SPONSOR: Sen. Townsend & Sen. Poore & Rep. Griffith & Rep. Minor-Brown
Sens. Hoffner, Huxtable, Richardson, Seigfried, Sokola, Walsh; Reps. Carson, Gorman, Morrison, Romer, Ross Levin

DELAWARE STATE SENATE
153rd GENERAL ASSEMBLY

SENATE BILL NO. 12
AS AMENDED BY
SENATE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 18 AND TITLE 29 OF THE DELAWARE CODE RELATING TO THE DELAWARE PRE AUTHORIZATION ACT OF 2025.

WHEREAS, according to a 2023 survey of physicians conducted by the American Medical Association, 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 care that meets all of the following:

SD : MD : CBK : 4761530097
DLS : HVW : CBM : 5081530073
Released: 06/25/2025 08:51 PM

a. Is for a specific medical problem, condition, or illness being managed by a health-care provider, including tests, procedures, and rehabilitation initially requested by the health-care provider.

b. Is performed at the site of service.

c. Is not out-of-network care.

( ) "Urgent health-care service" means a covered health-care service subject to prior authorization that is delivered on an expedited basis for the treatment of an acute condition with symptoms of sufficient severity pursuant to a determination by a licensed treating health-care provider, operating within the health-care provider's scope of practice and professional expertise, that the failure to provide the service is likely to result in serious, long-term health complications or a material deterioration in the covered person's or enrollee's condition and prognosis.

§ ~~3372.~~ §3372. Disclosure and review of preauthorization ~~requirements.~~ requirements; adverse determinations.

(c) (1) If an insurer, health-benefit plan, ~~or~~ health-service corporation, or utilization review entity intends either to implement a new preauthorization requirement or restriction, either to implement a new preauthorization 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 care service and all contracted health-care providers who provide the 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 (c)(1) of this section, if an insurer, health benefit plan, health-service corporation, or utilization review entity changes utilization review terms, such as clinical criteria, for a health-care service, the change in utilization review terms does not apply to covered persons with an existing authorization for the health-care service, and will apply only upon re-authorization of the health-care service. An insurer, health benefit plan, health-service corporation, or utilization review entity must provide notice to covered persons at least 6 months before any changes to utilization review terms for a health-care service, unless those changes were due to clinical guideline status changes, recalls, market withdrawals or relevant FDA published safety information.

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

(2) For appeals:

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

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

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

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

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

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

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

a. Any compensation paid to the physician is not contingent upon the outcome of the review.

b. At least one of the following requirements is satisfied:

1. The physician is licensed in any United States jurisdiction with appropriate training, knowledge, or experience in the same or similar specialty that typically manages or consults on the health-care service in question.

2. The physician is licensed in any United States jurisdiction, in consultation with an appropriately qualified third-party health-care provider licensed in the same or similar medical specialty as the requesting physician, or a health-care provider with experience related to the covered person's associated condition. Any compensation paid to the consulting health-care provider may not be contingent upon the outcome of the review.

(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 clean pre-authorization request submitted by a physician or representative of a physician are reviewed and determined by a physician who meets all of the following requirements, in addition to the requirements set forth in paragraph (e)(1) of this section:

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

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

c. 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 clean pre-authorization request is submitted by a health-care provider other than a physician, an adverse determination or review in an appeal from an adverse determination must be made by a health-care provider licensed in the same or similar profession as the health-care provider submitting the request for pre-authorization, or a licensed health-care provider in consultation with an appropriately qualified third-party health-care provider licensed in the same or similar medical specialty as the requesting health-care provider. Any compensation paid to the health-care provider or consulting health-care provider may not be contingent upon the outcome of the review of the clean pre-authorization request or appeal from an adverse determination.

(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 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 of 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 that any utilization review entity used to perform utilization 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 AM and 7:00 PM and during reasonable business hours Saturday through Sunday.

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 obligation with respect to pre-authorization ~~in non-emergency 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 of obtaining a clean pre-authorization ~~or of~~ using services described in § 3377 of this title.

(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~~ 5 business days of receipt of a clean pre-authorization not submitted ~~through electronic pre-authorization.~~ using services described in § 3377 of this title. For purposes of this subsection, a clean preauthorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(c) 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~~ 3 business days of receipt of a clean pre-authorization ~~through electronic pre-authorization~~ submitted using services described in § 3377 of this title. 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.

