STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

SENATE BILL 2011 By: Garvin

AS INTRODUCED

An Act relating to health benefit plans; amending 36 O.S. 2021, Section 4405.1, which relates to credentialing; prohibiting health benefit plan from requiring certain evidence; 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 (MEWA), or

1 (7) employer self-insured plans that are not exempt
2 pursuant to the federal Employee Retirement
3 Income Security Act (ERISA) provisions, and
4 b. the term "health benefit plan" shall not include:
5 (1) individual plans,
6 (2) plans that only provide coverage for a specified
7 disease, accidental death, or dismemberment for
8 wages or payments in lieu of wages for a period
9 during which an employee is absent from work
10 because of sickness or injury or as a supplement
11 to liability insurance,
12 (3) Medicare supplemental policies as defined in
13 Section 1882(g)(1) of the federal Social Security
14 Act (42 U.S.C., Section 1395ss),
15 (4) workers' compensation insurance coverage,
16 (5) medical payment insurance issued as a part of a
17 motor vehicle insurance policy, or
18 (6) long-term care policies, including nursing home
19 fixed indemnity policies, unless the Insurance
20 Commissioner determines that the policy provides
21 comprehensive benefit coverage sufficient to meet
22 the definition of a health benefit plan; and
23 2. "Credentialing" or "recredentialing", as applied to
24 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. <u>A health benefit plan shall be prohibited from requiring evidence of malpractice liability insurance of a physician or other healthcare provider as a condition to credentialing or recredentialing.</u>

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, 2024.

59-2-3332 TEK 1/18/2024 3:36:25 PM