SPONSOR: Sen. Townsend & Rep. Minor-Brown & Rep. Baumbach
Sen. Huxtable

DELAWARE STATE SENATE
152nd GENERAL ASSEMBLY

SENATE BILL NO. 10

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO HEALTH INSURANCE AND PRE-AUTHORIZATION REQUIREMENTS.

WHEREAS, according to a 2023 survey of physicians conducted by the American Medical Association (https://www.ama-assn.org/system/files/prior-authorization-survey.pdf), physician offices spend approximately 2 business days per week dealing with insurance pre-authorization requirements and on average complete 45 pre-authorizations per physician each week; and

WHEREAS, in this same survey: (i) 94% of physicians reported that pre-authorization requirements have delayed necessary care for patients; (ii) 89% of physicians reported that pre-authorization requirements had a "somewhat or significant negative impact" on patient clinical outcomes; (iii) 80% of physicians reported that pre-authorization requirements can lead to patients abandoning treatments; (iv) more than 60% of physicians reported that pre-authorization requirements have led to ineffective initial treatments or additional office visits; and (v) 33% of physicians reported that pre-authorization requirements have led to a serious adverse event (death, hospitalization, disability/permanent bodily damage, or other life-threatening event); and

WHEREAS, the General Assembly believes that reforming the laws relating to insurance pre-authorization practices is an important part of keeping Delaware residents healthy and assuring that patients can access necessary medical care in a timely manner.

NOW, THEREFORE:

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 33, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows and by redesignating accordingly:

§ 3371. Definitions.

In this section, the following words have the meanings indicated:

( ) "Episode of Care" means a specific medical problem, condition, or illness being managed, including tests, procedures, and rehabilitation initially requested by a health-care practitioner to be performed at the site of service, excluding out of network care.

( ) "Urgent health-care service" means a health-care service deemed by a provider to require expedited pre-authorization review in that a delay in treatment could do any of the following:

a. Negatively affect the ability of the covered person to regain maximum function.

b. Subject the covered person to severe pain that cannot be adequately managed without receiving the care or treatment that is the subject of the utilization review as quickly as possible.

§ 3372. Disclosure and review of pre-authorization requirements; utilization review; specific requirements related to adverse determinations.

(c)(1) If an insurer, health-benefit plan, or health-service corporation intends either to implement a new pre-authorization requirement or restriction, or amend an existing requirement or restriction, they shall provide covered persons who are currently authorized by the utilization review entity for coverage of the affected health-care service and all contracted health-care providers who provide affected health-care service or services of written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. Such notice may be delivered electronically or by other means.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, if an insurer, health-benefit plan, health-service corporation, or utilization review entity changes coverage terms for a health-care service or the clinical criteria used to conduct pre-authorization reviews for a health-care service, the change in coverage terms or change in clinical criteria shall not apply until the next plan year for any covered person who received pre-authorization for a health-care service using the coverage terms or clinical criteria in effect before the effective date of the change.

(d)(1) Insurers, health-benefit plans, and health-service corporations utilizing pre-authorization shall report de-identified statistics regarding pre-authorization approvals, denials, and appeals to the Delaware Health Information Network in a format and frequency, no less than twice annually, of the Delaware Health Information Network's request. The Department may also request this data at any time. The statistics shall include, but may be expanded upon or further delineated by regulation, categories for all of the following:

~~(1)~~ a. For denials, the aggregated reasons for denials such as, but not limited to, medical necessity or incomplete pre-authorization submission.

~~(2)~~ b. For appeals:

~~a.~~ 1. Practitioner specialty;

~~b.~~ 2. Medication, diagnostic test, or diagnostic procedure;

~~c.~~ 3. Indication offered;

~~d.~~ 4. Reason for underlying denial; and

~~e.~~ 5. Number of denials overturned upon appeal.

(2) The Department shall, by July 15 of each calendar year, prepare and make available to the public on its website a report detailing the aggregate number of pre-authorization approvals, denials, and appeals reported pursuant to paragraph (1) of this subsection during the prior calendar year by each insurer, health-benefit plan, or health-service corporation utilizing pre-authorization review.

