfill a request.
 - A bit worried about “...the specific denial or adjustment codes applied to reduce costs or deny a procedure...” – gets very technical and nuanced very quickly when it comes to covered vs. noncovered and the underlying diagnosis and risk level status that inform the treatment plan recommendations.
 - Again, we aren’t 100/80/50 plan, with coinsurance, and annual maximum + deductible. We have no deductible or annual plan maximums and utilize copays not coinsurance. This just equates to a square peg and round hole – still not grasping the balance between price transparency and the Adverse Benefit Determination (ABD) and Appeal of ABD.
 - All of which is to say I am still unclear about how this doesn’t comingle with Grievance and Appeal functions. Perhaps I’m wrong, but this seems like an enhanced version of predetermination that may not be “binding” but is getting into denial and/or adjustment codes which seemingly would encroach into the space of formal benefit decisions and G&A rights and responsibilities.
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