IN THE DISTRICT COURT FOR LANCASTER COUNTY, NEBRASKA

NEBRASKA DENTAL ASSOCIATION, Plaintiff, v. NEBRASKA DEPARTMENT OF INSURANCE, and BRUCE R. RAMGE, Director of the Nebraska Department of Insurance, in his official capacity, Defendants.	Case No. _____ **COMPLAINT**

COMES NOW, Plaintiff Nebraska Dental Association, and for its Complaint against Defendants Nebraska Department of Insurance and Bruce R. Ramge, Director of the Nebraska Department of Insurance, in his official capacity, states and alleges as follows:

INTRODUCTION

1. This is an action for declaratory judgment pursuant to the Nebraska Administrative Procedures Act, Neb. Rev. Stat. § 84-911, to determine the validity of a rule or regulation, or in the alternative pursuant to the Nebraska Uniform Declaratory Judgment Act, id. § 25-21,149 to -164, to determine a question of actual controversy between the parties; to restrain the Defendants from acting in contravention and outside the scope of the duties imposed upon and authority vested in him by Neb. Rev. Stat. § 44-101.01; and for a determination of the meaning of Neb. Rev. Stat. §§ 44-3805 and 44-7,105.

PARTIES

2. Plaintiff, the Nebraska Dental Association (hereinafter, the "NDA"), is a non-profit corporation organized under the laws of Nebraska, whose purpose is to encourage improvement of the health of the public and to promote the art and science of dentistry. Founded in 1865, it is a professional organization with more than 1,000 members statewide, representing all areas of dentistry. The NDA's members are providers of dental services that comprise approximately 68% of all dental providers in the State. The NDA represents the interests of its constituent members and is authorized to appear on behalf of its members in this litigation. The NDA's primary place of business is in Lincoln, Lancaster County, Nebraska.

3. Defendant Nebraska Department of Insurance (the "Department") is an agency of the State of Nebraska with the powers and attendant responsibilities set forth in Neb. Rev. Stat. § 44-101.01. The Department conducts its business from its office in Lincoln, Lancaster County, Nebraska.

4. Defendant Bruce R. Ramge, Director of the Department, is the chief administrative officer of the Department as set forth in Neb. Rev. Stat. § 44-101.01, and is named here in his official capacity only. Ramge acts in his official capacity and conducts the business of the Department from its office in Lincoln, Lancaster County, Nebraska.

JURISDICTION AND VENUE

5. This Court has jurisdiction over the subject matter of this action pursuant to Neb. Rev. Stat. §§ 84-911, 25-21,149, and 24-302.

6. Venue is proper in the District Court for Lancaster County, Nebraska, pursuant to Neb. Rev. Stat. §§ 84-911 and 25-403.01.

FACTUAL ALLEGATIONS

7. In 2010, and effective July 15 of that year, the Nebraska Legislature added subsection (3) to Neb. Rev. Stat. § 44-3805, which provides:

> (1) A prepaid dental service plan may be offered on an individual or group basis. Each person covered under a group contract shall be issued a certificate of coverage.
>
> (2) No contract or certificate for dental service may be issued in this state unless a copy of the form has been filed with and approved by the director.
>
> (3) No prepaid dental service plan offered in this state shall limit any fees charged for services **that are not covered** by the plan.

[Emphasis supplied].

8. In 2012, and effective July 19 of that year, the Nebraska Legislature enacted Neb. Rev. Stat. § 44-7,105, which provides:

> Notwithstanding section 44-3,131, (1) an individual or group sickness or accident policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state and a hospital, medical, or surgical expense-incurred policy, (2) a self-funded employee benefit plan to the extent not preempted by federal law, and (3) a certificate, agreement, or contract to provide limited health services issued by a prepaid limited health service organization as defined in section 44-4702 shall not include a provision, stipulation, or agreement establishing or limiting any fees charged for dental services **that are not covered** by the policy, certificate, contract, agreement, or plan.

[Emphasis supplied].

9. On December 8, 2014, the Department issued a document titled "NOTICE – Interpretation of 'Covered Service' in New Laws About Dental Plans" (hereinafter, the "Notice"). In the Notice, the Department interpreted "covered

services" in reference to the phrase "services that are not covered" as used in sections 44-3805 and 44-7,105. The Department stated that "[i]nsurance and dental professionals implementing § 44-3805 and § 44-7,105 have discovered that 'covered service' is subject to two interpretations," a statement that is disputed by this lawsuit. The Department then articulated what it contended are the two ways of construing the term "covered service" and announced that "[t]he Department allows dental plans to use either definition of 'covered service' in provider contracts." The Department stated it would continue to allow either definition "until a definition is supplied by the Legislature or the courts." A true and correct copy of the Notice is attached hereto as Exhibit A and may be found on the Department's website at https://doi.nebraska.gov/news/notice-interpretation-%E2%80%9Ccovered-service%E2%80%9D-new-laws-about-dental-plans.