(e) Utilization review; specific requirements related to adverse determinations –

(1) When a request for pre-authorization of health-care service is submitted by a physician or representative of a physician, an insurer, health-benefit plan, health-service organization, or utilization review entity must ensure that any adverse determination is made by a physician who meets all the following requirements:

a. Possesses a current, unrestricted license in good standing to practice medicine in any United States jurisdiction.

b. Has experience treating and managing patients with the medical condition or disease for which pre-authorization of the health-care service is requested.

(2) An insurer, health-benefit plan, health-service corporation, or utilization review entity must ensure that all appeals of an adverse determination related to a request for pre-authorization submitted by a physician or representative of a physician are reviewed and determined by a physician who meets all the following requirements:

a. Possesses a current, unrestricted license in good standing to practice medicine in any United States jurisdiction.

b. Practices in the same or similar specialty as a physician who typically manages the medical condition or disease of the covered person in the appeal.

c. Is knowledgeable of, and has experience providing, the health-care service under review in the appeal.

d. Was not directly involved in making the adverse determination under appeal.

e. Reviews and considers all clinical aspects of the health-care service under appeal, including all medical records of the covered person submitted as part of the pre-authorization process.

(3) When a request for pre-authorization of health-care service is submitted by a health-care provider other than a physician, an adverse determination or review in an appeal from an adverse determination may be

made by a health-care provider licensed in the same profession as the health-care provider submitting the request for pre-authorization.

(4) A utilization review entity must, within 15 days of the receipt of an appeal of an adverse determination, notify the covered person and health-care provider submitting the request for pre-authorization of the determination on the appeal. If the utilization review entity cannot make a determination within the 15-day period because additional information, documentation, or medical records are required to complete a review of the health-care service under appeal, the utilization review entity must notify the covered person and health-care provider submitting the request for pre-authorization in writing within the 15-day period specifying the additional information, documentation, or medical records required to complete the determination on appeal and shall have 15 days from the receipt thereof to make a determination on the appeal and notify the covered person and health-care provider. The written notification required by this paragraph must include all the following:

a. A summary of the findings supporting the determination made in the appeal.

b. The qualifications of any reviewer involved in making the determination in the appeal, including any license, certification, or specialty designation of any reviewer.

c. The relationship between the covered person's diagnosis or disease being treated and the review criteria used as the basis for the determination in the appeal, including the specific basis for the determination made.

(5) An insurer, health-benefit plan, or health-service corporation must ensure than that any utilization review entity used to perform pre-authorization review complies with all of the following:

a. Performs utilization review on weekends.

b. Provides access to a medical director or other clinical decision-maker Monday through Friday between the hours of 7:00 a.m. to 7:00 p.m.

c. Has established procedures for the submission of appeals in writing, electronically, or by telephone.

d. Provides a minimum of 30 days from the date of an adverse determination for the submission of an appeal.

§ 3373. Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

(a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health-care provider within ~~2 business days~~ 48 hours of obtaining a clean pre-authorization or of using services described in § 3377 of this title.

Notwithstanding any provision in an insurance policy, contract, or certificate to the contrary, a health-care provider may, subject to applicable coverage limitations, co-insurance requirements, and deductibles, specifically request pre-authorization to prescribe a branded pharmaceutical drug rather than a generic or biologic equivalent.

(b) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within ~~8 business~~ 4 days of receipt of a clean pre-authorization not submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(c)(1) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within ~~5 business days~~ 72 hours of receipt of a clean pre-authorization submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(2) No later than January 1, 2024, each insurer, health-benefit plan, health-service corporation, and utilization review entity must allow for and accept electronic pre-authorization requests and must respond to electronic pre-authorization requests through the same website, mobile application, digital platform, or other method as the electronic pre-authorization request was submitted.

(d) If a utilization review entity requires pre-authorization of an urgent health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 24 hours of receipt of a clean pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(e)(1) If a utilization review entity requires pre-authorization of a patient transfer, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 24 hours of receipt of a clean pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(2) Notwithstanding the provisions in paragraph (1) of this subsection, when an insurer, health-benefit plan, or health-service corporation, has determined that a lower level of care at a health-care facility is clinically appropriate, the insurer, health-benefit plan, or health-service corporation may not require pre-authorization for medically necessary interfacility transport of the covered person.

§ 3375. Retrospective denial.

