



SPONSOR: Rep. Baumbach & Sen. Henry
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Williams; Sens. Hall-Long, Lopez, Sokola

HOUSE OF REPRESENTATIVES
148th GENERAL ASSEMBLY

HOUSE BILL NO. 381

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO PRE-AUTHORIZATION.

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

1 Section 1. Amend Title 18, Chapter 33 of the Delaware Code to add a new heading for Subchapter I and to add a
2 new Subchapter II making deletions as shown by strike through and insertions as shown by underline as follows:

3 CHAPTER 33. HEALTH INSURANCE CONTRACTS

4 Subchapter I. General Provisions.

5 § 3301 Scope of chapter.

6 Subchapter II. Pre-Authorization Transparency.

7 § 3371. Definitions.

8 (a) In this section, the following words have the meanings indicated:

9 (1) “Adverse determination” means a benefit denial, reduction or termination, a denial of certification, a
10 determination that an admission or continued stay, or course of treatment, or other covered health service does not
11 satisfy the insurance policy’s clinical requirements for appropriateness, necessity, health care setting and/or level of
12 care.

13 (2) “Clean pre-authorization” means when a submission is made to satisfy pre-authorization in which the data
14 for all relevant fields is provided and in the format called for by the utilization review entity.

15 (3) “Clinical criteria” means the written policies, written screening procedures, drug formularies or lists of
16 covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols
17 and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness
18 of health care services.

19 (4) “Covered person” means an individual and/or family who has entered into a contractual arrangement, or
20 on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier provides
21 health insurance for such person or persons.

22 (5) “Electronic pre-authorization” means a submission of information via a website, the Delaware Health
23 Information Network, or other method via the internet as delineated by regulation and as accepted by the utilization
24 review entity.

25 (6) “Emergency health care services” means those services identified in §§ 3349 and 3565 of this title.

26 (7) “Health care service” means any services or supplies included in the furnishing to any individual of
27 medical care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing
28 to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human
29 illness, injury, disability or disease.

30 (8) “Medically necessary” means providing of health care services or products that a prudent physician would
31 provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that
32 is all of the following:

33 a. In accordance with generally accepted standards of medical practice;

34 b. Consistent with the symptoms or treatment of the condition;

35 c. Not solely for anyone’s convenience; and

36 d. Not including investigational or experimental health care services.

37 (9) “NCPDP SCRIPT standard” means the most recent standard adopted of the National Council for
38 Prescription Drug Programs SCRIPT adopted by the United States Department of Health and Human Services. To fall
39 within this definition, any version released subsequent to passage of this section must be compatible to the version in
40 use in 2015.

41 (10) “Pre-authorization” means a requirement by a carrier or health insurance plan that states clinicians need
42 to submit a treatment plan, service request, or other prior notification to the carrier for evaluation of appropriateness of
43 the plan or if the service is medically necessary before treatment is rendered and thereby lets the insured and clinician
44 know in advance which procedures and pharmaceuticals are covered.

45 (11) “Utilization review entity” means an individual or entity which performs pre-authorization for one or
46 more of the following entities:

47 a. An employer with employees in Delaware who are covered under a health benefit plan or health
48 insurance policy which does not fall under the Employee Retirement Income Security Act (ERISA);

49 b. An insurer, health benefit plan, or health service corporation that writes health insurance policies,
50 performs pre-authorization, or entity to which these capabilities have been delegated;

51 c. A preferred provider organization, or health maintenance organization;

52 d. Any other individual or entity that provides, offers to provide, or administers hospital, outpatient,
53 medical, or other health benefits to a person treated by a health care provider in Delaware under a policy, plan, or
54 contract.

55 § 3372 Disclosure and review of pre-authorization requirements.

56 (a) A utilization review entity shall make any current pre-authorization requirements and restrictions readily
57 accessible on its website and in written or electronic form upon request for covered persons, health care providers,
58 government entities, and the general public. Requirements shall be described in detail but also in clear, easily-
59 understandable language. Clinical criteria shall be described in language easily understandable by a health care provider.

