STATE OF OKLAHOMA

2nd Session of the 44th Legislature (1994)

HOUSE BILL NO. 2576 By: Maddox (Jim)

AS INTRODUCED

An act relating to workers' compensation and the State Insurance Fund; amending 85 O.S. 1991, Sections 3, as last amended by Section 51, Chapter 366, O.S.L. 1993, 14, as last amended by Section 7, Chapter 349, O.S.L. 1993, 17, 43 and 61, as last amended by Section 12, Chapter 349, O.S.L. 1993 (85 O.S. Supp. 1993, Sections 3, 14 and 61), which relate to the Workers' Compensation Act; amending Section 18, Chapter 349, O.S.L. 1993 (85 O.S. Supp. 1993, Section 201.1), which relates to the Physician Advisory Committee; amending 85 O.S. 1991, Sections 132, 134 and 139, as amended by Section 2, Chapter 60, O.S.L. 1992 (85 O.S. Supp. 1993, Section 139), which relate to the State Insurance Fund; amending 36 O.S. 1991, Section 624, which relates to insurance companies; defining term; modifying the authority of an employee to select a physician; providing for certified managed care programs; stating duties of the Insurance Commissioner of the State of Oklahoma; providing procedures relating to certification and supervision of managed care programs; requiring certain rules; modifying grounds for and procedures relating to the selection of a third physician;

modifying effect of determinations by third physicians; requiring certain notices; updating statutory references; expanding duties of the Physician Advisory Committee; transferring certain duties of the Board of Managers of the State Insurance Fund to the State Board for Property and Casualty Rates; prohibiting the approval of certain rates; deleting obsolete language; updating statutory references; modifying the power and authority of the State Insurance Fund Commissioner or delegated officer in conducting the business and affairs of the State Insurance Fund; requiring the Insurance Commissioner to examine the State Insurance Fund; subjecting the State Insurance Fund to certain provisions governing insurance companies; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY 85 O.S. 1991, Section 3, as last amended by Section 51, Chapter 366, O.S.L. 1993 (85 O.S. Supp. 1993, Section 3), is amended to read as follows:

Section 3. As used in the Workers' Compensation Act:

1. "Administrator" means the Administrator of workers' compensation as provided for in the Workers' Compensation Act.

2. "Court" means the Workers' Compensation Court.

3. "Employer", except when otherwise expressly stated, means a person, partnership, association, limited liability company,

corporation, and the legal representatives of a deceased employer, or the receiver or trustee of a person, partnership, association, corporation, or limited liability company, departments, instrumentalities and institutions of this state and divisions thereof, counties and divisions thereof, public trusts, boards of education and incorporated cities or towns and divisions thereof, employing a person included within the term "employee" as herein defined.

4. "Employee" means any person engaged in the employment of any person, firm, limited liability company or corporation covered by the terms of the Workers' Compensation Act, and shall include workers associating themselves together under an agreement for the performance of a particular piece of work, in which event such persons so associating themselves together shall be deemed employees of the person having the work executed; provided, that if such associated workers shall employ a worker in the execution of such contract, then as to such employed worker, both the associated employees and the principal employer shall at once become subject to the provisions of the Workers' Compensation Act relating to independent contractors. Sole proprietors, members of a partnership, members of a limited liability company who own at least ten percent (10%) of the capital of the limited liability company or any stockholder-employees of a corporation who own ten percent (10%) or more stock in the corporation are specifically excluded from the foregoing definition of "employee", and shall not be deemed to be employees as respects the benefits of the Workers' Compensation Act. Provided, a sole proprietor, member of a partnership, member of a limited liability company who owns at least ten percent (10%) of the capital of the limited liability company or any stockholder-employee of a corporation who owns ten percent (10%) or more stock in the corporation who does not so elect to be covered by a policy of insurance covering benefits under the Workers' Compensation Act,

when acting as a subcontractor, shall not be eligible to be covered under the prime contractor's policy of workers' compensation insurance; however, nothing herein shall relieve the entities enumerated from providing workers' compensation insurance coverage for their employees. Sole proprietors, members of a partnership, members of a limited liability company who own at least ten percent (10%) of the capital of the limited liability company or any stockholder-employees of a corporation who own ten percent (10%) or more stock in the corporation may elect to include the sole proprietors, any or all of the partnership members, any or all of the limited liability company members or any or all stockholder-employees as employees, if otherwise qualified, by endorsement to the policy specifically including them under any policy of insurance covering benefits under the Workers' Compensation Act. When so included the sole proprietors, members of a partnership, members of a limited liability company or any or all stockholder-employees shall be deemed to be employees as respects the benefits of the Workers' Compensation Act. "Employee" shall also include any person who is employed by the departments, instrumentalities and institutions of this state and divisions thereof, counties and divisions thereof, public trusts, boards of education and incorporated cities or towns and divisions thereof. "Employee" shall also include a member of the Oklahoma National Guard while in the performance of duties only while in response to state orders and any authorized voluntary or uncompensated worker, rendering services as a fire fighter, peace officer or civil defense worker. "Employee" shall also include a participant in a sheltered workshop program which is certified by the United States Department of Labor. "Employee" shall not include a person, commonly referred to as an owner-operator, who owns or leases a truck-tractor or truck for hire, if the owner-operator actually operates the truck-tractor or truck and if the person contracting with the owner-operator is

not the lessor of the truck-tractor or truck. Provided however, an owner-operator shall not be precluded from workers' compensation coverage under the Workers' Compensation Act if the owner-operator elects to participate as a sole proprietor.