(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 submitted using services described in § 3377 of this title. 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 submitted using services described in § 3377 of this title. 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 (e)(1) of this section, 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.

(f) 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 48 hours of receipt of a clean pre-authorization submitted not using services described in § 3377 of this title. 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.

(g) If a utilization review entity requires pre-authorization of a patient transfer, the 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 48 hours of receipt of a clean pre-authorization not submitted using services described in § 3377 of this title. 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.

§ 3376. Effect and ~~Length~~ length of pre-~~authorization.~~ 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~~ 90 days, 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) 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. Any new treatment or additional testing or procedures related o r unrelated to the specific medical problem, condition, or illness being managed may require a separate pre-authorization.

(d) Pre-authorization of other covered services in-network - 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 covered health-care services provided by in-network providers included in the group is deemed to be approved.

§ 3377. Electronic standards for ~~pharmaceutical~~ pre-authorization.

(a) No later than January 1, 2018, the insurer must accept and respond to pre-authorization requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT standard ePA transactions. Facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

(b) No later than January 1, 2027, an insurer, health-benefit plan, health-service corporation, or 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.

(c) No later than January 1, 2027, an insurer, health-benefit plan, health-service corporation, or utilization review entity must establish a provider portal that includes all of the following features:

(1) Electronic submission of pre-authorization requests.

(2) Access to the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's applicable medical policies.

(3) Information necessary to request a peer-to-peer review.

(4) Contact information for the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's relevant clinical or administrative staff.

(5) For any health-care service that requires pre-authorization that is not subject to electronic submission via the provider portal, copies of applicable forms.

(6) Instructions for the submission of pre-authorization requests if the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's provider portal is unavailable for any reason.

(d) Within 12 months following establishment of a provider portal under subsection (c) of this section, the insurer, health-benefit plan, health-service corporation, or utilization review entity may require a health-care provider seeking pre-authorization to submit the request via the provider portal unless one of the following exemptions applies:

(i) The portal is not available and operational at the time of attempted submission.

(ii) The health-care provider does not have access to the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's operational provider portal.

(iii) The health-care provider satisfies an allowance by the insurer, health benefit plan, health service corporation, or utilization review entity for submission other than through the provider portal.

Section 2. Amend Chapter 35, 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:

§ 3581. Definitions. [For application of this section, see 82 Del. Laws, c. 44, § 3].

For purposes of this subchapter, the following definitions apply:

( ) "Episode of Care" means care that meets all of the following:

a. Is for a specific medical problem, condition, or illness being managed by a health-care provider, including tests, procedures, and rehabilitation initially requested by the health-care provider.

b. Is performed at the site of service.

c. Is not out-of-network care.

( ) "Urgent health-care service" means a covered health-care service subject to prior authorization that is delivered on an expedited basis for the treatment of an acute condition with symptoms of sufficient severity pursuant to a determination by a licensed treating health-care provider, operating within the health-care provider's scope of practice and professional expertise, that the failure to provide the service is likely to result in serious, long-term health complications or a material deterioration in the covered person's or enrollee's condition and prognosis.

§ 3582. Disclosure and review of pre-authorization ~~requirements;~~ requirements; adverse determinations.

(c) (1) If an insurer, health-benefit plan, or health-service corporation, or utilization review entity 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 the 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 (c)(1) of this section, if an insurer, health benefit plan, health-service corporation, or utilization review entity changes utilization review terms, such as clinical criteria, for a health-care service, the change in utilization review terms does not apply to covered persons with an existing authorization for the health-care service, and will apply only upon re-authorization of the health-care service. An insurer, health benefit plan, health-service corporation, or utilization review entity must provide notice to covered persons at least 6 months before any changes to utilization review terms for a health-care service, unless those changes were due to clinical guideline status changes, recalls, market withdrawals or relevant FDA published safety information.

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

(2) For appeals:

1. Practitioner ~~specialty;~~ specialty.

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

3. Indication ~~offered;~~ offered.

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

5. Number of denials overturned upon appeal.

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

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

a. Any compensation paid to the physician is not contingent upon the outcome of the review.

b. At least one of the following requirements is satisfied:

1. The physician is licensed in any United States jurisdiction with appropriate training, knowledge, or experience in the same or similar specialty that typically manages or consults on the health-care service in question.