60 (b) If a utilization review entity intends either to implement a new pre-authorization requirement or restriction, or
61 amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement
62 is not implemented unless the utilization review entity's website has been updated to reflect the new or amended
63 requirement or restriction. This shall not extend to expansion of coverage for new health care services.

64 (c) If a utilization review entity intends either to implement a new pre-authorization requirement or restriction, or
65 amend an existing requirement or restriction, the utilization review entity shall provide covered persons who are currently
66 using the affected health care service and all contracted health care practitioners who provide affected health care service or
67 services of written notice of the new or amended requirement or amendment no less than 60 days before the requirement or
68 restriction is implemented. Such notice may be delivered electronically or by other means as agreed to by the receiving
69 entity.

70 (d) Entities utilizing pre-authorization shall make de-identified statistics available regarding pre-authorization
71 approvals and denials on their website in a readily accessible format. The statistics shall include, but may be expanded upon
72 or further delineated by regulation, categories for all of the following:

73 (1) Practitioner specialty;

74 (2) Medication, diagnostic test, or diagnostic procedure;

75 (3) Indication offered;

76 (4) Reasons for denial such as, but not limited to, medical necessity or incomplete pre-authorization
77 submission; and

78 (5) Denials overturned upon appeal.

79 § 3373 Utilization review entity's obligations with respect to pre-authorizations in non-emergency circumstances.

80 (a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must
81 complete its process or render an adverse determination and notify the covered person and the covered person's health care

82 provider within 2 business days of obtaining a clean pre-authorization or within 2 calendar days if using services described
83 in § 3379 of this title.

84 (b) If a utilization review entity requires pre-authorization of a health care service, the utilization review entity
85 must make a pre-authorization or adverse determination and notify the covered person and the covered person's health care
86 provider of the pre-authorization or adverse determination within 5 calendar days of obtaining a clean pre-authorization not
87 submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the
88 results of any face-to-face clinical evaluation or second opinion that may be required.

89 (c) If a utilization review entity requires pre-authorization of a health care service, the utilization review entity
90 must make a pre-authorization or adverse determination and notify the covered person and the covered person's health care
91 provider of the pre-authorization or adverse determination within 3 calendar days of obtaining a clean pre-authorization
92 through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any
93 face-to-face clinical evaluation or second opinion that may be required.

94 § 3374 Utilization review entity's obligations with respect to Pre-Authorization concerning emergency health care
95 services.

96 A utilization review entity must follow all emergency procedures as delineated in §§ 3349 and 3565 of this title.

97 § 3375 Retrospective denial.

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

103 § 3376 Length of pre-authorization.

104 A pre-authorization shall be valid for one year from the date the health care provider receives the pre-
105 authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per
106 § 3372 of this title.

107 § 3377 Electronic standards for pharmaceutical pre-authorization.

108 No later than January 1, 2017, the insurer must accept and respond to pre-authorization requests under the
109 pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT standard ePA transactions.
110 Facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

111 § 3378 Health care services deemed preauthorized if a utilization review entity fails to comply with the
112 requirements of this Subchapter.

113 Any failure by a utilization review entity to comply with the deadlines and other requirements specified in this
114 Subchapter will result in any health care services subject to review to be automatically deemed preauthorized.

115 § 3379 Waiver prohibited.

116 The provisions of this Subchapter cannot be waived by contract. Any contractual arrangement in conflict with the
117 provisions of this Subchapter or that purports to waive any requirements of this Subchapter is null and void.

118 Section 2. Amend Title 18 to add a new Subchapter V to Chapter 35 of the Delaware Code by making deletions as
119 shown by strike through and insertions as shown by underline as follows:

120 Subchapter V. Pre-Authorization Transparency.

121 § 3581. Definitions.