5. "Employment" includes work or labor in a trade, business, occupation or activity carried on by an employer for pecuniary gain or any authorized voluntary or uncompensated worker rendering services as a fire fighter, peace officer or civil defense worker.

6. "Compensation" means the money allowance payable to an employee as provided for in the Workers' Compensation Act.

7. a. "Injury" or "personal injury" means only accidental injuries arising out of and in the course of employment and such disease or infection as may naturally result therefrom and occupational disease arising out of and in the course of employment as herein defined. Provided, only injuries having as their source a risk not purely personal but one that is reasonably connected with the conditions of employment shall be deemed to arise out of the employment.

b. "Injury" or "personal injury" includes heart-related or perivascular injury, illness or death if resultant from stress in excess of that experienced by a person in the conduct of everyday living. Such stress must arise out of and in the course of a claimant's employment.

c. "Injury" or "personal injury" shall not include mental injury that is unaccompanied by physical injury.

8. "Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the injury, including the reasonable value of board, rent, housing, lodging, or similar advantage received from the employer.

9. "Insurance carrier" shall include stock corporations, reciprocal or interinsurance associations, or mutual associations with which employers have insured, and employers permitted to pay compensation, directly under the provisions of paragraph 4 of subsection A of Section 61 of this title.

10. "Occupational disease" means only that disease or illness which is due to causes and conditions characteristic of or peculiar to the particular trade, occupation, process or employment in which the employee is exposed to such disease.

11. "Permanent impairment" means any anatomical or functional abnormality or loss after reasonable medical treatment has been achieved, which abnormality or loss the physician considers to be capable of being evaluated at the time the rating is made. Except as otherwise provided herein, any examining physician shall only evaluate impairment in accordance with the latest publication of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" in effect at the time of the injury. However, revisions to the guides made by the American Medical Association which are published after January 1, 1989, shall be operative one hundred twenty (120) days after the last day of the month of publication. The examining physician shall not follow the guides based on race or ethnic origin and shall not deviate from said guides except as may be specifically provided for in the guides. These officially adopted guides shall be the exclusive basis for testimony and conclusions with regard to permanent impairment with the exception of paragraph 3 of Section 22 of this title, relating to scheduled member injury or loss; and impairment, including pain or loss of strength, may be awarded with respect to those injuries or areas of the body not specifically covered by said guides.

12. "Permanent total disability" means incapacity because of accidental injury or occupational disease to earn any wages in any employment for which the employee is or becomes physically suited

and reasonably fitted by education, training or experience; loss of both hands, or both feet, or both legs, or both eyes, or any two thereof, shall constitute permanent total disability.

13. "Permanent partial disability" means permanent disability which is less than total and shall be equal to or the same as permanent impairment.

14. "Arising out of" pertains to occupational causation. An accidental injury or disease arises out of employment if work caused more than fifty percent (50%) of the claimant's injury or disease.

SECTION 2. AMENDATORY 85 O.S. 1991, Section 14, as last amended by Section 7, Chapter 349, O.S.L. 1993 (85 O.S. Supp. 1993, Section 14), is amended to read as follows:

Section 14. A. The employer shall promptly provide for an injured employee such medical, surgical or other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus as may be necessary after the injury. The attending physician shall supply the injured employee and the employer with a full examining report of injuries found at the time of examination and proposed treatment, this report to be supplied within seven (7) days after the examination; also, at the conclusion of the treatment the attending physician shall supply a full report of his treatment to the employer of the injured employee.

B. The employer's selected physician shall have the right to examine the injured employee. A report of such examination shall be furnished the injured employee within seven (7) days after such examination.

C. If the employer fails or neglects to provide the same within a reasonable time after knowledge of the injury, the injured employee, during the period of such neglect or failure, may do so at the expense of the employer; provided, however, that the injured employee, or another in his behalf, may obtain emergency treatment at the expense of the employer where such emergency treatment is not

provided by the employer. ~~Notwithstanding any other provision of this section, the employee may select a physician of his choice to render necessary medical treatment, at the expense of the employer. The attending physician so selected by the employee shall notify the employer and/or the insurance carrier within seven (7) days after examination or treatment was first rendered.~~

D. The term "physician" as used in this section shall mean any person licensed in Oklahoma as a medical doctor, chiropractor, chiropodist, dentist, osteopathic physician or optometrist. The Court may accept testimony from a psychologist if the testimony is made under the direction of a medical doctor. If such injured employee should become deceased, whether or not he has filed a claim, such fact shall not affect liability for medical attention previously rendered, and any person or persons entitled to such benefits may enforce charges therefor as though such employee had survived.

E. Whoever renders medical, surgical or other attendance or treatment, nurse and hospital service, medicine, crutches and apparatus, or emergency treatment, may submit such charges and duration of treatment to the Administrator of the Court for review in accordance with the rules of the Administrator. Such charges and duration of treatment shall be limited to the usual, customary and reasonable charges and duration of treatment as prescribed and limited by a schedule of fees and treatment for all medical providers to be adopted, after notice and public hearing, by the Administrator. Said fee and treatment schedule shall be based on the usual, customary and reasonable medical charges of health care providers in the same trade area for comparable treatment of a person with similar injuries and the duration of treatment prevailing in this state for persons with similar injuries. The fee and treatment schedule shall be reviewed biennially by the Administrator and, after such review, and notice and public hearing,

