Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF INSURANCE

OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 311, 333, 3371, and 3571S (18 **Del.C.** §§311, 333, 3371 & 3571S)
18 **DE Admin. Code** 1313

FINAL

ORDER

1313 Arbitration of Health Insurance Disputes Between Carriers and Providers

Proposed amended Regulation 1313 relating to Arbitration of Health Insurance Disputes Between Carriers and Providers was published in the Delaware *Register of Regulations* on September 1, 2016. The comment period remained open until October 3, 2016. There was no public hearing on proposed amended Regulation 1313. Public notice of the proposed amended Regulation 1313 was published in the *Register of Regulations* in conformity with Delaware law.

SUMMARY OF THE EVIDENCE AND INFORMATION SUBMITTED

Comments were received on the proposed amended Regulation 1313 from:

- Letter received from Peter J. Shanley, Esquire, on behalf of his clients Emergency Medicine Coalition of Delaware (EMCODE) and the Delaware Chapter of the American College of Emergency Physicians (Delaware ACEP).

The collective comments were reviewed and considered, with an additional amendment being suggested. Changes were made to the proposed amended Regulation 1313 by adding a new subsection 9.1.3 that clarifies arbitrations involving emergency care services are already governed by Administrative Code 1316; and those changes are not substantive.

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, 333, 3371 and 3571S 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 amended Regulation 1313 best serve the interests of the public and of insurers and comply with Delaware law.

DECISION AND EFFECTIVE DATE

Based on the provisions of 18 **Del.C.** §§311, 333, 3371 and 3571S; and 29 **Del.C.** Ch. 101, and the record in this docket, I hereby adopt proposed amended Regulation 1313 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 amended Regulation 1313 last appeared in the *Register of Regulations* Vol. 20, Issue 3, pages 150-154.

IT IS SO ORDERED this 1st day of November, 2016.

Karen Weldin Stewart, CIR-ML
Insurance Commissioner

1313 Arbitration of Health Insurance Disputes Between Carriers and Providers

1.0 Purpose and Statutory Authority

The purpose of this Regulation is to implement 18 **Del.C.** §§333, 3371 and 3571S, which requires health insurance carriers to submit to arbitration any dispute with a health care provider regarding reimbursement for an individual claim, procedure or service upon a request for arbitration by the health care provider. This Regulation is promulgated pursuant to 18 **Del.C.** §§311, 333, 3371 and ~~6408~~ 3571S and 29 **Del.C.** Ch. 101. This Regulation should not be construed to create any cause of action not otherwise existing at law.

19 DE Reg. 924 (04/01/16)

2.0 Definitions

"**Carrier**" or "**insurance 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.

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

"**Health care provider**" or "**provider**" shall have the same meaning as defined at 18 **Del.C.** §333(a)(1).

"**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.

"**Petition filing**" means either each patient or each procedure code, determined by the basis of the filing.

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3.0 Notice

3.1 At the time a carrier provides to a health care provider written notice of a carrier's final decision regarding reimbursement for an individual claim, procedure or service, if the decision does not authorize reimbursement of the provider's charge in its entirety, the carrier shall give the provider written notice of the provider's right to arbitration. Such notice may be separate from or a part of the written notice of the carrier's decision. Any such notice given to a provider shall, at a minimum, contain the following language:

"You have the right to seek review of our decision regarding the amount of your reimbursement. The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to review of this decision or any right of review based on your contract with us. You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at 302-674-7322 or by sending an email to: DOI-arbitration@state.de.us. All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final."

3.2 Such notice is not required if the Commissioner has determined, pursuant to Section 6.0 of this regulation, that the insurance carrier has a program that is substantially similar to the arbitration procedure provided pursuant to 18 **Del.C.** §333 and this Regulation.

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4.0 Procedure

4.1 Petition for Arbitration

4.1.1 A health care provider or his authorized representative may request review of a carrier's final reimbursement decision through arbitration by delivering a Petition for Arbitration and all supporting documentation to the Department so that it is received by the Department no later than 60 days after the receipt of the carrier's final reimbursement decision. The Department shall make available, by mail and on its web site, a standardized form for a Petition for Arbitration.

4.1.2 A health care provider or his authorized representative must deliver to the Department an original and one copy of the Petition for Arbitration.

4.1.3 At the time of delivering the Petition for Arbitration to the Department, a health care provider or his authorized representative must also:

4.1.3.1 send a copy of the Petition and supporting documentation to the carrier by certified mail, return receipt requested;

4.1.3.2 deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to the carrier by certified mail, return receipt requested; and

4.1.3.3 deliver to the Department a non-refundable filing fee. The fee shall be $50 for claims of $1,000 or less, in all other cases the fee shall be $100.