(a) The utilization review entity may not revoke, limit, condition or restrict a pre-authorization on ground of medical necessity after the date the health-care provider received the pre-authorization. Any language attempting to disclaim payment for health-care services on the basis of changes to medical necessity that have been pre-authorized and delivered while under coverage shall be null and void. A proper notification of policy changes validly delivered as per § 3372 of this title may void a pre-authorization if received after pre-authorization but before delivery of the service.

(b) An insurer, health-benefit plan, or health-service corporation may not deny or limit coverage of a health-care service already delivered to a covered person solely on the basis of a lack of pre-authorization, to the extent that the health-care services would otherwise have been covered by the insurer, health-benefit plan, or health-service corporation had pre-authorization been obtained.

§ 3376. Effect and ~~Length~~ length of pre-authorization; limitation per episode of care.

(b) A pre-authorization for a health-care service shall be valid for a period of time that is reasonable and customary for the specific service, but no less than ~~60 days~~ 7 months, from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3372 of this title.

(c) Continuity of Care – If a covered person obtains coverage from a new insurer, health-benefit plan, or health-service corporation that uses a different utilization review entity than the covered person's previous insurer, health-benefit plan, or health-service organization, the new insurer, health-benefit plan, or health-service corporation must comply with any pre-authorization for health-care services approved by the previous insurer, health-benefit plan, or health-services organization during the first 60 days following the covered person's enrollment with the new insurer, health-benefit plan, or health-service organization. An insurer, health-insurance plan, or health-service corporation may require during the 60-day period that a newly enrolled covered person or such person's attending health-care provider submit documentation confirming any pre-authorization issued by the covered person's prior insurer, health-benefit plan, or health-service organization. Further, during this 60-day period the utilization review entity used by the covered person's new insurer, health-benefit plan, or health-service organization may conduct its own utilization review of any health-care service as to which pre-authorization was approved by the covered person's previous insurer, health-benefit plan, or health-service organization.

(d) Limitation per episode of care - An insurer, health-benefit plan, or health-service corporation may not require more than 1 pre-authorization for an episode of care; provided that any additional testing or procedures related or unrelated to the specific medical problem, condition, or illness being managed may require a separate pre-authorization.

(e) Pre-Authorization of bundled services – If a utilization review entity gives pre-authorization of a health-care service as part of a group of services for which a bundled payment is charged, pre-authorization of all other health-care services included in the group (e.g., anesthesia) is deemed to be approved.

Section 2. Amend Chapter 35, Title 18 of the Delaware Code by making deletions as shown by strikethrough, insertions as shown by underline, and redesignating existing paragraphs as follows:

§ 3581. Definitions.

In this section, the following words have the meanings indicated:

( ) "Episode of Care" means a specific medical problem, condition, or illness being managed, including tests, procedures, and rehabilitation initially requested by a health care practitioner to be performed at the site of service, excluding out of network care.

( ) "Urgent health-care service" means a health-care service deemed by a provider to require expedited pre-authorization review in that a delay in treatment could do any of the following:

a. Negatively affect the ability of the covered person to regain maximum function.

b. Subject the covered person to severe pain that cannot be adequately managed without receiving the care or treatment that is the subject of the utilization review as quickly as possible.

§ 3582. Disclosure and review of pre-authorization requirements; utilization review; specific requirements related to adverse determinations.

(c)(1) If an insurer, health-benefit plan, or health-service corporation intends either to implement a new pre-authorization requirement or restriction, or amend an existing requirement or restriction, they shall provide covered persons who are currently authorized by the utilization review entity for coverage of the affected health-care service and all contracted health-care providers who provide affected health-care service or services of written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. Such notice may be delivered electronically or by other means.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, if an insurer, health-benefit plan, health-service corporation, or utilization review entity changes coverage terms for a health-care service or the clinical criteria used to conduct pre-authorization reviews for a health-care service, the change in coverage terms or change in clinical criteria shall not apply until the next plan year for any covered person who received pre-authorization for a health-care service using the coverage terms or clinical criteria in effect before the effective date of the change.

