153rd GENERAL ASSEMBLY
FISCAL NOTE

BILL:	**SENATE BILL NO. 12**
AS AMENDED BY:	**SA 1**
SPONSOR:	**Senator Townsend**
DESCRIPTION:	**AN ACT TO AMEND TITLE 18 AND TITLE 29 OF THE DELAWARE CODE RELATING TO THE DELAWARE PRE AUTHORIZATION ACT OF 2025.**

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, renewed, modified, altered, amended or reissued on or after December 31, 2026.
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:
    a. Requiring an insurer, health benefit plan, health-service corporation or utilization review entity 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.
    b. Setting qualifications for who can adjudicate a pre-authorization request and appeal of adverse determination.
    c. Setting timelines and content requirements of an outcome of an appeal to a preauthorization denial.
    d. Setting requirements for utilization review entities.
    e. Shortening the timelines for pre-authorization determination and notification of the healthcare provider.
    f. Requiring a plan to establish a portal to accept and respond to electronic inquiries through the same platform as the request was received. Within 12 months of establishing the portal, 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 this portal with some exceptions.
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. The extent to which current pre-authorization reviews may already be in compliance with the requirements of the Act, as well as any potential future costs for compliance, are unknown. As

such, the Statewide Benefits Office of the Department of Human Resources estimates the impact to the State Employee Group Health Insurance Program ("GHIP") to be indeterminable. Any operational requirements of this Act would be incorporated in future contract negotiations with the GHIP third party administrators and pharmacy benefit manager.

5. This Act requires the Department of Health and Social Services ("DHSS") ensure, to the extent feasible, that carriers administering health insurance contracts relating to Medicaid assistance comply with pre-authorization standards established by this Act. Due to lack of available related data, DHSS is unable to determine any fiscal impact to the Medicaid program. Any operational requirements of this Act would be incorporated in future contract negotiations with the Medicaid Managed Care Organizations.

Cost:

Fiscal Year 2026:	Not Applicable
Fiscal Year 2027:	Indeterminable
Fiscal Year 2028:	Indeterminable

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