4.1.4 The Department may refuse to accept any Petition that is not timely filed or does not otherwise meet the criteria for arbitration, including the disputes described in 18 **Del.C.** §333(j)(1) - (3).

4.2 Response to Petition for Arbitration

4.2.1 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.

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

4.2.2.1 send a copy of the Response and supporting documentation to the health care provider or his authorized representative by first class U.S. mail, postage prepaid; and

4.2.2.2 deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to the health care provider or his authorized representative.

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

4.2.4 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.

4.2.4.1 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.

4.2.4.2 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 fifteen (15) days after notice of the default judgment.

4.3 Summary Dismissal of Petition by the Arbitrator

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

4.4 Appointment of Arbitrator

4.4.1 Upon receipt of a petition filed in proper form, the Department shall assign an Arbitrator who 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.

4.4.2 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 patient whose care is at issue in the dispute.

4.5 Arbitration Hearing

4.5.1 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.

4.5.2 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.

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

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

4.5.5 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.

4.5.6 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.

4.5.7 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 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.

4.6 Arbitrator’s Written Decision.

4.6.1 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.

4.6.2 The Arbitrator’s decision is binding upon the parties except as provided in 18 **Del.C.** §333(f).

4.7 Arbitration Costs

4.7.1 In arbitrations commenced pursuant to 18 **Del.C.** §§333, 3371 and 3571S, the Arbitrator shall allocate to each party a percentage of the costs of arbitration. The arbitrator may award to the health care provider the filing fee, if the health care provider should prevail.

5.0 Carrier Recordkeeping Reporting Requirements

5.1 A carrier shall maintain written or electronic records for five years, after completion of the arbitration process, documenting all Petitions for Arbitration including, at a minimum, the following information:

5.1.1 The date the petition was filed;

5.1.2 The name and identifying information of the health care provider on whose behalf the petition was filed;

5.1.3 A general description of the reason for the petition; and

5.1.4 The date and description of the Arbitration decision or other disposition of the petition.

5.2 A carrier shall file with its annual report to the Department the total number of Petitions for Arbitration filed, with a breakdown showing:

5.2.1 The total number of final reimbursement decisions upheld through arbitration; and

5.2.2 The total number of final reimbursement decisions reversed through arbitration.

5.3 A carrier shall make available to the Department upon request any of the information specified in the foregoing subsections 4.1 and 4.2.

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6.0 Exemption from Arbitration Requirement

Any carrier having a dispute resolution method established by contract with its providers which method the carrier believes to be substantially similar to the arbitration method described by this regulation may submit information regarding said method to the Insurance Commissioner for a determination as to whether the carrier should be exempted from the arbitration requirement of 18 **Del.C.** §333. The information submitted shall include a copy of the contractual language as well as any other information the carrier believes is relevant to the Insurance Commissioner's decision.

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7.0 Non-Retaliation

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

19 DE Reg. 924 (04/01/16)

8.0 Confidentiality of Health Information

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

19 DE Reg. 924 (04/01/16)

9.0 Additional Provisions for Arbitrations Conducted Pursuant to 18 Del.C. §§3371 and 3571S

9.1 Arbitrations conducted pursuant to 18 **Del.C.** §§3371 and 3571S shall reflect the objectives of those statutory provisions of protecting consumers from surprise bills and not creating incentives for providers to be out-of-network.

9.1.1 In addition to any other documentation required by this regulation, the parties to these arbitrations may present documentation or arguments during arbitration regarding how a particular award or request for reimbursement may incentivize providers to become out-of-network providers, and the Arbitrator shall consider such documentation and/or arguments in rendering a final decision.

9.1.2 Notwithstanding anything herein to the contrary, an arbitration award in favor of a provider that exceeds the opposing carrier's in-network reimbursement rate shall not be considered prima facie evidence of an incentive for providers to be out-of-network.

[9.1.3 The provisions of this Regulation 1313 shall not apply to arbitration which is subject to Regulation 1316 as authorized in 18 Del.C. §3349(b) and 18 Del.C. §3565(b).]

~~9~~10.0 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.

19 DE Reg. 924 (04/01/16)

10~~1~~1.0 Effective Date

This Regulation shall become effective 10 days after being published as a final regulation.

11 DE Reg. 1061 (02/01/08)
19 DE Reg. 924 (04/01/16)
20 DE Reg. 372 (11/01/16) (Final)