(d)(1) Insurers, health-benefit plans, and health-service corporations utilizing pre-authorization shall report de-identified statistics regarding pre-authorization approvals, denials, and appeals to the Delaware Health Information

Network in a format and frequency, no less than twice annually, of the Delaware Health Information Network's request. The Department may also request this data at any time. The statistics shall include, but may be expanded upon or further delineated by regulation, categories for all of the following:

~~(1)~~ a. For denials, the aggregated reasons for denials such as, but not limited to, medical necessity or incomplete pre-authorization submission.

~~(2)~~ b. For appeals:

~~a.~~ 1. Practitioner specialty;

~~b.~~ 2. Medication, diagnostic test, or diagnostic procedure;

~~c.~~ 3. Indication offered;

~~d.~~ 4. Reason for underlying denial; and

~~e.~~ 5. Number of denials overturned upon appeal.

(2) The Department shall, by July 15 of each calendar year, prepare and make available to the public on its website a report detailing the aggregate number of pre-authorization approvals, denials, and appeals reported pursuant to paragraph (1) of this subsection during the prior calendar year by each insurer, health-benefit plan, or health-service corporation utilizing pre-authorization review.

(e) Utilization review; specific requirements related to adverse determinations –

(1) When a request for pre-authorization of health-care service is submitted by a physician or representative of a physician, an insurer, health-benefit plan, health-service organization, or utilization review entity must ensure that any adverse determination is made by a physician who meets all the following requirements:

a. Possesses a current, unrestricted license in good standing to practice medicine in any United States jurisdiction.

b. Has experience treating and managing patients with the medical condition or disease for which pre-authorization of the health-care service is requested.

(2) An insurer, health-benefit plan, health-service corporation, or utilization review entity must ensure that all appeals of an adverse determination related to a request for pre-authorization submitted by a physician or representative of a physician are reviewed and determined by a physician who meets all the following requirements:

a. Possesses a current, unrestricted license in good standing to practice medicine in any United States jurisdiction.

b. Practices in the same or similar specialty as a physician who typically manages the medical condition or disease of the covered person in the appeal.

c. Is knowledgeable of, and has experience providing, the health-care service under review in the appeal.

d. Was not directly involved in making the adverse determination under appeal.

e. Reviews and considers all clinical aspects of the health-care service under appeal, including all medical records of the covered person submitted as part of the pre-authorization process.

(3) When a request for pre-authorization of health-care service is submitted by a health-care provider other than a physician, an adverse determination or review in an appeal from an adverse determination may be made by a health-care provider licensed in the same profession as the health-care provider submitting the request for pre-authorization.

(4) A utilization review entity must within 15 days of the receipt of an appeal of an adverse determination notify the covered person and health-care provider submitting the request for pre-authorization of the determination on the appeal. If the utilization review entity cannot make a determination within the 15-day period because additional information, documentation, or medical records are required to complete a review of the health-care services under appeal, the utilization review entity must notify the covered person and health-care provider submitting the request for pre-authorization in writing within the 15-day period specifying the additional information, documentation, or medical records required to complete the determination on appeal and shall have 15 days from the receipt thereof to make a determination on the appeal and notify the covered person and health-care provider. The written notification required by this paragraph must include all the following:

a. A summary of the findings supporting the determination made in the appeal.

b. The qualifications of any reviewer involved in making the determination in the appeal, including any license, certification, or specialty designation of any reviewer.

c. The relationship between the covered person's diagnosis or disease being treated and the review criteria used as the basis for the determination in the appeal, including the specific basis for the determination made.

(5) An insurer, health-benefit plan, or health-service corporation must ensure than that any utilization review entity used to perform pre-authorization review complies with all of the following:

a. Performs utilization review on weekends.

b. Provides access to a medical director or other clinical decision-maker Monday through Friday between the hours of 7:00 a.m. to 7:00 p.m.

c. Has established procedures for the submission of appeals in writing, electronically, or by telephone.

d. Provides a minimum of 30 days from the date of an adverse determination for the submission of an appeal.

§ 3583. Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

(a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health-care provider within ~~2 business days~~ 48 hours of obtaining a clean pre-authorization or of using services described in § 3377 of this title. Notwithstanding any provision in an insurance policy, contract, or certificate to the contrary, a health-care provider may, subject to applicable coverage limitations, co-insurance requirements, and deductibles, specifically request pre-authorization to prescribe a branded pharmaceutical drug rather than a generic or biologic equivalent.

