

STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

SENATE BILL 1631

By: Coleman

AS INTRODUCED

An Act relating to insurance; amending 36 O.S. 2021, Section 4405.1, which relates to credentialing or recredentialing of health care providers; requiring certain notice following credential application determination; updating statutory language; updating statutory reference; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 36 O.S. 2021, Section 4405.1, is amended to read as follows:

Section 4405.1. A. As used in this section:

1. a. "Health benefit plan" or "plan" means:

- (1) group hospital or medical insurance coverages,
- (2) not-for-profit hospital or medical service or indemnity plans,
- (3) prepaid health plans,
- (4) health maintenance organizations,
- (5) preferred provider plans,
- (6) ~~Multiple Employer Welfare Arrangements~~ multiple employer welfare arrangements (MEWA), or

1 (7) employer self-insured plans that are not exempt
2 pursuant to the federal Employee Retirement
3 Income Security Act of 1974 (ERISA) provisions,
4 and

5 b. the term "~~health benefit plan~~" health benefit plan
6 shall not include:

7 (1) individual plans,

8 (2) plans that only provide coverage for a specified
9 disease, accidental death, or dismemberment for
10 wages or payments in lieu of wages for a period
11 during which an employee is absent from work
12 because of sickness or injury or as a supplement
13 to liability insurance,

14 (3) Medicare supplemental policies as defined in
15 Section 1882(g)(1) of the federal Social Security
16 Act (42 U.S.C., Section 1395ss),

17 (4) workers' compensation insurance coverage,

18 (5) medical payment insurance issued as a part of a
19 motor vehicle insurance policy, or

20 (6) long-term care policies, including nursing home
21 fixed indemnity policies, unless the Insurance
22 Commissioner determines that the policy provides
23 comprehensive benefit coverage sufficient to meet
24 the definition of a health benefit plan; and
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1 2. "Credentialing" or "recredentialing", as applied to
2 physicians and other health care providers, means the process of
3 accessing and validating the qualifications of such persons to
4 provide health care services to the beneficiaries of a health
5 benefit plan. Credentialing or recredentialing may include, but is
6 not limited to, an evaluation of licensure status, education,
7 training, experience, competence and professional judgment.

8 Credentialing or recredentialing is a prerequisite to the final
9 decision of a health benefit plan to permit initial or continued
10 participation by a physician or other health care provider.

11 B. 1. Any health benefit plan that is offered, issued or
12 renewed in this state shall provide for credentialing and
13 recredentialing of physicians and other health care providers based
14 on criteria provided in the uniform credentialing application
15 required by Section 1-106.2 of Title 63 of the Oklahoma Statutes.

16 2. Health benefit plans shall make information on such criteria
17 available to physician and other health care provider applicants,
18 participating physicians, and other participating health care
19 providers and shall provide applicants with a checklist of materials
20 required in the application process.

21 3. Physicians or other health care providers under
22 consideration to provide health care services under a health benefit
23 plan in this state shall apply for credentialing or recredentialing
24 on the uniform credentialing application and shall provide the

1 documentation as outlined in the plan's checklist of materials
2 required in the application process.

3 C. A health benefit plan shall determine whether a
4 credentialing or recredentialing application is complete. If an
5 application is determined to be incomplete, the plan shall notify
6 the applicant in writing within ten (10) calendar days of receipt of
7 the application. The written notice shall specify the portion of
8 the application that is causing a delay in processing and explain
9 any additional information or corrections needed.

10 D. 1. In reviewing the application, the health benefit plan
11 shall evaluate each application according to the plan's checklist of
12 required materials that accompanies the application.

13 2. When an application is deemed complete, the plan shall
14 initiate requests for primary source verification and malpractice
15 history within seven (7) calendar days.

16 3. A malpractice carrier shall have twenty-one (21) calendar
17 days within which to respond after receipt of an inquiry from a
18 health benefit plan. Any malpractice carrier that fails to respond
19 to an inquiry within the time frame may be assessed an
20 administrative penalty by the Insurance Commissioner.

21 E. 1. Upon receipt of primary source verification and
22 malpractice history by the plan, the plan shall determine if the
23 application is a clean application. If the application is deemed
24 clean, a plan shall have forty-five (45) calendar days within which
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1 to credential or recredential a physician or other health care
2 provider. As used in this paragraph, "clean application" means an
3 application that has no defect, misstatement of facts,
4 improprieties, including a lack of any required substantiating
5 documentation, or particular circumstance requiring special
6 treatment that impedes prompt credentialing or recredentialing.

7 2. If a plan is unable to credential or recredential a
8 physician or other health care provider due to an ~~application's~~
9 application not being clean, the plan may extend the credentialing
10 or recredentialing process for sixty (60) calendar days. At the end
11 of sixty (60) calendar days, if the plan is awaiting documentation
12 to complete the application, the physician or other health care
13 provider shall be notified of the reason for the delay by certified
14 mail. The physician or other health care provider may extend the
15 sixty-day period upon written notice to the plan within ten (10)
16 calendar days; otherwise the application shall be deemed withdrawn.
17 In no event shall the entire credentialing or recredentialing
18 process exceed one hundred eighty (180) calendar days.

19 3. If an application for credentialing or recredentialing is
20 denied, the plan shall notify the applicant in writing the reason
21 for the denial and what corrective actions the applicant may
22 consider within ten (10) calendar days of the determination to deny
23 the application.
24

1 4. A health benefit plan shall be prohibited from solely basing
2 a denial of an application for credentialing or recredentialing on
3 the lack of board certification or board eligibility and from adding
4 new requirements solely for the purpose of delaying an application.

5 ~~4.~~ 5. Any health benefit plan that violates the provisions of
6 this section may be assessed an administrative penalty by the
7 Commissioner.

8 F. Within thirty-one (31) days after a provider has been
9 credentialed by a health benefit plan following the completion of
10 the credentialing or recredentialing process pursuant to this
11 section, the health benefit plan shall consider the provider in-
12 network for purposes of reimbursement.

13 SECTION 2. This act shall become effective November 1, 2024.

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