



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.

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

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

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

15 NOW, THEREFORE:

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

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

19 § 3371. Definitions.

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

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

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

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

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

29 § 3372. Disclosure and review of pre-authorization requirements; utilization review; specific requirements related
30 to adverse determinations.

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

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

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

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

49 (2) b. For appeals:

50 a. 1. Practitioner specialty;

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

52 c. 3. Indication offered;

53 d. 4. Reason for underlying denial; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

85 (4) A utilization review entity must, within 15 days of the receipt of an appeal of an adverse
86 determination, notify the covered person and health-care provider submitting the request for pre-authorization of
87 the determination on the appeal. If the utilization review entity cannot make a determination within the 15-day
88 period because additional information, documentation, or medical records are required to complete a review of the
89 health-care service under appeal, the utilization review entity must notify the covered person and health-care
90 provider submitting the request for pre-authorization in writing within the 15-day period specifying the additional
91 information, documentation, or medical records required to complete the determination on appeal and shall have
92 15 days from the receipt thereof to make a determination on the appeal and notify the covered person and health-
93 care provider. The written notification required by this paragraph must include all the following:

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

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

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

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

102 a. Performs utilization review on weekends.

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

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

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

109 § 3373. Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

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

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

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

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

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

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

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

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

142 § 3375. Retrospective denial.

143 (a) The utilization review entity may not revoke, limit, condition or restrict a pre-authorization on ground of
144 medical necessity after the date the health-care provider received the pre-authorization. Any language attempting to
145 disclaim payment for health-care services on the basis of changes to medical necessity that have been pre-authorized and
146 delivered while under coverage shall be null and void. A proper notification of policy changes validly delivered as per §
147 3372 of this title may void a pre-authorization if received after pre-authorization but before delivery of the service.

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

152 § 3376. Effect and Length length of pre-authorization; limitation per episode of care.

153 (b) A pre-authorization for a health-care service shall be valid for a period of time that is reasonable and customary
154 for the specific service, but no less than ~~60 days~~ 7 months, from the date the health-care provider receives the pre-
155 authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per §
156 3372 of this title.

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

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

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

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

177 § 3581. Definitions.

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

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

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

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

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

187 § 3582. Disclosure and review of pre-authorization requirements; utilization review; specific requirements related
188 to adverse determinations.

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

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

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

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

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

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

208 ~~a.~~ 1. Practitioner specialty;

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

210 ~~c.~~ 3. Indication offered;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

243 (4) A utilization review entity must within 15 days of the receipt of an appeal of an adverse determination
244 notify the covered person and health-care provider submitting the request for pre-authorization of the
245 determination on the appeal. If the utilization review entity cannot make a determination within the 15-day period
246 because additional information, documentation, or medical records are required to complete a review of the health-
247 care services under appeal, the utilization review entity must notify the covered person and health-care provider
248 submitting the request for pre-authorization in writing within the 15-day period specifying the additional
249 information, documentation, or medical records required to complete the determination on appeal and shall have
250 15 days from the receipt thereof to make a determination on the appeal and notify the covered person and health-
251 care provider. The written notification required by this paragraph must include all the following:

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

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

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

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

260 a. Performs utilization review on weekends.

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

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

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

267 § 3583. Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

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

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

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

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

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

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

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

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

301 § 3585. Retrospective denial.

302 (a) The utilization review entity may not revoke, limit, condition or restrict a pre-authorization on ground of
303 medical necessity after the date the health-care provider received the pre-authorization. Any language attempting to
304 disclaim payment for health-care services on the basis of changes to medical necessity that have been pre-authorized and
305 delivered while under coverage shall be null and void. A proper notification of policy changes validly delivered as per §
306 3372 of this title may void a pre-authorization if received after pre-authorization but before delivery of the service.

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

311 § 3586. Effect and Length length of pre-authorization; limitation per episode of care.

312 (b) A pre-authorization for a health-care service shall be valid for a period of time that is reasonable and customary
313 for the specific service, but no less than ~~60 days~~ 7 months, from the date the health-care provider receives the pre-
314 authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per §
315 3372 of this title.

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

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

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

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

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

336 § 5210. Authority and duties of the State Employee Benefits Committee.

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

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

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

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

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

353 Section 7. This Act shall be known as and may be referred to as the “Delaware Pre-Authorization Reform
354 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."

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