2. The physician is licensed in any United States jurisdiction, in consultation with an appropriately qualified third-party health-care provider licensed in the same or similar medical specialty as the requesting physician, or a health-care provider with experience related to the covered person's associated condition. Any compensation paid to the consulting health-care provider may not be contingent upon the outcome of the review.

(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 clean pre-authorization request submitted by a physician or representative of a physician are reviewed and determined by a physician who meets all the following requirements, in addition to the requirements set forth in paragraph (e)(1) of this section:

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

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

c. 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 clean pre-authorization request is submitted by a health-care provider other than a physician, an adverse determination or review in an appeal from an adverse determination must be made by a health-care provider licensed in the same or similar profession as the health-care provider submitting the request for pre-authorization, or a licensed health-care provider in consultation with an appropriately qualified third-party health-care provider licensed in the

same or similar medical specialty as the requesting health-care provider. Any compensation paid to the health-care provider or consulting health-care provider may not be contingent upon the outcome of the review of the clean pre-authorization request or appeal from an adverse determination.

(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, documents, 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 of 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 then that any utilization review entity used to perform utilization 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 Frida y between the hours of 7:00 AM to 7:00 PM and during reasonable business hours Saturday through Sunday.

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 non-emergency 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 of obtaining a clean pre-authorization or of using services described in ~~§ 3377~~ § 3587 of this title.

(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~~ 5 business days of receipt of a clean pre-authorization ~~through electronic pre-authorization~~ not submitted using services described in § 3587 of this title. 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) 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~~ 3 business days of receipt of a clean pre-authorization ~~through electronic pre-authorization.~~ submitted using services described in § 3587 of this title. 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.

(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 submitted using services described in § 3587 of this title. 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 submitted using services described in § 3587 of this title. 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 (e)(1) of this section, 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.

(f) 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 48 hours of receipt of a clean pre-authorization submitted not using services described in §

3587 of this title. 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.

(g) If a utilization review entity requires pre-authorization of a patient transfer, the 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 48 hours of receipt of a clean pre-authorization not submitted using services described in § 3387 of this title. 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.

§ 3586. ~~Length~~ Effect and length of pre- ~~authorization.~~ 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~~ 90 days, 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 § 3582 of this title.

(c) 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. Any new treatment or additional testing or procedures related or unrelated to the specific medical problem, condition, or illness being managed may require a separate pre-authorization.

(d) Pre-authorization of other covered services in-network - 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 covered health-care services provided by in-network providers included in the group is deemed to be approved.

§ 3587. Electronic standards for ~~pharmaceutical~~ pre-authorization.

(a) No later than January 1, 2018, the insurer must accept and respond to pre-authorization requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT standard ePA transactions. Facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

(b) No later than January 1, 2027, an insurer, health-benefit plan, health-service corporation, or 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.

(c) No later than January 1, 2027, an insurer, health-benefit plan, health-service corporation, or utilization review entity must establish a provider portal that includes all of the following features:

(1) Electronic submission of pre-authorization requests.

(2) Access to the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's applicable medical policies.

(3) Information necessary to request a peer-to-peer review.

(4) Contact information for the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's relevant clinical or administrative staff.

(5) For any health-care service that requires pre-authorization that is not subject to electronic submission via the provider portal, copies of applicable forms.

(6) Instructions for the submission of pre-authorization requests if the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's provider portal is unavailable for any reason.

(d) Within 12 months following establishment of a provider portal under subsection (c) of this section, the insurer, health-benefit plan, health-service corporation, or utilization review entity may require a health-care provider seeking pre-authorization to submit the request via the provider portal unless one of the following exemptions applies:

(i) The portal is not available and operational at the time of attempted submission.

(ii) The health-care provider does not have access to the insurer's, health-benefit plan's, health service corporation's, or utilization review entity's operational provider portal.

(iii) The health-care provider satisfies an allowance by the insurer, health benefit plan, health service corporation, or utilization review entity for submission other than through the provider portal.

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 under § 9602 of this title has 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 apply to all health insurance policies, contracts, or certificates issued, renewed, modified, altered, amended or reissued in this state after December 31, 2026.

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. This Act shall be known as and may be referred to as the “Delaware Pre-Authorization Reform Act of 2025”.