122 For purposes of this Subchapter, the following definitions apply:

123 (1) “Adverse determination” means a benefit denial, reduction or termination, a denial of certification, a
124 determination that an admission or continued stay, or course of treatment, or other covered health service does not
125 satisfy the insurance policy’s clinical requirements for appropriateness, necessity, health care setting and/or level of
126 care.

127 (2) “Clean pre-authorization” means when a submission is made to satisfy pre-authorization in which the data
128 for all relevant fields is provided and in the format called for by the utilization review entity.

129 (3) “Clinical criteria” means the written policies, written screening procedures, drug formularies or lists of
130 covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols
131 and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness
132 of health care services.

133 (4) “Covered person” means an individual or family, or both, who has entered into a contractual arrangement,
134 or on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier
135 provides health insurance for such person.

136 (5) “Electronic pre-authorization” is a submission of information via a website, the Delaware Health
137 Information Network, or other method via the internet as delineated by regulation and as accepted by the utilization
138 review entity.

139 (6) “Emergency health care services” means those services identified in §§ 3349 and 3565 of this title.

140 (7) "Health care service" means any services or supplies included in the furnishing to any individual of
141 medical care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing
142 to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human
143 illness, injury, disability or disease.

144 (8) "Medically necessary" means providing of health care services or products that a prudent physician would
145 provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that
146 is all of the following:

147 a. In accordance with generally accepted standards of medical practice;

148 b. Consistent with the symptoms or treatment of the condition;

149 c. Not solely for anyone's convenience; and

150 d. Not including investigational or experimental health care services.

151 (9) "NCPDP SCRIPT standard" means the most recent standard adopted of the National Council for
152 Prescription Drug Programs SCRIPT adopted by the United States Department of Health and Human Services. To fall
153 within this definition, any version released subsequent to passage of this section must be compatible to the version in
154 use in 2015.

155 (10) "Pre-authorization" means a requirement by a carrier or health insurance plan that states clinicians need
156 to submit a treatment plan, service request, or other prior notification to the carrier for evaluation of appropriateness of
157 the plan or if the service is medically necessary before treatment is rendered. It lets the insured and clinician know in
158 advance which procedures and pharmaceuticals are covered.

159 (11) "Utilization review entity" means an individual or entity which performs pre-authorization for one or
160 more of the following entities:

161 a. An employer with employees in Delaware who are covered under a health benefit plan or health
162 insurance policy which does not fall under the Employee Retirement Income Security Act (ERISA);

163 b. An insurer, health benefit plan, or health service corporation that writes health insurance policies,
164 performs pre-authorization, or entity to which these capabilities have been delegated;

165 c. A preferred provider organization, or health maintenance organization;

166 d. Any other individual or entity that provides, offers to provide, or administers hospital, outpatient,
167 medical, or other health benefits to a person treated by a health care provider in Delaware under a policy, plan, or
168 contract.

169 § 3582 Disclosure and review of pre-authorization requirements.

170 (a) A utilization review entity shall make any current pre-authorization requirements and restrictions readily
171 accessible on its website and in written or electronic form upon request for covered persons, health care providers,
172 government entities, and the general public. Requirements shall be described in detail but also in clear, easily-
173 understandable language. Clinical criteria shall be described in language easily understandable by a health care provider.

174 (b) If a utilization review entity intends either to implement a new pre-authorization requirement or restriction, or
175 amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement
176 is not implemented unless the utilization review entity's website has been updated to reflect the new or amended
177 requirement or restriction. This shall not extend to expansion of coverage for new health care services.

178 (c) If a utilization review entity intends either to implement a new pre-authorization requirement or restriction, or
179 amend an existing requirement or restriction, the utilization review entity shall provide covered persons who are currently
180 using the affected health care service and all contracted health care practitioners who provide affected health care service or
181 services of written notice of the new or amended requirement or amendment no less than 60 days before the requirement or
182 restriction is implemented. Such notice may be delivered electronically or by other means as agreed to by the receiving
183 entity.

