STATE OF OKLAHOMA

1st Session of the 55th Legislature (2015)

CONFERENCE COMMITTEE
SUBSTITUTE
FOR ENGROSSED
HOUSE BILL NO. 2217 By: Mulready of the House

and

Stanislawski of the Senate

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 2011, Section 4405.1, which relates to credentialing or recredentialing of physicians and other health care providers; requiring a health benefit plan to consider the provider in-network for purposes of reimbursement within certain time period; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2011, 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 (MEWA), or

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

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

(1) individual plans,

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

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

(4) workers' compensation insurance coverage,

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

(6) long-term care policies, including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides

comprehensive benefit coverage sufficient to meet the definition of a health benefit plan; and

2. "Credentialing" or "recredentialing", as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health benefit plan. Credentialing or recredentialing may include, but is not limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment.

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

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

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

3. Physicians or other health care providers under consideration to provide health care services under a health benefit

plan in this state shall apply for credentialing or recredentialing on the uniform credentialing application and shall provide the documentation as outlined in the plan's checklist of materials required in the application process.

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

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

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

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

E. 1. Upon receipt of primary source verification and malpractice history by the plan, the plan shall determine if the

application is a clean application. If the application is deemed clean, a plan shall have forty-five (45) calendar days within which to credential or recredential a physician or other health care provider. As used in this paragraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

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

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

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

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

SECTION 2. This act shall become effective November 1, 2015.

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