DEPARTMENT OF INSURANCE

OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 311and 332 (18 **Del.C.** §§311 & 332)

FINAL

ORDER

1315 Arbitration of Health Insurance Disputes Between Individuals and Carriers

Proposed Regulation 1315 relating to Arbitration of Health Insurance Disputes Between Individuals and Carriers was published in the Delaware *Register of Regulations* on January 1, 2016. The comment period remained open until February 1, 2016. There was no public hearing on proposed Regulation 1315. Public notice of the proposed Regulation 1315 was published in the *Register of Regulations* in conformity with Delaware law.

SUMMARY OF THE EVIDENCE AND INFORMATION SUBMITTED

No comments were received on the proposed Regulation; and no changes are being made to the proposed Regulation 1315.

FINDINGS OF FACT

Based on Delaware law and the record in this docket, I make the following findings of fact:

1. 18 **Del.C.** §§311 and 332 require a regulation to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of the Code.
2. The requirements of proposed Regulation 1315 best serve the interests of the public and of insurers and comply with Delaware law, and are not likely to impose additional costs or burdens upon individuals and/or small businesses.

DECISION AND EFFECTIVE DATE

Based on the provisions of 18 **Del.C.** §§311 and 332; and 29 **Del.C.** Ch. 101, and the record in this docket, I hereby adopt proposed Regulation 1315 as may more fully and at large appear in the version attached hereto to be effective 10 days after being published as final.

TEXT AND CITATION

The text of proposed Regulation 1315 last appeared in the *Register of Regulations* Vol. 19, Issue 7, pages 569-573.

IT IS SO ORDERED this 1st day of April, 2016
Karen Weldin Stewart, CIR-ML
Insurance Commissioner

1315 Arbitration of Health Insurance Disputes Between Individuals and Carriers

1.0 Purpose and Statutory Authority

The purpose of this Regulation is to implement 18 **Del.C.** §332, which requires health insurance carriers to submit to arbitration disputes with a covered person or authorized representative regarding adverse determinations upon a request for arbitration by the covered person. This Regulation is promulgated pursuant to 18 **Del.C.** §§311 and 332; and 29 **Del.C.** Ch. 101. This Regulation should not be construed to create any cause of action not otherwise existing at law.

2.0 Definitions

"**Adverse determination**" means a decision by a carrier to deny (in whole or in part), reduce, or terminate health insurance benefits or a determination that an admission or continued stay, or course of treatment, or other covered health service does not satisfy the insurance policy's clinical requirements for appropriateness, necessity, health care setting and/or level of care.

"**Authorized representative**" means an individual who a covered person willingly acknowledges to represent his interests during the arbitration process, including but not limited to a provider to whom a covered person has assigned the right to collect sums due from a carrier for health care services rendered by the provider to

the covered person. A carrier may require the covered person to submit written verification of his consent to be represented. If a covered person has been determined by a physician to be incapable of assigning the right of representation, the covered person may be represented by a family member or a legal representative.

"**Carrier**" means any entity that provides health insurance in this State. Carrier includes an insurance company, health service corporation, managed care organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. Carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health insurance.

"**Covered person**" means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier provides health insurance for such person or persons.

"**Department**" means the Delaware Insurance Department.

"**Duration of an Emergency Medical Condition**" means a period of time that begins with an Emergency Medical Condition and ends when the Emergency Medical Condition is either treated or stabilized as such stabilization is evidenced by post stabilization care [as referenced in 18 **Del.C.** §§3349(c)(3) and 3565(c)(3)] in a hospital where such post stabilization care is not within the definition of emergency care services.

"**Emergency care provider**" means a provider of emergency care services including a provider who also provides health care services that aren't emergency care services.

"**Emergency care services**" means those services identified in 18 **Del.C.** §§3349(d) and 3565(d) performed at any time during the Duration of an Emergency Medical Condition, including any covered service providing for the transportation of a patient to a hospital emergency facility for an emergency medical condition including air and sea ambulances so long as medical necessity criteria are met.