the Administrator shall be empowered to amend or alter said fee and treatment schedule to ensure its adequacy; provided, however, the fee and treatment schedule shall not be amended or altered until 1995 except to require the utilization of the latest Current Procedural Terminology (CPT) codes as published by the American Medical Association or to provide for the reduction of charges or duration of treatment. The Administrator's review of medical and treatment charges pursuant to this section shall be conducted pursuant to the fee and treatment schedule in existence at the time the medical care or treatment was provided. The order of the Administrator approving medical and treatment charges pursuant to this section shall be enforceable by the Court in the same manner as provided in the Workers' Compensation Act for the enforcement of other compensation payments. Any party feeling aggrieved by the order, decision or award of the Administrator shall, within ten (10) days, have the right to request a hearing on such medical and treatment charges by a judge of the Workers' Compensation Court. The judge of the Court may affirm the decision of the Administrator, or reverse or modify said decision only if it is found to be contrary to the fee and treatment schedule existing at the time the said medical care or treatment was provided. The order of the judge shall be subject to the same appellate procedure set forth in Section 3.6 of this title for all other orders of the Court. The right to recover charges for every type of medical care for personal injuries arising out of and in the course of covered employment as herein defined, shall lie solely with the Workers' Compensation Court, and all jurisdiction of the other trial courts of this state over such action is hereby abolished. The foregoing provision, relating to approval and enforcement of such charges and duration of treatment, shall not apply where a written contract exists between the employer or insurance carrier and the person who renders such

medical, surgical or other attendance or treatment, nurse and hospital service, or furnishes medicine, crutches or apparatus.

F. The Court or Administrator shall have authority on application of employee or employer or its insurance carrier to order a change of physicians at the expense of the employer when, in its judgment, such change is desirable or necessary; provided, the employer shall not be liable to make any of the payments provided for in this section, in case of contest of liability, where the Court shall decide that the injury does not come within the provisions of the Workers' Compensation Act.

G. If the employee chooses a physician for treatment and subsequently changes physicians without the approval of the Court or Administrator, or without agreement of the parties, the maximum liability of the employer for the aggregate expenses of all such subsequent physicians shall be Five Hundred Dollars ($500.00). Provided, the limitations shall not apply to referrals by the treating physician for treatment or diagnostic procedures.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 14.2 of Title 85, unless there is created a duplication in numbering, reads as follows:

A. Any self-insured employer or the employer's workers' compensation insurance carrier may direct an employee's medical care as required under the Workers' Compensation Act by selecting a certified managed care program pursuant to this section. Notwithstanding any other provision of law, those employees who are subject to such certified managed care program shall receive medical care in the manner prescribed by the program. The selection of a certified managed care program shall not preclude an employee from seeking emergency medical treatment as provided in Section 14 of Title 85 of the Oklahoma Statutes. An employee must exhaust the dispute resolution procedure of a certified managed care program prior to filing a petition or otherwise seeking relief on any issue

related to managed care or choice of physician. If the employee has exhausted the dispute resolution procedure and seeks a change of physician, the employee shall file a request as provided for in subsection D of this section. Notice of an employer's authority under this subsection to direct an employee's medical care shall be provided to employees pursuant to Section 43 of Title 85 of the Oklahoma Statutes and to the Workers' Compensation Court pursuant to Section 61 of Title 85 of the Oklahoma Statutes.

B. The Insurance Commissioner of the State of Oklahoma shall certify an entity as a certified managed care program for purposes of the Workers' Compensation Act and shall promulgate such rules as may be necessary to implement the provisions of subsection A of this section. Such rules shall authorize any person to petition the Commissioner for decertification of a managed care program from the list of certified programs for material violation of any rules promulgated pursuant to this subsection.

C. 1. Employees who are not subject to a certified managed care program, shall receive medical care in the manner prescribed by this subsection.

2. The employer shall initially either select the physician for the injured employee or permit the injured employee to make the selection. Subject to the provisions of this subsection, that selection shall be in effect during the first sixty (60) calendar days from the date the employee receives treatment from the initially selected physician.

3. After the expiration of the initial sixty-day period set forth in paragraph 2 of this subsection, the party who did not make the initial selection may select a physician of his choice to be the only authorized treating physician and from whom the employee will continue to receive treatment. Unless the employee and employer otherwise agree, the party seeking such a change shall file a notice of the name and address of the new physician with the other party at

least ten (10) calendar days before treatment from that physician begins. The Workers' Compensation Court shall promulgate rules governing forms, which employers shall post in conspicuous places, to enable this notice to be promptly and efficiently provided. This notice may be filed on or after the fiftieth day of the sixty-day period set forth in this subsection.

D. 1. If a party objects to the choice of physician made pursuant to subsection A of this section, and exhausts the dispute resolution procedure of such certified managed care program or objects to the choice of physician made pursuant to paragraph 3 of subsection C of this section, such party shall file an objection to that choice with the Workers' Compensation Court within ten (10) calendar days from receiving the notice. The objecting party also shall provide notice of that objection to the other party. If the employer does not file his objection within the ten (10) calendar days from receipt of notice, then the employer shall be liable for the cost of treatment provided by the employee's physician until the employer does file his objection and the court has rendered its decision as set forth in paragraph 3 of this subsection. If the employee does not file his objection within ten (10) calendar days from receipt of notice, then the employer shall only be liable for the cost of treatment from the physician selected by the employer, subject to the provisions of this subsection. Nothing in this subsection shall remove the employer's obligation to provide reasonable and necessary health care services to the employee so long as the employee complies with the provisions of this section.

