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COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF INSURANCE

DOMESTIC AND FOREIGN INSURERS BULLETIN NO. 163

TO: **ALL HEALTH INSURANCE INSURERS, HEALTH BENEFIT PLANS, HEALTH SERVICE CORPORATIONS, AND UTILIZATION REVIEW ENTITIES OPERATING IN DELAWARE, AND OTHER INTERESTED PARTIES**

RE: **IMPLEMENTATION OF SENATE BILL NO. 12 - DELAWARE PRE-AUTHORIZATION ACT OF 2025**

DATED: **November 3, 2025**

The Delaware Department of Insurance issues this Bulletin to inform stakeholders of the enactment of Senate Bill No. 12, as amended by Senate Amendment No. 1 ("SB 12") of the 153rd General Assembly, referred to as the Delaware Pre-Authorization Act of 2025 (the "Act"). The Act applies to all health insurance policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued in this State after December 31, 2026.

SB 12 establishes uniform, enforceable standards for the pre-authorization of health-care services across Delaware. It amends Chapters 33 and 35 of Title 18 of the Delaware Code and makes conforming amendments to Title 29, Chapter 52, thereby extending these standards to the State Employee Health Benefits Program. Finally, SB 12 requires DHSS, to the extent feasible, to enter into contracts with its Medicaid MCOs that contain the same pre-authorization standards as set forth in the Insurance Code.

The Act is designed to:

- Reduce administrative burdens on providers and carriers
- Improve timely access to medically necessary care
- Increase transparency and consistency in utilization review practices

Key Provisions of SB 12:

Definitions

- Introduces statutory definitions for:
  - Episode of Care
  - Urgent health-care service

  These definitions clarify the scope and timing of services subject to pre-authorization.

Notice Requirements

- An insurer, health-benefit plan, health-service corporation, or utilization review entity must provide at least 6 months' advance notice to covered persons before implementing changes to utilization review terms, unless changes are due to:
  - Updated clinical guidelines

- Product recalls
- Market withdrawals
- FDA published safety alerts

Review and Appeals

- **Physician Review Requirements:**
  - An insurer, health-benefit plan, health-service corporation, or utilization review entity must ensure any adverse determination related to a clean pre-authorization is made by a physician who:
    - Is not compensated based on the outcome of the review
    - Is licensed in any U.S. jurisdiction and either:
      - Has appropriate training, knowledge, or experience in the same or similar specialty that typically manages or consults on the health-care service in review, or
      - Consults with a qualified third-party health-care provider licensed in the relevant specialty or a provider with experience related to the covered person's associated condition, who also is not compensated based on the outcome of the review

- **Appeals by Physicians**:
  - In addition to the Physician Review Requirements provided above, a carrier, health-benefit plan, health-service corporation, or utilization review entity must meet the following requirements when a physician appeals an adverse determination:
    - Must be reviewed by a physician who:
      - Meets the same criteria listed above under "Physician Review Requirements"
      - Possesses an active, unrestricted license in good standing to practice medicine in any U.S. jurisdiction
      - Was not directly involved in the original determination
      - Reviews and considers all clinical aspects of the health care service and relevant documentation submitted

- **Reviews and Appeals by Non-Physician Providers** (e.g., nurse practitioner, physical therapist, behavioral health professional):
  - When a clean pre-authorization request is submitted by a health-care provider other than a physician, any adverse determination or review in appeal from an adverse determination must be conducted by one of the following:
    - A health-care provider licensed in the same or similar profession as the requesting provider; or
    - A licensed health-care provider in consultation with a qualified third-party provider licensed in the same or similar medical specialty as the requesting provider.

  Any compensation paid to the reviewing or consulting provider may not be contingent upon the outcome of the review or the appeal.

- **Appeal Timeline**:

- **15-Day Determination Window**
  - Utilization review entities must notify the covered person and provider of the appeal decision within 15 days of receiving an appeal
- **Extension for Additional Information**
  - If the appeal lacks required documentation or clinical information, the entity must notify the covered person and provider in writing within the **15-day** window, specifying what is required.
- **Additional 15 Day Determination Window After Receipt**:
  - Once the requested information is received, the entity has **15 additional days** to issue a final determination and notify all parties.

- **Appeal Written Determination Notice**
  - Written determination on appeal must include:
    - A summary of findings supporting the appeal decision
    - The qualifications of the reviewer(s), including licenses, certifications, or specialties
    - The clinical rationale, linking the diagnosis or condition to the review criteria and the specific basis for the determination

- **Utilization Review Standards**
  - **Weekend Review Availability**:
    - Utilization reviews must be conducted seven days a week
  - **Clinical Access Hours**:
    A medical director or clinical decision-maker must be available:
    - Monday-Friday: 7:00 AM to 7:00 PM
    - Saturday-Sunday: During reasonable business hours
  - **Flexible Appeal Submission**:
    - Appeals must be accepted in writing, electronically, or by telephone
  - **Appeal Submission Window**:
    - Covered persons and providers must be given **at least 30 days** from the adverse determination date to submit an appeal