(b) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within ~~8 business~~ 4 days of receipt of a clean pre-authorization not submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(c)(1) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within ~~5 business days~~ 72 hours of receipt of a clean pre-authorization submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(2) No later than January 1, 2024, each insurer, health-benefit plan, health-service corporation, and utilization review entity must allow for and accept electronic pre-authorization requests and must respond to electronic pre-authorization requests through the same website, mobile application, digital platform, or other method as the electronic pre-authorization request was submitted.

(d) If a utilization review entity requires pre-authorization of an urgent health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider

of the determination within 24 hours of receipt of a clean pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(e)(1) If a utilization review entity requires pre-authorization of a patient transfer, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 24 hours of receipt of a clean pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(2) Notwithstanding the provisions in paragraph (1) of this subsection, when an insurer, health-benefit plan, or health-service corporation has determined that a lower level of care at a health-care facility is clinically appropriate, the insurer, health-benefit plan, or health-service corporation may not require pre-authorization for medically necessary interfacility transport of the covered person.

§ 3585. Retrospective denial.

(a) The utilization review entity may not revoke, limit, condition or restrict a pre-authorization on ground of medical necessity after the date the health-care provider received the pre-authorization. Any language attempting to disclaim payment for health-care services on the basis of changes to medical necessity that have been pre-authorized and delivered while under coverage shall be null and void. A proper notification of policy changes validly delivered as per § 3372 of this title may void a pre-authorization if received after pre-authorization but before delivery of the service.

(b) An insurer, health-benefit plan, or health-service corporation may not deny or limit coverage of a health-care service already delivered to a covered person solely on the basis of a lack of pre-authorization, to the extent that the health-care services would otherwise have been covered by the insurer, health-benefit plan, or health-service corporation had pre-authorization been obtained.

§ 3586. Effect and ~~Length~~ length of pre-authorization; limitation per episode of care.

(b) A pre-authorization for a health-care service shall be valid for a period of time that is reasonable and customary for the specific service, but no less than ~~60 days~~ 7 months, from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3372 of this title.

(c) Continuity of Care – If a covered person obtains coverage from a new insurer, health-benefit plan, or health-service corporation that uses a different utilization review entity than the covered person's previous insurer, health-benefit plan, or health-service organization, the new insurer, health-benefit plan, or health-service corporation must comply with any pre-authorization for health-care services approved by the previous insurer, health-benefit plan, or health-services

organization during the first 60 days following the covered person's enrollment with the new insurer, health-benefit plan, or health-service organization. An insurer, health-insurance plan, or health-service corporation may require during the 60-day period that a newly enrolled covered person or such person's attending health-care provider submit documentation confirming any pre-authorization issued by the covered person's prior insurer, health-benefit plan, or health-service organization. Further, during this 60-day period the utilization review entity used by the covered person's new insurer, health-benefit plan, or health-service organization may conduct its own utilization review of any health-care service as to which pre-authorization was approved by the covered person's previous insurer, health-benefit plan, or health-service organization.

(d) Limitation per episode of care - An insurer, health-benefit plan, or health-service corporation may not require more than one pre-authorization for an episode of care; provided that any additional testing or procedures related or unrelated to the specific medical problem, condition, or illness being managed may require a separate pre-authorization.

(e) Pre-Authorization of bundled services – If a utilization review entity gives pre-authorization of a health-care service as part of a group of services for which a bundled payment is charged, pre-authorization of all other health-care services included in the group (e.g., anesthesia) is deemed to be approved.

Section 3. Amend § 5210, Title 29 of the Delaware Code by making deletions as shown by strikethrough and insertions as shown by underline as follows:

§ 5210. Authority and duties of the State Employee Benefits Committee.

The State Employee Benefits Committee established by § 9602 of this title shall have the following powers, duties and functions under this chapter:

( ) Ensure that carriers administering plans for group health insurance under this chapter comply with all requirements and provisions concerning pre-authorization set forth in Chapter 33, Subchapter II, and Chapter 35, Subchapter V of Title 18.

Section 4. Effective Date. This act shall take effect on January 1 of the calendar year following its enactment and apply to all individual and group health insurance policies, contracts, or certificates issued or renewed in this State or after the effective date.