10. The two constructions set forth in the Department's notice are:

> 1. "Covered service" could be defined as any service for which the insurer or plan actually covered (paid) part of the dental provider's bill, with "noncovered service" defined as any service for which the insurer pays no money to the dental provider.
>
> 2. "Covered service" could also be defined as any service covered in the contract, with "noncovered service" defined as any service for which the contract does not provide payment under any circumstances.

11. On July 22, 2019, the Department reissued the Notice as a Guidance Document, identified as Bulletin CB-143. A true and correct copy of the Guidance Document is attached hereto as Exhibit B and may be found on

the Department's website at https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/CB143_0.pdf.

12. The Department, by virtue of its Notice/Guidance Document setting forth contradictory interpretations of the term "covered service," purports to "allow" dental insurers and plans to dictate the fee a dental provider may charge its own patient for services provided to that patient, even when the service rendered is not covered, i.e. is not paid for by the policy or plan. This contravenes sections 44-3805 and 44-7,105.

13. Section 44-101.01 confers upon the Defendants the power and duty to enforce and execute the insurance laws of the State of Nebraska only for the purpose of carrying out the true spirit and meaning of Chapter 44 and all laws relating to the business of insurance in the State of Nebraska, and only permits the Defendants to issue certificates or licenses as provided for in Chapter 44.

14. The Defendants do not have authority to issue certificates or licenses for, or otherwise approve, dental insurance policies, plans, certificates, agreements, or contracts that dictate the fee a dental provider may charge for a dental service for which the insurer or plan does not actually pay all or some part of the bill for the dental service actually provided, in contravention of sections 44-3805 and 44-7,105.

15. NDA members have experienced billing disputes with insurers or plans who, in express reliance on the Notice/Guidance Documents, purport to dictate the fees NDA members may charge for dental services for which the insurer or plan did not actually pay. This has primarily occurred in connection

with four types of provisions: "alternate benefits"; "frequency limitations"; "age/dependent-status restrictions"; and "waiting periods."

16. "Alternate benefit" provisions allow an insurer or plan to bill a dental provider for a cheaper, "alternate" dental service than the one actually provided to the patient. As an example, a patient may request a white ceramic filling, but the policy or plan may only cover cheaper, metallic fillings. NDA members have experienced billing disputes in which the insurer or plan will unilaterally "downcode" the dental provider's submitted bill, which contains the billing code for the service, to a billing code for a significantly cheaper, "alternate" service. The insurer or plan will then pay the dental provider only for the cheaper, downcoded dental service, notwithstanding the fact that the downcoded dental service is not the dental service that was actually provided. The insurer or plan then purports to dictate that the dental provider may not bill the patient for the difference in price between the dental service provided and the downcoded dental service, taking such a position in express reliance on the Notice/Guidance Document.

17. "Frequency limitation" provisions limit the covered individual to a certain number of times he or she may receive a specified dental service during a specific period of time. For example, some policies limit coverage to two fillings per calendar year, and do not cover dental services that exceed the frequency limitation. Nonetheless, NDA members have experienced billing disputes with insurers or plans who, in express reliance on the Department's Notice/Guidance Document, attempt to dictate to dental providers the fee they may charge their

own patients for dental services they have actually rendered when the service exceeds the frequency limitation. This despite the fact that the service is not covered, i.e. the insurer or plan will not, itself, pay for that service.

18. "Age/dependent-status restrictions" provide that specified dental services will not be covered for persons of certain ages or of a certain dependency status. For example, a plan may not cover fluoride varnish to persons who are not dependents. Nonetheless, NDA members have experience billing disputes with insurers or plans who, in express reliance on the Notice/Guidance Document, attempt to dictate to dental providers the fee they may charge their own patients for dental services they have rendered to persons who are not covered for that service due to an applicable age or dependent-status restriction.

19. Some policies or plans require a "waiting period" before a patient's benefits take effect. NDA members have experienced billing disputes with insurers or plans who, in express reliance on the Notice/Guidance Document, attempt to dictate to dental providers the fee they may charge their own patients for dental services they have rendered to persons who are not covered for that service due to an applicable waiting period.

20. The billing practices and resultant disputes identified in paragraphs 15 through 18 above are not exhaustive, but are illustrative of the disputes experienced by NDA members and caused by the Defendants' unauthorized approval of dental insurance policies, plans, certificates, agreements, and contracts that—whether directly or through provider contracts—dictate fees to dental providers for dental services that are not covered.