2. If the employee or employer disagrees with the choice of the physician of the other party at any time, and they cannot otherwise agree, then the dissenting party shall file a request for a change of physicians with the Workers' Compensation Court. The Court shall adopt rules governing forms, which employers shall post in

conspicuous places, explaining how to file a request for change of a physician with the Workers' Compensation Court.

3. The request shall state the reasons for the request and may state the applicant's choice for a different physician. The applicant shall bear the burden of proving to the Court that the care being received is not reasonable. The Court shall render a decision within seven (7) days from the date the request is filed. If the Court grants the request, the decision shall designate either the applicant's choice of physician or a different physician.

4. If the employee continues to receive treatment or services from a physician rejected by the employer and not in compliance with the Court's ruling, then the employer is not required to pay for any of the additional treatment or services provided to that employee by that physician.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 14.3 of Title 85, unless there is created a duplication in numbering, reads as follows:

A. Any person or entity may make written application to the Insurance Commissioner of the State of Oklahoma to have a program certified that provides management of quality treatment to injured employees for injuries and diseases compensable under the Workers' Compensation Act. Each application for certification shall be accompanied by a fee of One Thousand Five Hundred Dollars ($1,500.00). A program may be certified to provide services to a limited geographic area. A certificate is valid for the period the Commissioner prescribes unless revoked or suspended. Application for certification shall be made in the form and manner and shall set forth information regarding the proposed program for providing services as the Commissioner may prescribe. The information shall include, but not be limited to:

1. A list of the names of all medical providers who will provide services under the managed care program, together with

appropriate evidence of compliance with any licensing or certification requirements for those providers to practice in this state; and

2. A description of the places and manner of providing services under the program.

B. 1. The Commissioner shall certify a managed care program if the Commissioner finds that the program:

a. proposes to provide quality services for all medical services that may be required by the Workers' Compensation Act in a manner that is timely, effective and convenient for the employee,

b. is reasonably geographically convenient to employees it services,

c. provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service,

d. provides adequate methods of peer review, utilization review and dispute resolution to prevent inappropriate, excessive or medically unnecessary treatment, and excludes participation in the program by those individuals who violate these treatment standards,

e. provides aggressive case management for injured employees and a program for early return to work,

f. provides a timely and accurate method of reporting to the Commissioner necessary information regarding medical service costs and utilization to enable the Commissioner to determine the effectiveness of the program,

g. authorizes necessary emergency medical treatment for an injury provided by a medical provider not a part of the managed care program,

h. assures reasonable access to medical providers available under the managed care program and includes an adequate number of such providers to give employees convenient geographic accessibility to treatment and adequate flexibility to choose from among those who provide services under the program, and

i. complies with any other requirement the Commissioner determines is necessary to provide quality medical services and health care to injured employees.

2. The Commissioner may accept findings, licenses or certifications of other state agencies as satisfactory evidence of compliance with a particular requirement of this section.

C. The Commissioner shall refuse to certify or shall revoke or suspend the certification for a managed care program if the Commissioner finds that the program for providing medical or health care services fails to meet the requirements of this section, or service under the program is not being provided in accordance with the terms of a certified program.

D. No person who participates in forming consortiums collectively negotiating fees or otherwise solicits or enters into contracts in a good faith effort to provide medical or health care services according to the provisions of this section shall be examined or subject to administrative or civil liability regarding any such participation except pursuant to the Commissioner's active supervision of such activities and the managed care program. Before engaging in such activities, the person shall provide notice of intent to the Commissioner in a form prescribed by the Commissioner.

E. The Commissioner shall promulgate such rules as may be necessary to implement the provisions of this section.

SECTION 5. AMENDATORY 85 O.S. 1991, Section 17, is amended to read as follows:

Section 17. A. The determination of disability shall be the responsibility of the Court. Any claim submitted by an employee for compensation for permanent disability must be supported by competent medical testimony which shall include an evaluation by a physician stating his opinion of the employee's percentage of permanent impairment and whether or not the impairment is job-related and caused by the accidental injury or occupational disease. For purposes of this section, a physician shall have the same meaning as defined in Section 14 of this title and shall include a person licensed by another state who would be qualified to be a licensed physician under the laws of Oklahoma. The written medical testimony of any physician shall be on a form provided by the Administrator.

When the medical testimony to be introduced on behalf of the employee and employer is divergent by more than ~~twenty-five percent (25%)~~ twenty percent (20%) as to the extent of permanent impairment of the employee or when there is any disagreement in the evidence as to the nature, extent or medical cause of the medical permanent impairment, or if the employee has no lost time from employment, any party may challenge such testimony by giving written notice to all other parties and to the Administrator. The written notice shall be given prior to or during any prehearing conference. Upon receipt of such notice, the ~~challenging party and the party challenged~~ Court shall select a third physician ~~who~~ from a list developed by the Physician Advisory Committee pursuant to Section 201.1 of this title. The third physician shall be afforded a reasonable opportunity to examine the employee together with all medical records involved and any other medical data or evidence that he may consider to be relevant. The third physician shall be the arbiter of the dispute and shall issue a verified written report on a form provided by the Administrator to the Court stating his finding of the percentage of permanent impairment of the employee and whether

or not the impairment is job-related and caused by the accidental injury or occupational disease.