Pre-Authorization Timelines & Duration

- Pre-authorization or adverse determination must be issued within the following timeframes after receipt of a clean pre-authorization request:
  - **Pharmaceutical benefit requests**
    - **2** business days of receiving a clean request.
  - **Standard requests**
    - Non-electronic: Response provided within **5** business days.
    - Electronic: Response provided within **3** business days
  - **Urgent health-care services**
    - Non-electronic: Response provided within **48** hours
    - Electronic: Response provided within **24** hours
  - **Patient transfers**:
    - Non-electronic: Response provided within **48** hours
    - Electronic: Response provided within **24** hours

- **Pre-Authorization Duration**:
    - Must remain valid for **at least 90 days** from the provider's receipt of the determination, or longer if clinically appropriate for the service, subject to continued coverage, eligibility, and applicable, properly-noticed policy changes.

Interfacility Transport

- Pre-authorization is not required for medically necessary interfacility transport

Episode of Care & Bundled Services

- Single Pre-Authorization Per Episode:
    - Only one pre-authorization per episode of care is required. Note: new or unrelated treatments, tests, or procedures may require separate authorization
- If part of a bundled payment, all in-network covered services within the group are deemed approved

Electronic Provider Portal Standards

- **Platform Consistency by January 1, 2027**:
    - An insurer, health-benefit plan, health-service corporation, or utilization review entity must accept and respond to electronic pre-authorization requests via the same platform used for submission (e.g., website, mobile app, digital portal, or other method) as the electronic request was submitted
- **Required Portal Features**:
    - By no later than January 1, 2027, each insurer, health-benefit plan, health-service corporation, and utilization review entity must establish a provider portal.
    - The portal must include the following features:
        - Electronic submission of pre-authorization requests
        - Access to the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's applicable medical policies
        - Information necessary to request a peer-to-peer review
        - Contact information for the insurer's, health-benefit plan's, health-service corporation's, or utilization review entity's relevant clinical or administrative staff
        - For any health-care service that requires pre-authorization that is not subject to electronic submission via the provider portal, copies of applicable forms
        - 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
- **Enforcement Timeline for Portal Use**:
    - Within 12 months following the establishment of a provider portal under Title 18 of the Delaware Code, a health-care provider seeking pre-authorization may be required to submit the request via the provider portal unless one of the following exemptions apply:
        - The portal is not available and operational at the time of submission
        - The health-care provider lacks access to the operational portal
        - The health-care provider qualifies for an approved alternate submission method other than through the provider portal

Action Required for Regulated Entities

- All health insurance carriers, health-benefit plans, health-service corporations, and utilization review entities operating in Delaware must:
    - Update internal workflows and systems to comply with new response deadlines
    - Ensure specialist reviewers are assigned for adverse determinations
    - Prepare systems for integration with standardized electronic platforms
    - Review and revise utilization review policies to meet transparency requirements and portal standards

Electronic Provider Portal Compliance

- To support implementation of the Act's electronic pre-authorization standards, the following model and checklist illustrate what a compliant provider portal should include by the January 1, 2027 deadline.

  These features are illustrative, not exhaustive or prescriptive, and are intended to guide implementation in alignment with statutory requirements.

  Sample Portal Design Features
    - **Secure Login Access (45 C.F.R. § 164.312)**:
        - Role-based access controls with multi-factor authentication, consistent with industry standards and general HIPAA compliance expectations for safeguarding protected health information
    - **Pre-Authorization Submission**:
        - Structured forms, document upload, real-time validation
    - **Medical Policy Library**:
        - Searchable, versioned clinical guidelines
    - **Peer-to-Peer Review Request**:
        - Request form, reviewer contact info
    - **Contact Directory:**
        - Clinical and administrative staff details
    - **Downloadable Forms**:
        - For services not supported electronically
    - **Downtime Submission Instructions**:
        - Clear alternate procedures

PROVIDER PORTAL COMPLIANCE CHECKLIST			
Requirement	**SB 12 Mandate**	**Sample Portal Feature**	**Meets Requirement ✓**
Electronic submission capability	Must allow electronic pre-authorization requests	Structured digital intake forms	

Access to medical policies	Must provide access to applicable medical policies	Searchable policy library with version tracking	
Peer-to-peer review tools	Must include info necessary to request peer-to-peer review	Dedicated request form and reviewer contact info	
Contact information for staff	Must provide contact info for clinical/administrative staff	Staff directory with escalation contacts	
Forms for non-electronic services	Must include copies of applicable forms	Downloadable PDFs for offline use	
Downtime instructions	Must include instructions for submission if portal is unavailable	Clear alternate submission procedures	
Enforcement timeline and exemptions	May require portal use 12 months after launch, with specific exemptions	Built-in flexibility for access issues and approved waivers	

Questions, comments, or requests for clarification about this Bulletin should be emailed to compliance@delaware.gov.

This Bulletin shall be effective immediately and shall remain in effect unless withdrawn or superseded by subsequent law, regulation or bulletin.

Trinidad Navarro
Delaware Insurance Commissioner

NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Delaware Department of Insurance if additional information is needed.