Section 5. The Department of Health and Social Services must, to the extent feasible, assure that contracts awarded to carriers providing health insurance under § 505(3) of Title 31 after the effective date of this Act include the requirements and provisions concerning pre-authorization set forth in Chapter 33, Subchapter II and Chapter 35, Subchapter V of Title 18.

Section 6. The Department of Insurance shall within 180 days after enactment promulgate a uniform pre-authorization form which all health care providers in this State may use to request pre-authorization and that all health insurers, health-benefit plans, health-service corporations, and utilization review entities must accept as sufficient to request pre-authorization of health-care services.

Section 7. This Act shall be known as and may be referred to as the "Delaware Pre-Authorization Reform Act of 2023".

SYNOPSIS

This legislation is the Delaware Pre-Authorization Reform Act of 2023.

Section 1 of the Act applies to Health Insurance Contracts regulated under Chapter 33 of Title 18.

Section 1 provides that changes in coverage terms for a health-care service or in the clinical criteria used to conduct pre-authorization reviews for a health-care service will not apply until the next plan year, for any covered person who received pre-authorization for the service prior to the change. It also requires the Delaware Department of Insurance to publish on its website information concerning the aggregate number of pre-authorization approvals, denials, and appeals for each insurer, health-benefit plan, or health-care service corporation using pre-authorization review.

In addition, Section 1 sets qualifications for who may make determinations with regard to requests for pre-authorization of health-care services and appeals of adverse determinations; a timeline and required contents for the notification of an outcome of appeal of an adverse determination or a notification that additional information is necessary to make the determination of appeal; and requirements for any utilization review entity used to perform pre-authorization review by an insurer, health-benefit plan, or health-service corporation.

Section 1 also shortens the timelines for the determination of pre-authorization requests and notification to the health-care provider of the determination. For requests for pre-authorization of non-urgent health-care services not submitted electronically, the utilization review entity must notify the health-care provider within 4 days of receipt of the request; for requests submitted electronically, notification must be given within 72 hours of receipt. For requests for pre-authorization for urgent health-care services, notification must be given within 24 hours of receipt.

By January 1, 2024, insurers, health-benefit plans, health-service corporations, and utilization review entities must accept and respond to electronic pre-authorization requests through the same platform as the electronic request was submitted.

Further, an insurer, health-benefit plan, or health-service corporation may not deny or limit coverage of a service already provided on the grounds that pre-authorization was not obtained, if such services would have been covered had pre-authorization been obtained.

In addition, Section 1 extends the time period that a pre-authorization is valid for from 60 days to 7 months. If a covered person changes insurers, health-benefit plans, or health-service corporations, the new insurer, health-benefit plan, or health-service corporation must comply with any existing pre-authorizations during the first 60 days of the new coverage. Finally, Section 1 provides that no more than 1 pre-authorization may be required for a single episode of care, and that if pre-authorization is granted as to a health-care services that is part of a group of services for which a bundled payment is charged, pre-authorization for the other health-care services included in the group is deemed to be approved as well.

Section 2 of the Act applies to Group and Blanket Health Insurance under Chapter 35 of Title 18 and makes the same changes to pre-authorization standards and procedures that Section 1 of the Act makes to Health Insurance Contracts regulated under Chapter 33 of Title 18.

Section 3 of the Act provides that the State Employee Benefits Committee established under § 9602 of the Title 29 of the Delaware Code must ensure that carriers administering plans for group health insurance comply with the requirements and provisions for pre-authorization set forth in Chapter 33, Subchapter II and Chapter 35, Subchapter V of Title 18.

Section 4 of the Act provides that the Act will take effect on January 1 of the calendar year following enactment and will apply to policies, contracts, or certificates issued or renewed after that effective date.

Section 5 of the Act provides that the Department of Health and Social Services must, to the extent feasible, assure that contracts awarded to carriers providing health insurance relating to Medicaid assistance comply with the requirements and provisions for pre-authorization set forth in Chapter 33, Subchapter II and Chapter 35, Subchapter V of Title 18.

Section 6 of the Act provides that the Department of Insurance will promulgate a uniform pre-authorization form within 180 days of enactment.

Section 7 provides that this Act is known as the "Delaware Pre-Authorization Reform Act of 2023."

Author: Senator Townsend