SSB 5351 Collaborative – Workgroup
Draft Recommendation: Pricing Transparency and
as of 5.15.26

Pricing Transparency - Draft Recommendation
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, dentists should be required to disclose prices, at a minimum for routine procedures prior to a visit.
- Upon request by a patient, a dentist 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 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.
- Establishing an option for patients to obtain a low- or set-cost second opinion.

******The information on the following pages are individual Workgroup member comments prior to the May 15th Workgroup meeting. The draft recommendation on the previous page reflects the Workgroups modifications following discussion of the info and comments below. This information is being provided as background info for the full Collaborative and is not part of the draft recommendation for consensus.***

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1. **Draft Recommendation – Specialty Providers, WSDA, Denturist Association, WSSOMS Edit**

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, dentists should be required to disclose prices, at a minimum for routine procedures prior to a visit.
- Upon request by a patient, ***a in-network*** dental provider must make a pre-determination request of the carrier. Upon receipt of sufficient information, the carrier must respond within 2 days. Carriers must disclose to in and out of network providers what information is required to fulfill a pre-determination request." This pre-determination information from carriers must include a list of the factors (aka clinical criteria) that could influence the coverage decision, including amount.
- Establishing an option for patients to obtain a low- or set-cost second opinion

Ron's Comments: currently out of network dentist with many insurance carriers do not have access to that information through the carriers via web portals. This means that the OON dentist would need to mail in a pre-determination request and wait. I would be fine with the existing language after the insurance carriers allow all licensed dentist in State of Washington to have access to their web portals, etc. where a pre-determination can be processed in that time.

Question for the carriers, if an out-of-network dentist mails in a pre-determination, does the carriers have the capacity to turn that pre-determination around within 2 days currently? MS Co-pilot says processing can take 10-14 days. My personal experience is that this can take 6-8 weeks on average.

Jina's Comments:

I think everyone agrees patients should better understand costs, insurance coverage, and what to expect before moving forward with treatment. From the specialist side, there are definitely parts of this proposal that make sense and could help patients. At the same time, there are some areas that would create pretty significant operational and clinical issues for practices if they move forward as currently written. I just wanted to share some thoughts from what we are actually seeing day to day in practice.

Binding pre-determinations. This is honestly probably the biggest concern for us. Pre-determinations can absolutely help patients, especially when they are trying to plan

financially for larger treatment. We already encourage them often for bigger surgical cases. The issue is that they are still estimates, and there are just too many things that can change between the time something is submitted and the time treatment actually happens.
We see situations all the time where:
• benefits change,
• employers change,
• annual maximums get used somewhere else,
• coordination of benefits changes,
• or the insurance company gives one answer initially and another once the claim is processed.

Sometimes additional clinical findings also come up during treatment that change what is needed. The hard part for offices is that patients usually do not get upset with the carrier when this happens. They get upset with the dental office, even when the office submitted everything correctly. Making pre-determinations binding could end up shifting a lot of insurance-related financial risk onto providers when we really do not control the plans, the policies, or the final benefit decisions.

We also continue to run into major inconsistencies between carriers. Honestly, sometimes even between representatives at the same carrier. One team member may spend over an hour on hold, get one answer, document it, and then later someone else at the carrier says something completely different.

Mandatory pre-determination requests. I understand the intent behind this, but operationally I think this would become very difficult for many offices. Especially, the smaller practices. In specialty practices especially, treatment planning is not always simple or quick. Cases may involve:
• CBCT scans,
• periodontal charting,
• pathology review,
• coordination with restorative doctors,
• surgical planning,
• and different treatment options depending on what is found clinically.

Submitting formal pre-determinations every single time a patient requests one would add a huge amount of administrative work. A lot of offices are already stretched thin trying to keep up with staffing shortages, insurance calls, narratives, attachments, and documentation requests. Some of our team members are already spending 1–3 hours on hold with insurance companies on certain days just trying to get clarification or follow up on claims. If pre-determinations become mandatory, there really needs to be:
• standardized requirements between carriers,
• simpler submission processes,
• accountability on carrier turnaround times,

• and honestly some recognition of the staffing cost this creates for offices. Otherwise, most of the burden falls onto the provider side.

Price transparency without enough clinical context. We support transparency. I just think there needs to be acknowledgment that dentistry is very individualized. Especially in surgical and periodontal care, treatment recommendations can change significantly after:
• radiographs,
• periodontal measurements,
• CBCT findings,
• tissue evaluation,
• bone levels,
• and the actual clinical exam.

Sometimes patients come in expecting one thing and the diagnosis ends up being something very different. We worry generalized pricing could unintentionally create frustration if patients expect exact numbers before a full evaluation has happened.
There is also concern about dentistry becoming too focused on shopping by price alone when things like provider experience, long-term outcomes, emergency availability, and complexity of care matter too.