B. ~~When the challenging party and the challenged party are for any reason unable or unwilling to agree upon the appointment of a third physician within ten (10) days, the Court shall appoint the third physician.~~ Upon receipt of the third physician's report, ~~the~~ a party shall have the right to object to the introduction into evidence of the report. The objection must be made by giving written notification to all parties and to the Court within five (5) days after receipt of the report. The physicians must then testify in person or by deposition. All findings of the third physician shall be final unless the Court determines that such findings are arbitrary and capricious.

C. Any physician who is appointed or selected pursuant to the provisions of this section shall be reimbursed for the medical examination, reports and fees in a reasonable and customary amount set by the Court, and these costs shall be borne by the employer.

~~C.~~ D. The parties may stipulate to the appointment of a third physician, even in the absence of divergent medical testimony.

~~D. The impairment rating determined by the third physician may be followed by the Court. If the Court deviates from the third physician's impairment rating by more than ten percent (10%), the Court shall specifically identify the basis for such deviation in its order.~~

SECTION 6. AMENDATORY 85 O.S. 1991, Section 43, is amended to read as follows:

Section 43. A. The right to claim compensation under the Workers' Compensation Act shall be forever barred unless, within two (2) years after the date of accidental injury or death, a claim for compensation is filed with the Workers' Compensation Court. Provided however, a claim may be filed within two (2) years of the last payment of any compensation or remuneration paid in lieu of

compensation or medical treatment which was authorized by the employer or the insurance carrier. Provided further however, with respect to disease or injury caused by repeated trauma causally connected with employment, a claim may be filed within two (2) years of the date of last trauma or hazardous exposure. Provided further however, in the case of asbestosis, silicosis or exposure to nuclear radiation causally connected with employment, a claim may be filed within two (2) years of the date of last hazardous exposure or within two (2) years from the date said condition first becomes manifest by a symptom or condition from which one learned in medicine could, with reasonable accuracy, diagnose such specific condition, whichever last occurs. The filing of any form or report by the employer or insurance carrier shall not toll the above limitations.

B. When a claim for compensation has been filed with the Administrator as herein provided, unless the claimant shall in good faith request a hearing and final determination thereon within five (5) years from the date of filing thereof or within five (5) years from the date of last payment of compensation or wages in lieu thereof, same shall be barred as the basis of any claim for compensation under the Workers' Compensation Act and shall be dismissed by the Court for want of prosecution, which action shall operate as a final adjudication of the right to claim compensation thereunder. Provided, that any claims heretofore filed and pending on the effective date of the Workers' Compensation Act before the State Industrial Court shall likewise be barred after the expiration of five (5) years from the filing date or within five (5) years from the date of last payment of compensation or wages in lieu thereof.

C. The jurisdiction of the Court to reopen any cause upon an application based upon a change in condition shall extend for that period of time measured by the maximum number of weeks that could be awarded for the particular scheduled member where the change of

condition occurred, or for three hundred (300) weeks in the case of injuries to the body or injuries not otherwise scheduled under the provisions of Section 22 of this title, and unless filed within said period of time after the date of the last order, shall be forever barred.

D. Each employer shall post a notice advising employees that they are covered by the Workers' Compensation Act ~~and~~, that ombudsman services are available at the Workers' Compensation Court and that the employer may be authorized under the Workers' Compensation Act to direct employees' medical care by selecting a managed care program. The form of the notice shall be prescribed by the rules of the Court. No other notice to the employee shall be required other than said poster required by this section; provided that nothing in this subsection shall be construed to toll the Statute of Limitations provided above.

SECTION 7. AMENDATORY 85 O.S. 1991, Section 61, as last amended by Section 12, Chapter 349, O.S.L. 1993 (85 O.S. Supp. 1993, Section 61), is amended to read as follows:

Section 61. A. An employer shall secure compensation to his employees in one of the following ways:

1. By insuring and keeping insured the payment of such compensation with any stock corporation, mutual association, or other concerns authorized to transact the business of workers' compensation insurance in this state, or by exchanging contracts of indemnity or interinsurance, pursuant to reasonable rules prescribed by the Administrator providing for and securing the payment of the compensation provided for in the Workers' Compensation Act. When an insurer issues a policy to provide workers' compensation benefits pursuant to the provisions of the Workers' Compensation Act, the insurer shall file, or cause to be filed, with the Administrator a notice in such form and detail as the Administrator may prescribe by rule. The notice shall identify whether the employer is authorized

to direct employees' medical care by selecting a managed care program and shall contain the name, address, and principal occupation of the employer, the number, effective date, and expiration date of the policy, and such other information as may be required by the Administrator. The notice shall be filed by the insurer within thirty (30) days after the effective date of the policy. Any insurer who fails to file the notice required by this subsection shall be liable for an administrative violation and subject to a fine by the Administrator of not more than One Thousand Dollars ($1,000.00);

2. By obtaining and keeping in force guaranty insurance with any company authorized to do guaranty business in this state. Each company that issues such guaranty insurance shall file a copy of the contract with the Administrator within thirty (30) days after the effective date of the contract. Any company that fails to file a copy of the contract as required by this subsection shall be liable for an administrative violation and subject to a fine by the Administrator of not more than One Thousand Dollars ($1,000.00);

3. Subject to the approval of the Administrator, by entering into or continuing an agreement with his employees to provide a scheme of compensation, benefits, or insurance in lieu of the compensation and insurance provided for in the Workers' Compensation Act. The scheme shall not provide less than the benefits secured by the Workers' Compensation Act nor vary the compensation period for disabilities or the provisions of the Workers' Compensation Act with respect to periodic payments or the percentage that those payments shall bear to weekly wages, except that the sums required may be increased. The Administrator shall approve a scheme that provides for contributions by workers, only when it confers benefits commensurate with such contributions and in addition to those required by the Workers' Compensation Act; or