184 (d) Entities utilizing pre-authorization shall make de-identified statistics available regarding pre-authorization
185 approvals and denials on their website in a readily accessible format. The statistics shall include, but may be expanded upon
186 or further delineated by regulation, categories for all of the following:

187 (1) Practitioner specialty;

188 (2) Medication, diagnostic test, or diagnostic procedure;

189 (3) Indication offered;

190 (4) Reasons for denial such as, but not limited to, medical necessity or incomplete pre-authorization
191 submission; and

192 (5) Denials overturned upon appeal.

193 § 3583 Utilization review entity's obligations with respect to pre-authorizations in non-emergency circumstances.

194 (a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must
195 complete its process or render an adverse determination and notify the covered person and the covered person's health care
196 provider within 2 business days of obtaining a clean pre-authorization or within 2 calendar days if using services described
197 in § 3382 of this title.

198 (b) If a utilization review entity requires pre-authorization of a health care service, the utilization review entity
199 must make a pre-authorization or adverse determination and notify the covered person and the covered person's health care

200 provider of the pre-authorization or adverse determination within 5 calendar days of obtaining a clean pre-authorization not
201 submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the
202 results of any face-to-face clinical evaluation or second opinion that may be required.

203 (c) If a utilization review entity requires pre-authorization of a health care service, the utilization review entity
204 must make a pre-authorization or adverse determination and notify the covered person and the covered person's health care
205 provider of the pre-authorization or adverse determination within 3 calendar days of obtaining a clean pre-authorization
206 through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any
207 face-to-face clinical evaluation or second opinion that may be required.

208 § 3584 Utilization review entity's obligations with respect to pre-authorization concerning emergency health care
209 services.

210 A utilization review entity must follow all emergency procedures as delineated in §§ 3349 and 3565 of this title.

211 § 3585 Retrospective denial.

212 The utilization review entity may not revoke, limit, condition or restrict a pre-authorization on ground of medically
213 necessary after the date the health care provider received the pre-authorization. Any language attempting to disclaim
214 payment for services that have been pre-authorized as medically necessary and delivered while under coverage shall be null
215 and void. A proper notification of policy changes validly delivered as per § 3582 of this title may void a pre-authorization if
216 received after pre-authorization but before delivery of the service.

217 § 3586 Length of pre-authorization.

218 A pre-authorization shall be valid for one year from the date the health care provider receives the pre-
219 authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per
220 § 3382 of this title.

221 § 3587 Electronic standards for pharmaceutical pre-authorization.

222 No later than January 1, 2017, the insurer must accept and respond to pre-authorization requests under the
223 pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT standard ePA transactions.
224 Facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

225 § 3588 Health care services deemed preauthorized if a utilization review entity fails to comply with the
226 requirements of this Subchapter.

227 Any failure by a utilization review entity to comply with the deadlines and other requirements specified in this
228 Subchapter will result in any health care services subject to review to be automatically deemed preauthorized.

229 § 3589 Waiver Prohibited.

230 The provisions of this Subchapter cannot be waived by contract. Any contractual arrangement in conflict with the
231 provisions of this Subchapter or that purports to waive any requirements of this Subchapter is null and void.

232 Section 3. This Act shall take effect on January 1, 2017.

233 Section 4. Severability. If any provision of this Act or the application thereof to any person or circumstance is
234 held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without
235 the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

SYNOPSIS

Patients struggle every day to receive necessary care, suffering symptoms longer than appropriate and encountering unnecessary stress factors as they engage in the complicated system of health insurance. One such factor is Pre-Authorization, a tool designed to save the money by making sure that care is necessary. For years patients and clinicians have been put through arduous appeals processes being told that they are necessary to keep costs down or worse, told after the fact that their care won't be paid for even when previously told otherwise. Yet, anecdotally, appeals to these decisions are nearly always granted after hours of staff and clinician time. Reliable data is difficult, if not impossible, to come by to evaluate if programs are worth the costs of time that they shift to the patient and clinician. This legislation requires greater transparency, efficiency, and fairness in pre-authorization programs.