Areas where we do think there is room for compromise. Clearer insurance transparency from carriers. This would honestly help everyone. We would strongly support carriers being required to provide clearer information around:
• coverage criteria,
• downgrades,
• exclusions,
• frequency limitations,
• and documentation requirements.

A huge amount of frustration comes from confusion around benefits. Most offices spend a lot of time trying to help patients understand plans that are not always very transparent or consistent. Reasonable pricing estimates for routine services. I think it is reasonable for patients to have access to estimated fee ranges for routine and fairly predictable services like:
• exams,
• preventive visits,
• periodontal maintenance,
• x-rays,
• and preventive care.

That feels very different than trying to provide exact estimates for individualized surgical or specialty treatment before an exam has even happened.

Encouraging pre-determinations for larger cases. We support encouraging pre-determinations for larger or more involved treatment plans where patients want additional financial clarity before proceeding. We just do not think they should become mandatory in every situation or legally binding against providers.

Better education around dental insurance. Honestly, one of the biggest issues we see is that many patients understandably think dental insurance works more like medical insurance than it actually does. We have so many patients coming into our practices alone that have no idea what their benefits are and rely on the dental providers office to explain their benefits. That confusion ends up falling back onto provider offices every day.
Most plans still have low annual maximums, exclusions, waiting periods, downgraded benefits, and a lot of limitations patients do not realize until treatment is needed.
More patient education around how dental benefits actually work would probably help reduce frustrations.

Second opinions. We support patients having access to second opinions, especially larger treatment plans. The only concern would be making sure any "low-cost" second opinion structure still reflects the actual time and responsibility involved. Reviewing records, imaging, CBCTs, diagnostics, and providing professional recommendations still takes significant provider time and carries liability. Alternatively, we could have insurance carriers cover second opinions in their plan sets for the patients. At the same time, I think it is important that future requirements recognize the reality of running a dental practice today and avoid placing additional insurance-related risk and administrative burden entirely on providers.

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2. Draft Recommendation – Regence/USAble Life Edits/Comments

Pre-determination Timeframes: 2 days is not doable. 14 days is doable. Clinical criteria documentation is currently in development and could be available once developed.

Low-cost or Set-cost Second Opinions: We do not prohibit second opinions. However, these services would share frequency limits with other evaluation codes and allow fewer benefits for other services. Patients may bring existing radiographs from their original dentist, which helps manage cost concerns and supports informed patient engagement. Establishing a separate pathway that allows repeated provider to provider visits would introduce unnecessary utilization risk and is not recommended.

Price Transparency: Information on providers is available for INN providers on the provider directory today. We agree that disclosures on pre-determinations and price information given over the phone are advisable. With regard to posting data on quality of dental care in the area, dentistry is not set up to measure quality outcomes and we do not have these metrics available.

3. Draft Recommendation – Delta Dental of Washington

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- Establishing an option for patients to obtain a low- or set-cost second opinion

DDWA Comments: DDWA is **supportive** of the language provided following the May 1 Workgroup ("Draft Potential Recommendations on Relative Payment 5.1, POTENTIAL RECOMMENDATION ON TRANSPARENCY – WORKGROUP STILL DISCUSSING").

DDWA does not agree with direction taken in recent e-mails (5/7 and 5/8) from several workgroup members to narrow the scope of this potential recommendation to in-network care situations only when a patients asks for a pre-determination. Most carriers and their in-network already have a pre-determination process of some kind; the gap exists when a patient is seeking care from an out-of-network provider for which their dental benefits coverage does not have a contractual requirement to perform a predetermination if requested by the patient.

4. Draft Recommendation – Willamette Dental

Willamette Dental

An Integrated Delivery System

(mutually responsible and at risk for financing and delivery of care)

"The Network"

Clinically Integrated Delivery System

Limited Health Care Service Contractor

RVU Payment Model

Standardized, numerical value assigned to procedures based on resources used.

In contrast, FFS fee schedule is the final dollar amount paid to a provider for a service.

RVUs determine how payment is distributed among services, while the fee schedule sets the actual reimbursement dollar amount.

RTU Payment Model

Based on Relative Time Units (RTUs)

-Promotes appropriate care

-Prevention of costly disease

-Eliminates possible incentives to overtreat

-Ideal for self-insured employers

Emergency Benefit for Out of Service Area

Ranges from $200-300 which covers any/all codes warranted to triage and stabalize an emergency situation, largely outside of PNW

RVU/RTU amount can be higher or lower than UCR depending on the CDT code.
This is due to Global Budgeting and Reimbursement Structure for Providers:
Fixed Salary + Individual Measure Performance + Dental Office Performance

If member goes outside "the Network" we will deny liability in full when claim is submitted.