"**Emergency Medical Condition**" shall have the meaning assigned to it by 18 **Del.C.** §§3349(e) and 3565(e).

"**Final coverage decision**" means the decision by a carrier at the conclusion of its internal review process upholding, modifying or reversing its adverse determination.

"**Grievance**" means a request by a covered person or his authorized representative that a carrier review an adverse determination by means of the carrier's internal review process.

"**Health care services**" means any services or supplies included in the furnishing to any individual of medical care or hospitalization, or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury, disability or disease.

"**Health insurance**" means a plan or policy issued by a carrier for the payment for, provision of, or reimbursement for health care services.

"**Network Emergency Care Provider**" is a provider who has a written participation agreement with the carrier to provide emergency care services or governing payment of emergency care services.

"**Non-Network Emergency Care Provider**" is a provider who is not a Network Emergency Care Provider.

"**Provider**" means an individual or entity, including without limitation, a licensed physician, a licensed nurse, a licensed physician assistant and a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, and a licensed hospital, who or which provides health care services in this State.

3.0 Arbitration Procedure to Review a Carrier's Final Coverage Decision

3.1 Petition for Arbitration

3.1.1 A covered person or his authorized representative may request review of a carrier's final coverage decision through arbitration by delivering a Petition for Arbitration and all supporting documentation to the Department so that it is received by the Department within sixty days of receipt by the covered person of written notice of the carrier's final coverage decision. The Department shall make available, by mail and on its web site, a standardized form for a Petition for Arbitration.

3.1.2 A covered person or his authorized representative must deliver to the Department an original and one copy of the Petition for Arbitration and all supporting documentation.

3.1.3 At the time of delivering the Petition for Arbitration and supporting documentation to the Department, a covered person or his authorized representative must also:

3.1.3.1 Send a copy of the Petition for Arbitration and supporting documentation to the carrier by certified mail, return receipt requested;

3.1.3.2 Deliver to the Department a Proof of Service confirming that a copy of the Petition was mailed to the carrier by certified mail, return receipt requested; and

3.1.3.3 Deliver to the Department a $75.00 filing fee.

3.1.4 The Department may refuse to accept any Petition that is not timely filed or does not otherwise meet the criteria for arbitration. If the subject of the Petition is appropriate for review through IHCAP (refer to Independent Health Care Appeal Program, Regulation 1301), the Department shall advise the covered person or his authorized representative of the procedure to obtain IHCAP review. If the subject of the Petition is appropriate for IHCAP review, the Petition for Arbitration will be treated as an IHCAP appeal for purposes of determining whether the IHCAP appeal is timely filed in accordance with subsection 5.1 of Regulation 1301.

3.2 Response to Petition for Arbitration

3.2.1 Within 20 days of receipt of the Petition, the carrier must deliver to the Department an original and one copy of a Response with supporting documents or other evidence attached.

3.2.2 At the time of delivering the Response to the Department, the carrier must also:

3.2.2.1 send a copy of the Response and supporting documentation to the covered person or his authorized representative by certified mail, return receipt requested;

3.2.2.2 deliver to the Department a proof of service confirming that a copy of the Response was mailed to the covered person or his authorized representative by certified mail, return receipt requested; and

3.2.2.3 deliver to the Department a $75.00 filing fee.

3.2.3 The Department may return any non-conforming Response to the carrier.

3.2.4 If the carrier fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition.

3.2.4.1 The Arbitrator may determine the matter in the nature of a default judgment after establishing that the Petition is properly supported and was properly served on the carrier.

3.2.4.2 The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than seven days after notice of the default judgment.

3.3 Summary Dismissal of Petition by the Arbitrator

3.3.1 If the Arbitrator determines that the subject of the Petition is not appropriate for arbitration or IHCAP or is meritless on its face, the Arbitrator may summarily dismiss the Petition and provide notice of such dismissal to the parties.