4. By furnishing satisfactory proof to the Administrator of the employer's financial ability to pay such compensation. The Administrator, pursuant to rules adopted by the Court or the Administrator for an individual self-insured or a group self-insurance association, shall require an employer that has:

a. less than one hundred ~~(100)~~ employees or less than One Million Dollars ($1,000,000.00) in net assets to:

(1) deposit with the Administrator securities, an irrevocable letter of credit or a surety bond payable to the state, in an amount determined by the Administrator which shall be at least an average of the yearly claims for the last three (3) years; or

(2) provide proof of excess coverage with such terms and conditions as is commensurate with their ability to pay the benefits required by the provisions of the Workers' Compensation Act.

b. one hundred ~~(100)~~ or more employees and One Million Dollars ($1,000,000.00) or more in net assets to:

(1) secure a surety bond payable to the state, or an irrevocable letter of credit, in an amount determined by the Administrator which shall be at least an average of the yearly claims for the last three (3) years; or

(2) secure excess insurance.

The Administrator may waive the requirements of this paragraph in an amount which is commensurate with the ability of the individual self-insured or group self-insurance association to pay the benefits required by the provisions of the Workers' Compensation Act. Irrevocable letters of credit required by this paragraph shall contain such terms as may be prescribed by the Administrator and shall be issued for the benefit of the Workers' Compensation Court

by a financial institution whose deposits are insured by the Federal Deposit Insurance Corporation. An employer authorized to self-insure as provided in this paragraph shall file with the Administrator a notice, in such form as may be prescribed by the Administrator, identifying whether the employer is authorized to direct employees' medical care by selecting a managed care program.

B. An employer, upon application to become a member of a group self-insurance association, shall file with the Administrator of the Workers' Compensation Court a notice, in such form as prescribed by the Administrator of the Court, acknowledging that the employer, by entering into a group self-insurance association, accepts joint and several liability. Such notice shall be submitted to the Workers' Compensation Court with the application for membership.

C. An employer who fails to comply with the provisions of this section shall be subject to the penalty provided for in Section 12 of this title.

D. Any employer that knowingly provides false information to the Administrator for purposes of becoming self-insured or a group self-insurance association shall be subject to the perjury laws of this state.

E. The provisions of this title shall not be construed to limit or restrict the ability of political subdivisions of this state or employers subject to the provisions of the Workers' Compensation Act from joining together to form group self-insurance associations pursuant to law or rules promulgated by the Court or the Administrator.

SECTION 8. AMENDATORY Section 18, Chapter 349, O.S.L. 1993 (85 O.S. Supp. 1993, Section 201.1), is amended to read as follows:

Section 201.1 A. There is hereby created a Physician Advisory Committee comprised of seven (7) members to be appointed as follows:

1. The Governor shall appoint three members, one of whom shall be licensed in this state as a doctor of medicine and surgery, one of whom shall be engaged in the practice of family medicine in a rural community of the state, and one of whom shall be an osteopathic physician; and

2. The President Pro Tempore of the Senate shall appoint two members, one of whom shall be licensed in this state as a doctor of medicine and surgery and one of whom shall be licensed in this state as a podiatric physician; and

3. The Speaker of the House of Representatives shall appoint two members, one of whom shall be licensed in this state as an osteopathic physician and one of whom shall be licensed in this state as a chiropractic physician.

B. The Committee shall:

1. Assist and advise the Administrator of the Workers' Compensation Court regarding utilization review as it relates to the medical practice and treatment of work-related injuries. Such utilization review shall include a review of reasonable and necessary treatment; abusive practices; needless treatments, testing, or procedures; or a pattern of billing in excess of or in violation of the Schedule of Medical Fees. The Physician Advisory Committee shall review and make findings and recommendations to the Administrator of the Workers' Compensation Court with respect to charges of inappropriate or unnecessary treatment or procedures, abusive practices, or excessive billing disclosed through utilization review~~.~~;

2. Assist the Administrator of the Workers' Compensation Court in reviewing medical practices of health care providers as provided for in Section 201 of ~~Title 85 of the Oklahoma Statutes~~ this title. The Committee shall review and make findings and recommendations to the Administrator with respect to charges of abusive practices by

health care providers providing medical services through the workers' compensation system~~.~~;

3. After public hearing, review and make recommendations for acceptable deviations from the American Medical Association's "Guides to the Evaluation of Permanent Impairment" using appropriate and scientifically valid data. Those recommendations may be adopted, in part or in whole, by the Administrator to be used as provided for in paragraph 11 of Section 3 and Section 22 of ~~Title 85 of the Oklahoma Statutes~~ this title;

4. After public hearing, review and make recommendations for treatment guidelines. Those recommendations may be adopted, in part or in whole, by the Administrator;

5. Provide general recommendations to the judges of the Workers' Compensation Court on the issues of injury causation and apportionment;

6. Conduct educational seminars for the judges of the Workers' Compensation Court, employers, employees, and other interested parties; ~~and~~

7. Assist the judges of the Workers' Compensation Court in accessing medical information from scientific literature; and

8. Develop a list of physicians certified to serve as third physicians for purposes of Section 17 of this title. In certifying, recertifying or decertifying a third physician, the Committee shall consider the qualifications, training, impartiality and commitment of the third physician to the provision of quality medical care at a reasonable cost. The Committee shall require, at a minimum, specialized workers' compensation training or experience under the Oklahoma workers' compensation system and board certification as a condition to certification or recertification. All third physicians shall be licensed to practice medicine or surgery in Oklahoma.