21. This action does not seek to determine the meaning of any private contract or a declaration of the legality or illegality of the positions taken by insurers or plans as set forth above, but instead seeks only a declaration that the Defendants do not have authority to approve dental insurance policies, plans, certificates, agreements, or contracts that contravene sections 44-3805 and 44-7,105; a declaration of the meaning of those statutes; and a declaration that the Notice and Guidance Document are invalid and attendant injunction restraining the Department and its director from implementing or enforcing them.

COUNT I—DECLARATORY JUDGMENT

22. Paragraphs 1 through 20 are hereby incorporated as if fully set forth herein.

23. The parties dispute the interpretation and application of Neb. Rev. Stat. §§ 44-3805 and 44-7,105. The NDA specifically disputes the Defendants' stated and ongoing position that those statutes permit the Defendants to allow dental insurance policies, plans, certificates, agreements, or contracts to dictate to dental providers—whether directly or through provider contracts—the fee to be charged for dental services which the insurer or plan does not pay all or some part of the bill for the dental service actually provided and identified by the dental provider.

24. The NDA seeks relief from invalid and unauthorized acts by Defendants in the form of a declaratory judgment, including a declaration that the Notice and Guidance Document are invalid.

25. The NDA seeks a ruling from the Court on the meaning of sections 44-3805 and 44-7,105. Specifically, the NDA requests a declaration that "services that are not covered," as used in those sections, means dental services for which the insurer or plan pays no money to the dental provider for the dental service actually provided.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays the Court enter an order:

a. Declaring that "dental services that are not covered," as that phrase is used in Neb. Rev. Stat. §§ 44-3805 and 44-7,105, means any dental service for which the insurer or plan pays no money to the dental provider for the service actually provided and identified by the dental provider, including but not limited to a dental procedure or service that a dental insurance policy, plan, certificate, agreement, or contract:

(1) Specifically identifies as a non-covered service;

(2) Specifically excludes;

(3) Specifically identifies as a covered service, but does not reimburse because of a contract limitation or exclusion such as, but not limited to, benefit maximums, waiting periods, alternate benefits, frequency limitations, or age/dependent-status restrictions;

b. Declaring that Neb. Rev. Stat. §§ 44-3805 and 44-7,105 prohibit a dental insurance policy, plan, certificate, agreement, or contract from dictating, providing for, stipulating to, establishing, limiting, mandating, "downcoding," or

capping—whether directly or through provider contracts—the fee a dental provider may charge a patient for a provided dental service that the insurer or plan does not cover, meaning a dental service for which the insurer or plan does not actually pay all or some part of the dental provider's charged fee for the service actually provided and identified by the dental provider;

c. Declaring that the Defendants are without authority to issue certificates or licenses for, or otherwise approve, any dental insurance policy, plan, certificate, agreement, or contract that dictates, provides for, stipulates to, establishes, limits, mandates, "downcodes," or caps—whether directly or through provider contracts—the fee a dental provider may charge a patient for a provided dental service that the insurer or plan does not cover, meaning a dental service for which the insurer or plan does not actually pay all or some part of the dental provider's charged fee for the service actually provided and identified by the dental provider;

d. Declaring that the Notice and Guidance Document alleged in paragraphs 8 and 10 of this Complaint are invalid and enjoining the Nebraska Department of Insurance from taking any action to implement or enforce them.

e. For any such further relief as the Court deems just and equitable.

DATED this 16th day of September, 2019.

[*Signature on Next Page.*]

NEBRASKA DENTAL ASSOCIATION,
Petitioner

By: /s/Nathan D. Clark

Renee Eveland - #23156
Nathan Clark - #25857
CLINE WILLIAMS WRIGHT
JOHNSON & OLDFATHER, L.L.P.
1900 U.S. Bank Building
233 South 13th Street
Lincoln, NE 68508
(402) 474-6900
reveland@clinewilliams.com
nclark@clinewilliams.com

4848-2294-0316, v. 3

EXHIBIT
A

NEBRASKA (/)
DEPARTMENT OF INSURANCE

NOTICE - Interpretation of “Covered Service” in New Laws About Dental Plans

December 08, 2014

To: All Interested Parties

Recently enacted Neb. Rev. Stat. § 44-3805(3) (2010) and § 44-7,105 (2012) prevent prepaid dental service plans, insurance policies, self-funded employee benefit plans, and prepaid limited health organization plans from dictating the price of dental services that they do not cover. Sections 44-3805 and 44- 7,105 do not provide a definition of the term “covered service.” Insurance and dental professionals implementing § 44-3805 and § 44-7,105 have discovered that “covered service” is subject to two interpretations.

1. “Covered service” could be defined as any service for which the insurer or plan actually covered (paid) part of the dental provider’s bill, with “noncovered service” defined as any service for which the insurer pays no money to the dental provider.
2. “Covered service” could also be defined as any service covered in the contract, with “noncovered service” defined as any service for which the contract does not provide payment under any circumstances.