3.4 Appointment of Arbitrator

3.4.1 Upon receipt of a proper Response, the Department shall assign an Arbitrator from a panel of Arbitrators and shall schedule the matter for a hearing so that the Arbitrator can render a written decision within 45 days of the delivery to the Department of the Petition for Arbitration.

3.4.2 The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties or with the provider whose service is at issue in the dispute.

3.5 Arbitration Hearing

3.5.1 The Arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department.

3.5.2 The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator.

3.5.3 If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party.

3.5.4 The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied.

3.5.5 Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed unless otherwise agreed by the parties.

3.5.6 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.

3.5.7 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties, other than information otherwise obtained by the Arbitrator pursuant to this Regulation, that has not been provided to the opposing party with at least five days' notice, except claims of a continuing nature that are set out in the filed papers.

3.6 Arbitrator's Written Decision.

3.6.1 The Arbitrator shall render his decision and mail a copy of the decision to the parties within 45 days of the filing of the Petition.

3.6.2 The Arbitrator's decision shall include allowable charges and payments for each service subject to arbitration for a period that will end on the 360th day after the date of the Arbitrator's decision.

3.6.3 The Arbitrator's decision is binding upon the carrier except as provided in 18 **Del.C.** §332(g).

3.7 Arbitration Costs.

3.7.1 In arbitrations commenced pursuant to 18 **Del.C.** §332 and Section 3.0 of this Regulation, the carrier shall pay the costs of arbitration, any compensation paid to the arbitrator not to exceed $250, and any additional related fees which exceed the filing fee of $75 required to commence arbitration. In the event the covered person prevails, the $75 filing fee paid by the covered person will be refunded by the carrier.

4.0 Carrier Recordkeeping and Reporting Requirements

4.1 A carrier shall maintain written or electronic records documenting all grievances and Petitions for Arbitration including, at a minimum, the following information:

4.1.1 For each grievance:

4.1.1.1 the date received;

4.1.1.2 name and plan identification number of the covered person on whose behalf the grievance was filed;

4.1.1.3 a general description of the reason for the grievance; and

4.1.1.4 the date and description of the final coverage decision.

4.1.2 For each Petition for Arbitration:

4.1.2.1 the date the Petition was filed;

4.1.2.2 name and plan identification number of the covered person on whose behalf the Petition was filed;

4.1.2.3 a general description of the reason for the Petition; and

4.1.2.4 date and description of the Arbitrator's decision or other disposition of the Petition.

4.2 A carrier shall file with its annual report to the Department the following information:

4.2.1 The total number grievances filed.

4.2.2 The total number of Petitions for Arbitration filed, with a breakdown showing:

4.2.2.1 the total number of final coverage decisions upheld through arbitration; and

4.2.2.2 the total number of final coverage decisions reversed through arbitration.

5.0 Non-Retaliation

5.1 A carrier shall not disenroll, terminate or in any way penalize a covered person who exercises his rights to file a grievance or Petition for Arbitration solely on the basis of such filing.

5.2 A carrier shall not terminate or in any way penalize a provider with whom it has a contractual relationship and who exercises, on behalf of a covered person, the right to file a grievance, or Petition for Arbitration solely on the basis of such filing.

6.0 Confidentiality of Health Information

Nothing in this Regulation shall supersede any federal or state law or regulation governing the privacy of health information.

7.0 Computation of Time

In computing any period of time prescribed or allowed by this Regulation, the day of the act or event after which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday or Sunday, or other legal holiday, or other day on which the Department is closed, in which event the period shall run until the end of the next day on which the Department is open. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays, and other legal holidays shall be excluded in the computation. As used in this section, "legal holidays" shall be those days provided by statute or appointed by the Governor or the Chief Justice of the State of Delaware.

8.0 Effective Date

This Regulation shall become effective ten days after being published as a final regulation.