C. The term of office for initial appointees shall expire March 1, 1994. Thereafter, successors in office shall serve at the pleasure of the appointing authority.

D. During their respective terms of office, the physicians appointed to the Physician Advisory Committee shall be strictly prohibited from serving as a third physician appointed by the Workers' Compensation Court pursuant to Section 17 of ~~Title 85 of the Oklahoma Statutes~~ <u>this title</u>.

E. Members of the Physician Advisory Committee shall receive no compensation for serving on the Committee but shall be reimbursed by the Workers' Compensation Court for their necessary travel expenses incurred in the performance of their duties in accordance with the State Travel Reimbursement Act.

F. Meetings of the Physician Advisory Committee shall be called by the Administrator but held at least quarterly. The presence of five members constitutes a quorum. No action shall be taken by the Physician Advisory Committee without the affirmative vote of at least five members.

G. The Administrator shall provide office supplies and personnel of the Workers' Compensation Court to assist the Committee in the performance of its duties.

SECTION 9. AMENDATORY 85 O.S. 1991, Section 132, is amended to read as follows:

Section 132. The State Insurance Fund Commissioner is hereby vested with full power, authority and jurisdiction over the State Insurance Fund. He shall perform any duties which are necessary or convenient in the exercise of any power, authority, or jurisdiction over the fund in the administration thereof, or in connection with the insurance business to be carried on by him under the provisions of Sections 131 through 151 of this title as fully and completely as a governing body of a private insurance carrier might or could do

including the acquisition, operation and maintenance of an electronic data processing facility.

The ~~Board of Managers of the State Insurance Fund~~ State Board for Property and Casualty Rates shall have full power and authority to fix and determine the rates to be charged by the State Insurance Fund for insurance. The State Board for Property and Casualty Rates shall not approve rates for insurance for the State Insurance Fund which are excessive, inadequate or unfairly discriminatory.

SECTION 10. AMENDATORY 85 O.S. 1991, Section 134, is amended to read as follows:

Section 134. In conducting the business and affairs of the State Insurance Fund, the Commissioner of the ~~said~~ fund, or other officer to whom such power and authority may be delegated by the Commissioner, as provided by ~~subsection 5, of Section 3, thereof~~ paragraph 5 of Section 133 of this title, shall have full power and authority to:

~~(1) To enter~~ 1. Enter into contracts of insurance, insuring employers against liability for compensation, and insuring to employees and other persons entitled thereto compensation as provided by ~~Chapter 72, Oklahoma Statutes, 1931.~~ the Workers' Compensation Act;

~~(2) To decline~~ 2. Decline to insure any risk in which the minimum requirements of the law with regard to construction, equipment and operation are not observed, or which is beyond the safe carrying of the State Insurance Fund, but shall not have power or authority, except as otherwise provided in this act to refuse to insure any compensation risk tendered with the premium therefor~~.~~;

~~(3) To enter~~ 3. Enter into contracts of insurance insuring persons, firms and corporations against loss, expense or liability by reason of bodily injury, death by accident, occupational disability, or occupational disease suffered by employees for which the insured may be liable or have assumed liability~~.~~;

~~(4) To reinsure~~ 4. Reinsure any risk or any part thereof~~.~~;

~~(5) To inspect~~ 5. Inspect and audit, or cause to be inspected and audited the payrolls of employers applying for insurance against liability for compensation~~.~~;

~~(6) To contract~~ 6. Contract with physicians, surgeons and hospitals for medical and surgical treatment and the care and nursing of injured persons entitled to benefits from said fund~~.~~;

~~(7) To meet~~ 7. Meet the reasonable expenses of conducting the business of the State Insurance Fund~~.~~;

~~(8) To produce~~ 8. Produce a reasonable surplus to cover catastrophe hazard; and

9. Create and administer a program whereby employers may appeal classification decisions or other decisions, including but not limited to decisions concerning experience modifiers and audits, which are disputed. The State Insurance Fund shall notify employers of the availability of the program.

SECTION 11. AMENDATORY 85 O.S. 1991, Section 139, as amended by Section 2, Chapter 60, O.S.L. 1992 (85 O.S. Supp. 1993, Section 139), is amended to read as follows:

Section 139. The entire expenses of administering "The State Insurance Fund" shall be paid out of such fund upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of State Finance for approval and payment. On or before the first day of June of each year, or as soon thereafter as possible, there shall be submitted to the Board of Managers of the State Insurance Fund, for approval, an estimated budget of expenses for the succeeding fiscal year. The State Insurance Fund Commissioner may not expend from the funds belonging to the State Insurance Fund for purposes of administering any sum in excess of the amount specified in such budget for any item of expense therein set forth unless such expenditure is authorized by the Board of Managers of the State Insurance Fund. In no event shall the entire

expenses of administration of the State Insurance Fund, as authorized for the entire year, exceed twenty percent (20%) of the earned premiums of said year. The Board of Managers shall cause to be made and completed within ninety (90) days after the end of each calendar year, an audit of the books of account and financial records of the fund for such calendar year, such audit to be made by an independent certified public accountant, a licensed public accountant, a firm of certified public accountants, or an accounting firm or individual holding a permit to practice accounting in this state.

