

1 **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2 STATE OF OKLAHOMA

3 2nd Session of the 59th Legislature (2024)

4 ENGROSSED SENATE
5 BILL NO. 1631

By: Coleman of the Senate

and

Tedford of the House

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

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

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

18 Section 4405.1. A. As used in this section:

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

20 (1) group hospital or medical insurance coverages,

21 (2) not-for-profit hospital or medical service or

22 indemnity plans,

23 (3) prepaid health plans,

24 (4) health maintenance organizations,

 (5) preferred provider plans,

1 (6) ~~Multiple Employer Welfare Arrangements~~ multiple
2 employer welfare arrangements (MEWA), or

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

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

9 (1) individual plans,

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

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

19 (4) workers' compensation insurance coverage,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 3. If an application for credentialing or recredentialing is
22 denied, the plan shall notify the applicant in writing the reason
23 for the denial and what corrective actions the applicant may
24

1 consider within ten (10) calendar days of the determination to deny
2 the application.

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

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

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

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

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17 COMMITTEE REPORT BY: COMMITTEE ON RULES, dated 04/09/2024 - DO PASS.
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