We understand the basis for this price transparency requirement from patient/consumer perspective and the application to a dentist in private practice (solo, small group, large group, etc.). However, in our model, providers' patient base wholly consists of our insurance companies covered lives – we don't accept patients in an out-of-network or private pay capacity as our providers are exclusive and captive. Moreover, and relatedly, our prices for procedures are based on RVU/RTU methodology as opposed to UCR and deemed confidential and proprietary. Effectively, we are not comfortable with a price disclosure mandate nor sure this even fits our situation as prices would be inherently tied to the patient's insurance plan design and coverage.

"Upon request by a patient, a dentist must make a pre-determination request of the carrier. Upon receipt of sufficient information, the carrier must respond within 2 days. Carriers must disclose to in and out of network providers what information is required to fulfill a pre-determination request. " This pre-determination information from carriers must include a list of the factors (aka clinical criteria) that could influence the coverage decision, including amount."

We have two sets of concerns/outstanding questions:

1. Based on our knowledge and analysis, we are unsure about the feasibility of predeterminations to meet expectations and intent without blurring lines with prior authorization, conflicting with current regulations, and the implications to Adverse Benefit Determination and review.
    a. Typically, predetermination is voluntary/optional offering by a carrier for their plan(s) and treated as such by regulators, which is different than prior authorizations. See WAC 284-43-2050 (21), which expressly demonstrates the optional/voluntary nature by carrier's predetermination requirements as conditioned on "…when provided for by the plan."
    b. Mandating use of predetermination and requiring guarantee of coverage/cost for procedures goes beyond its intended purpose and conflicts with WAC 284-43-2050(22), which states "Predetermination notices must clearly disclose to the enrollee and requesting provider or facility, that the determination is not a prior authorization and does not guarantee services will be covered."
    c. In effect, this is akin to redefining the purpose of and use for predetermination to such degree it contemplates a paradigm shift: a wholesale juxtaposition from post-service (retroactive) to pre-service (prospective front-loading) and blurs lines with prior authorization and utilization management.
    d. The implied redefined version and purpose of predetermination seemingly subsumes aspects of what prior authorization is intended for, and essentially seeks to establish guaranteed pre-service benefit and coverage decision that contemplates going beyond what WAC 284-43-2050(22) requires in terms of clinical criterion – represents comprehensive pre-service clinical review, including medical necessity.

2. How a predetermination mandate would impact and implicate Willamette Dental of Washington, Inc. given our operating model.
    a. This will not work for our model as it equates to a square peg and round hole situation: mandate prescriptive expectations that disrupt what we already provide and how it works in our unique model.
    b. **Plan Design:** Our plan designs have no deductible or annual maximum, and we strictly have predictable and fixed copays (not coinsurance).
    c. **Plan and Network Type:** DHMO is a vertically integrated dental delivery system, whereby providers are employees and don't submit claims. As the visual diagram of our enterprise model shows, we are not PPO and thus don't have in and out of network providers, we only have the network made up of employed providers.
    d. If the intent of predetermination is to provide coverage and cost estimates (if not guarantees), we do this by leveraging our vertically integrated relationship between providers and carrier using health information technology that co-locates a patient's insurance coverage with their patient chart (in EHR), which means coverage and cost estimates can be conducted and are already provided prior to treatment. We do not consider this a predetermination or prior authorization.

    WAC 284-43-2050

(21) A carrier or its designated or contracted representative must have a method that allows an enrollee, provider or facility to make a predetermination request when provided for by the plan.

(22) Predetermination notices must clearly disclose to the enrollee and requesting provider or facility, that the determination is not a prior authorization and does not guarantee services will be covered. The notice must state "A predetermination notice is not a prior authorization and does not guarantee services will be covered."

Predetermination notices must be delivered within five calendar days of receipt of the request. Predetermination notices will disclose to a provider or facility for an enrollee's plan:
(a) If a service is a benefit;
(b) If a prior authorization request is necessary;
(c) If any preservice requirements apply;
(d) If a prior authorization request is necessary or if a medical necessity review will be performed after the service has been delivered, the following information:
(i) The clinical review criteria used to evaluate the request; and
(ii) Any required documentation.
(e) Whenever a predetermination notice relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

Establishing an option for patients to obtain a low- or set-cost second opinion

In our model, a patient is afforded second opinions currently and many times they occur without the patient having to undertake a formal process. Many times, our provider will seek to consult with colleagues, both in same location and others, when they want to consult. This commonly happens in complex situation and/or when involving specialty providers as part of a complex treatment plan.