The Fund shall submit to the State Insurance Commissioner an annual financial statement in the same manner as a domestic insurance carrier. The Insurance Commissioner ~~may audit~~ <u>shall examine</u> the State Insurance Fund in the same manner as a domestic insurance company. The State Insurance Fund Commissioner shall provide a copy of the annual financial statement to the Governor and State Insurance Fund Board of Managers.

SECTION 12. AMENDATORY 36 O.S. 1991, Section 624, is amended to read as follows:

Section 624. Every insurance company, <u>including the State Insurance Fund,</u> copartnership, insurance association, interinsurance exchange, person, insurer, nonprofit hospital service and medical indemnity corporation, or health maintenance organization, doing business in the State of Oklahoma in the execution or exchange of contracts of insurance, indemnity or health maintenance services, or as an insurance company of any nature or character whatsoever, hereinafter referred to in this article as an insurance company, or company, shall, annually, on or before the last day of February, report under oath of the president or secretary or other chief officer of such company to the Insurance Commissioner, the total amount of direct written premiums, membership, application, policy and/or registration fees charged during the preceding calendar year,

or since the last return of such direct written premiums, membership, application, policy and/or registration fees was made by such company, from insurance of every kind upon persons or on the lives of persons resident in this state, or upon real and personal property located within this state, and/or upon any other risks insured within this state, provided, that with respect to the tax payable annually, considerations received for annuity contracts and payments received by a health maintenance organization from the Secretary of Health and Human Services pursuant to a contract issued under the provisions of 42 U.S.C., Section 1395 mm(g) shall no longer be deemed to be premiums for insurance and shall no longer be subject to the tax imposed by this section. Every such company shall, at the same time, pay to the Insurance Commissioner:

(1) An annual license fee as prescribed by Section 321 of this Code, except for the State Insurance Fund, and Health Maintenance Organizations which shall pay the annual license fee provided for in Section 2504 of Title 63 of the Oklahoma Statutes; and

(2) An annual tax on all of said direct written premiums after all returned premiums are deducted, and on all membership, application, policy and/or registration fees collected thereby, for the privileges of having written, continued and/or serviced insurance on lives, property and/or other risks in this state and of having made and serviced investments therein during the then expiring license year except premiums or fees paid by any county, city, town or school district funds or by their duly constituted authorities performing a public service organized pursuant to Sections 1001 through 1008 of Title 74 of the Oklahoma Statutes, or Sections 176 through 180.4 of Title 60 of the Oklahoma Statutes. Provided, no deduction shall be made from premiums for dividends paid to policyholders. The rate of taxation for calendar year 1988 shall be three percent (3%). For all subsequent calendar years, the rate of taxation for all entities subject to said tax shall be two

and twenty-five one-hundredths percent (2.25%). No tax shall be levied upon any assessment or policy fee collected during calendar years 1990 and 1991 in response to the requirements of the Insurance Commissioner pursuant to subsection A or subsection B of Section 1509 of this title provided, such funds are used for the sole purpose of paying losses and associated expenses. If any insurance company or other entity uses such funds for any purpose other than payment of losses and associated expenses, such entity shall be liable for the taxes levied pursuant to the provisions of this section which would have been otherwise levied and collected, including interest thereon at a rate equal to the annual average interest rate earned on state funds by the State Treasurer during such tax period.

For all insurance companies or other entities taxed pursuant to this section, the annual license fee and tax and all required membership, application, policy, registration, and agent appointment fees shall be in lieu of all other state taxes or fees, except those taxes and fees provided for in the Insurance Code and in Sections 2501 through 2510 of Title 63 of the Oklahoma Statutes, and the taxes and fees of any subdivision or municipality of the state, except ad valorem taxes and the tax required to be paid pursuant to Section 50001 of Title 68 of the Oklahoma Statutes. Any company, except the State Insurance Fund and health maintenance organizations, failing to make such returns and payments promptly and correctly shall forfeit and pay to the Insurance Commissioner, in addition to the amount of said taxes and fees, the sum of Five Hundred Dollars ($500.00); and the company so failing or neglecting for sixty (60) days shall thereafter be debarred from transacting any business of insurance in this state until said taxes, fees and penalties are fully paid, and the Insurance Commissioner shall revoke the license or certificate of authority granted to the agent or agents of that company to transact business in this state.

Provided, that when any such insurance company, copartnership, insurance association, interinsurance exchange, person, insurer, or nonprofit hospital service and indemnity corporation, applies for the first time for a license to do business in Oklahoma, it shall, at the time of making such application, pay a license fee as prescribed by Section 1425 of Article 14A of this Code, and, on or before the last day of February, following, pay the premium tax, membership, application, policy, registration, and agent appointment fees, as hereinbefore provided. Such license fee, tax and membership, application, policy, registration, and appointment fees shall be in lieu of all other state taxes or fees, except those taxes and fees provided for in the Insurance Code, and the taxes and fees of any subdivision or municipality of the state, except ad valorem taxes and the tax required to be paid pursuant to Section 50001 of Title 68 of the Oklahoma Statutes.

Any health maintenance organization failing to file premium tax returns and payments promptly and correctly shall forfeit and pay to the Insurance Commissioner, in addition to the amount of said taxes, the sum of Five Hundred Dollars ($500.00). Any health maintenance organization failing or neglecting to pay said tax and penalty shall be debarred from operating in this state and the State Department of Health shall revoke the license of the health maintenance organization, until said taxes and penalties are fully paid.

SECTION 13. This act shall become effective September 1, 1994.

44-2-8638 PS