

DEPARTMENT OF INSURANCE

OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 311 and 332 (18 **Del.C.** §§311 & 332)
18 **DE Admin. Code** 1315

PROPOSED

PUBLIC NOTICE

1315 Arbitration of Health Insurance Disputes Between Individuals and Carriers

A. Type of Regulatory Action Required

Re-proposal of amendments to an existing regulation.

B. Synopsis of Subject Matter of the Regulation

At 21 DE Reg 196 (September 1, 2017) the Department published a notice of its intent to amend Regulation 1315 and solicited written comments from the public for thirty (30) days as mandated by 29 **Del.C.** §10118(a).

In the Department's September 1 notice, the Department proposed to amend the definition of "Authorized Representative" to implement Section 3 of HB 100. Section 3 of HB 100 amended 18 **Del.C.** §332 to now require that an insurance carrier, when informing a covered person of its right to appeal an adverse coverage decision, must inform the covered person of the availability of assistance from the Delaware Department of Justice in the preparation of an appeal of an adverse determination involving treatment for substance abuse. HB 100 was signed into law on May 30, 2017, became effective on September 27, 2017 and sunsets on January 1, 2020 unless expressly reauthorized prior to that date. The Department also proposed non-substantive amendments in punctuation and grammar throughout Sections 3 and 4.

Summary of Comments Received With Agency Response and Explanation of Changes

The Governor's Advisory Council for Exceptional Citizens and the State Council for Persons with Disabilities submitted an identical set of comments on the substance of the proposed amendments. Both organizations endorsed the Department's proposed amendments. Following are the Department's summary of each comment and the Department's responses.

1. COMMENT: The commenters support the Department's proposed amendments to the regulation.

RESPONSE: The Department appreciates the commenters' support.

2. COMMENT: H.B. No. 100 (lines 37-38) contemplates retention of attorneys to represent individuals in substance abuse insurance disputes, but H.B. No. 100 (line 24) contemplates the use of "experts" in substance abuse insurance disputes. The term "expert" is not defined and could encompass professionals in the field of addiction who, under attorney supervision, could appear on a covered person's behalf in proceedings authorized by 18 **DE Admin Code** 1301. Therefore, in the definition of "Authorized Representative," it may be preferable to not categorically limit Department of Justice (DOJ) assistance to attorneys.

RESPONSE: The Department agrees that the definition of "Authorized Representative" should not be limited to "an attorney retained or employed by the Delaware Department of Justice." In addition to the reasons stated by the commenters, HB 100 at lines 51-53 states that, "The written forms provided by the carrier must inform the covered person of the availability of assistance in the preparation of an appeal of an adverse determination involving treatment for substance abuse . . . (emphasis added)." This provision does not limit the assistance to legal assistance. Therefore, with this proposal the Department is amending the definition of "Authorized Representative" to reflect that assistance is available from the Department of Justice, not just legal assistance.

3. COMMENT: The Department should consider providing a specific DOJ website address (with description of its substance abuse legal assistance program) in addition to a phone number.

RESPONSE: The Department agrees with the comment. With this proposal, the Department will add the DOJ's website address and email address to the definition of "Authorized Representative."

4. COMMENT: HB 100 can only be effective if covered persons denied substance abuse treatment receive timely and prominent notice of the availability of DOJ assistance. The Department of Insurance is charged with developing the language in such notices (lines 51-53). Unfortunately, this arbitration regulation omits any reference to such notice and does not otherwise inform persons of the availability of such assistance. At a minimum, the Department should consider adding a provision notifying an aggrieved person contesting denial of substance abuse treatment of possible DOJ assistance in subsections 3.14 and 3.5.

RESPONSE: The Department disagrees that a notice in addition to the notice provided in 18 **DE Admin. Code** 1301-4 is necessary. Regulations 1301 and 1315 are complementary regulations; adding the same notice in each regulation would be redundant. With the re-proposal of amendments to Regulation 1301 published elsewhere in this edition

of the *Register of Regulations*, the Department is proposing to amend the substance of the minimum required notices at 18 **DE Admin. Code** 1301-3.3.2 and 1301-4.0 to more fully describe the appeals options available to an insured.

In response to the comments received, the Department has determined to re-propose the amendments to Regulation 1315, with additional amendments that incorporate commenters' suggestions as noted in the above responses to comments.

The Department does not plan to hold a public hearing on the proposed amendments. The proposed amendments appear below and can also be viewed at the Department of Insurance website at <http://insurance.delaware.gov/information/proposedregs/>. The Department's docket number is DOI Docket No. 3572-2017. The re-proposal of companion amendments to Regulation 1301 may be viewed elsewhere in this edition of the *Register of Regulations*.

Any person may file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed new regulation must be received by the Department of Insurance no later than 4:30 p.m. EST, on Monday, the 4th day, December, 2017. Any such requests should be directed to:

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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~~ whom a covered person willingly acknowledges to represent his interests during the internal review process and/or an appeal through the arbitration process or the Independent Health Care Appeals Program, 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. In cases involving the existence or scope of private or public coverage for substance abuse treatment, assistance may be provided by or through the Delaware Department of Justice as an authorized representative, regardless of whether the covered person has been determined by a physician to be incapable of assigning the right of representation. The Department of Justice may be reached by calling 302-577-4206, by visiting <http://attorneygeneral.delaware.gov/doj-treatment-assistance/>, or by email at doj-treatment-assistance@state.de.us.

“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, using the standardized form available from the Department by mail and on its web site, and all supporting documentation to the Department so that ~~if the request for review~~ the request for review 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~~ 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~~ 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~~ 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. The Arbitrator may:
 - 3.2.4.1 ~~The Arbitrator may determine~~ 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; and
 - 3.2.4.2 ~~The Arbitrator may allow the re-opening of~~ Allow the matter to be reopened to prevent a manifest injustice. A request for re-opening must be made by the covered person or his authorized representative 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 that conforms with the requirements of this regulation, 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 presented to the parties 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~~ The date received;
 - 4.1.1.2 ~~name~~ Name and plan identification number of the covered person on whose behalf the grievance was filed;
 - 4.1.1.3 ~~a~~ A general description of the reason for the grievance; and
 - 4.1.1.4 ~~the~~ The date and description of the final coverage decision.
- 4.1.2 For each Petition for Arbitration:
- 4.1.2.1 ~~the~~ The date the Petition was filed;
 - 4.1.2.2 ~~name~~ Name and plan identification number of the covered person on whose behalf the Petition was filed;
 - 4.1.2.3 ~~a~~ A general description of the reason for the Petition; and
 - 4.1.2.4 ~~date~~ 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~~ The total number of final coverage decisions upheld through arbitration; and
 - 4.2.2.2 ~~the~~ 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. The amendment to the definition of "authorized representative" shall become effective 10 days after being published as a final regulation and shall sunset on January 1, 2020 unless expressly reauthorized prior to that date.

19 DE Reg. 925 (04/01/16)

21 DE Reg. 406 (11/01/17) (Prop.)