152nd GENERAL ASSEMBLY
FISCAL NOTE *REVISED*

BILL:	**SENATE BILL NO. 10**
SPONSOR:	**Senator Townsend**
DESCRIPTION:	**AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO HEALTH INSURANCE AND PRE-AUTHORIZATION REQUIREMENTS.**

Assumptions:

1. This Act is effective upon signature. The provisions of this Act relating to pre-authorization standards and procedures are effective for individual and group health insurance policies, contracts or certificates issued or renewed on or after January 1, 2025.
2. Prior authorization is a process by which a health insurance carrier reviews a request for certain health care services or drugs before consenting to cover the proposed treatment. Upon receiving a request, a carrier can approve or deny the request, or request additional information. A carrier can employ this practice for a variety of reasons, including as a cost-control mechanism or to verify medical necessity.
3. This Act amends existing and establishes new standards for pre-authorization for individual and group health insurance policies, contracts, or certificates to include:
    - Requiring changes in coverage terms or clinical criteria used to conduct pre-authorization reviews to not apply until the next plan year for a covered person who previously received pre-authorization for that coverage.
    - Setting qualifications for who can adjudicate a pre-authorization request and appeal of adverse determination.
    - Setting timelines and content requirements of an outcome of an appeal to a pre-authorization denial.
    - Shortening the timelines for pre-authorization determination and notification of the health-care provider.
    - Requiring plans to accept and respond to electronic inquiries through the same platform as the request was received.
    - Not allowing plans to deny coverage due to not receiving a pre-authorization if such services would have been covered if a pre-authorization had been received.
    - Extending the period that a pre-authorization is valid.
4. This Act requires the State Employee Benefits Committee ensure that carriers administering health insurance contracts under their purview comply with pre-authorization standards established by this Act.
5. The Statewide Benefits Office ("SBO") of the Department of Human Resources estimates the impact to the State Employee Group Health Insurance Program (GHIP) to be $14.7 million. This total includes the effect of anticipated formulary exceptions for specialty and non-specialty pharmaceuticals. This total also includes administrative impacts for the GHIP medical and pharmaceutical administrators due to increased staffing to accommodate quicker turnaround times and weekend hours, enhanced credentialing requirements which would require the hiring of specialty physicians, prohibiting changes in coverage terms during the plan year and for allowing previously completed services completed without a prior authorization to be covered retrospectively.

6. SBO also believes there is potentially another up to $28.6 million of current pharmaceuticals savings at risk within the GHIP due to the changes in the requirements for pre-authorizations.
7. This Act requires the Department of Health and Social Services ("DHSS") ensure that carriers administering health insurance contracts relating to Medicaid assistance comply with pre-authorization standards established by this Act. DHSS has stated that the fiscal impact to the Medicaid program is indeterminable but considered to be significant.
8. The Act requires the Department of Insurance (DOI) to promulgate a uniform pre-authorization form for all health care providers to use and that all plans must accept as sufficient for a pre-authorization request. The Act further requires DOI publish to the internet the aggregate number of pre-authorization approvals, denials and appeals for each plan. DOI anticipates the need for first year contractual support to assist in the design and promulgation of the pre-authorization form as well as for the analysis and publication of the required report in the amount of $33,165. Future years' costs to update required report are estimated to be $13,140. It is assumed these costs will require General Fund allocations.

Cost:

	GHIP	Medicaid	DOI
Fiscal Year 2025:	$14.7 million	Indeterminable, assumed significant	$33,165
Fiscal Year 2026:	$14.7 million	Indeterminable, assumed significant	$13,140
Fiscal Year 2027:	$14.7 million	Indeterminable, assumed significant	$13,140

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