For example: Jane’s dental policy provides maximum benefits of $1,000 per year. Jane already received the $1,000 in benefits this year, so she will pay out of pocket for any additional dental services. Jane goes to her dentist to have a tooth repaired. Fillings are covered under Jane’s policy, but because Jane has exceeded her annual maximum, she will pay the entire bill. Under definition (1), the filling is not “covered” because the insurer is not paying the bill, so Jane’s insurer cannot dictate the fee Jane’s dentist charges for the filling. Under definition (2), the filling is “covered” because the insurance policy pays for fillings when the patient has not exceeded annual benefit limits, so Jane’s insurer can require the dentist to charge only the contracted rate for the filling.

The Department allows dental plans to use either definition of “covered service” in provider contracts. This approach is based on testimony describing “covered services” in the legislative history for LB813 (codified at § 44-3805(3)) and LB810 (codified at § 44-7,105).

The Department will continue to interpret § 44-3805(3) and § 44-7,105 to allow either definition of “covered services” until a definition is supplied by the Legislature or the courts.

If you have any questions about this Notice, please contact Laura Arp at (402) 471-4635.

The Nebraska Department of Insurance
PO Box 82089
Lincoln, Nebraska 68501-2089
Phone: 402-471-2201
Consumer Affairs Hotline: 877-564-7323 (In-State Only)

Hours: 8:00 AM - 5:00 PM CST Monday through Friday

NEBRASKA

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DEPARTMENT OF INSURANCE

EXHIBIT B

Pete Ricketts, Governor

COVER SHEET

CB-143
July 22, 2019

BULLETIN

SUBJECT: INTERPRETATION OF "COVERED SERVICE" IN NEW LAWS ABOUT DENTAL PLANS

This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document.

Contents of CB-143 follow on next page.

Bruce R. Ramge, Director
Department of Insurance
1135 M Street, Suite 300
PO Box 82089
Lincoln, Nebraska 68501-2089
OFFICE 402-471-2201 FAX 402-471-4610
www.doi.nebraska.gov

NEBRASKA

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DEPARTMENT OF INSURANCE

Pete Ricketts, Governor

July 22, 2019
Bulletin CB-143

BULLETIN

SUBJECT: INTERPRETATION OF "COVERED SERVICE" IN NEW LAWS ABOUT DENTAL PLANS

On December 8, 2014, the Nebraska Department of Insurance issued a notice, "Interpretation of 'Covered Service' in New Laws about Dental Plans." In 2016, the Nebraska Legislature amended the Administrative Procedures Act to include a definition of a guidance document. Neb. Rev. Stat. § 84-901(5) defines a guidance document, in part, as any statement developed by an agency which lacks the force of law but provides information or direction of general application to the public to interpret or implement statutes or such agency's rules or regulations. A guidance document is binding on an agency until amended by the agency. Upon review, the Department has determined that the December 8 notice meets the definition of a guidance document and has been converted to the necessary format in Company Bulletin, CB-143.

Neb. Rev. Stat. § 44-3805(3) and § 44-7,105 prevent prepaid dental service plans, insurance policies, self-funded employee benefit plans, and prepaid limited health organization plans from dictating the price of dental services that they do not cover. Sections 44-3805 and 44-7,105 do not provide a definition of the term "covered service." Insurance and dental professionals implementing § 44-3805 and § 44-7,105 have discovered that "covered service" is subject to two interpretations.

1. "Covered service" could be defined as any service for which the insurer or plan actually covered (paid) part of the dental provider's bill, with "noncovered service" defined as any service for which the insurer pays no money to the dental provider.

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For example: Jane's dental policy provides maximum benefits of $1,000 per year. Jane already received the $1,000 in benefits this year, so she will pay out of pocket for any additional dental services. Jane goes to her dentist to have a tooth repaired. Fillings are covered under Jane's policy, but because Jane has exceeded her annual maximum, she will pay the entire bill. Under

Bruce R. Ramge, Director
Department of Insurance
1135 M Street, Suite 300
PO Box 82089
Lincoln, Nebraska 68501-2089
OFFICE 402-471-2201 FAX 402-471-4610
www.doi.nebraska.gov

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The Department allows dental plans to use either definition of "covered service" in provider contracts. This approach is based on testimony describing "covered services" in the legislative history for LB 813 (codified at § 44-3805(3)) and LB 810 (codified at § 44-7,105).

The Department will continue to interpret § 44-3805(3) and § 44-7,105 to allow either definition of "covered services" until a definition is supplied by the Legislature or the courts.

Questions concerning this bulletin should be directed to the Department's legal division at 402-471-2201.

Bruce R. Ramge

Bruce R. Ramge
Director